

RUC Recommendations For CPT 2005

RUC Meetings
September 2003, February 2004 and
April 2004

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2005**

TABLE OF CONTENTS

Anesthesia Procedures- Congenital Heart Infant Bypass	1
Tissue Debridement of Genitalia for Gangrene	2
Placement of Breast Radiotherapy: Afterloading Balloon Catheter	3
Osteochondral Procedures	4
Laryngoscopic Excision of Microscopic Non-Neoplastic Lesions	5
Bronchoscopy Stent Revisions, Endobronchial Ultrasound	6
Chronic Indwelling Pleural Catheter	7
Lung Transplantation	8
Heart-Lung, Heart Transplantation	9
Endovascular Graft for Abdominal Aortic Aneurysm	10
Endovenous Ablation Therapy	11
Upper Arm Cephalic Vein Transposition	12
Carotid Stenting	13
Endoscopic Anti-Reflux Procedures (STRETTA) for GERD	14
Gastric Restrictive Procedures	15
Intestine Transplantation	16
Proximal to Splenic Flexure Colonoscopy Aspiration Biopsy	17
Liver Transplantation	18
Stapling Hemorrhoidopexy	19
Pancreas Transplantation	20

Kidney Transplantation	21
Renal Pelvis – Ureter Therapeutic Agents Instillation	22
Pelvic Floor Defect Graft Repair	23
Vaginal Extra and Intraperitoneal Colpopexy	24
Endometrial Cryoablation Therapy	25
Hysteroscopic Fallopian Tube Cannulation and Placement of Permanent Implants	26
BSO Omentectomy with TAH for Malignancy	27
Cervical Laminoplasty	28
Osteoplastic Laminectomy	29
Ciliary Endoscopic Ablation	30
Dual X-Ray Absorptionmetry for Vertebral Assessment	31
Ophthalmic Ultrasound	A
Doppler Velocimetry Umbilical and Middle Cerebral Arteries	B
Radiopharmaceutical Therapy	C
Position Emission Tomography and Computed Procedures	D
Protein Electrophoresis	E
Flow Cytometry	F
In Situ Hybridization (eg, FISH) Procedures	G
Pediatric Specific Immunization Administration	H
Gastroesophageal Reflux Procedures and Esophagus – GE Junction Impedance Test	I
Esophageal Balloon Provocation	J
Rectal Barostat Sensation Test	K
ECG Vest	L

Intracranial Artery Transcranial Doppler Studies	M
High Altitude Hypoxia Simulation Test	N
Central Motor Evoked Potential Study	O
Complex Deep Brain Neurostimulator Generator – Transmitter Electronic Analysis	P

June 11, 2004

Terry Kay
Deputy Director
Hospital and Ambulatory Policy Group
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard, C4-01-15
Baltimore, Maryland 21244

Dear Mr. Kay,

The American Medical Association (AMA) staff has discovered that while the electronic copy of the AMA/Specialty Society RVS Update Committee recommendations for CPT 2005 submitted to the Centers for Medicare and Medicaid Services is complete, the paper copy of the submission was incomplete for the following issues:

- Placement of Breast Radiotherapy: Afterloading Balloon Catheter
- Position Emission Tomography and Computed Procedures
- Pediatric Specific Immunization Administration

Enclosed is the second paper submission of the recommendations for the above issues in their entirety. Please replace the original tabs with the newly provided tabs, ~~accordingly~~. You may contact Roseanne Eagle with any questions regarding this submission.

Sincerely,

cc: Ken Simon, MD
Rick Ensor
Edith Hambrick, MD
Marc Hartstein
Carolyn Mullen
Pam West, PT
Sherry Smith
Patrick Gallagher

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

May 27, 2004

Terry Kay
Deputy Director
Hospital and Ambulatory Policy Group
Center for Medicare Management
Centers for Medicare and Medicaid Services
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 2005. Also included in this submission are the practice expense refinement recommendations for existing CPT 2004 codes. The RUC is also re-submitting our previous recommendations for Excision of Lesions and Analysis of Spine Infusion Pumps as discussed in this letter and attachments. The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board is separately forwarding its recommendations to you, as well.

CPT 2005 New and Revised Codes

Enclosed is one binder of RUC recommendations for new and revised codes. The total number of coding changes for CPT 2005 is 236, including 133 additions, 77 revisions, and 26 deletions. Thirty-seven of these coding changes are not payable on the RBRVS (eg, laboratory services and vaccines), and accordingly, the RUC does not submit any information on these codes. In addition, eleven 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 143 recommendations at this time. Included in our submission are recommendations to reaffirm our previous work on immunization administration and to newly value new pediatric specific codes. **We urge CMS to include work relative values for all of these administration codes in conjunction with your work on other drug administration codes for 2005..**

The RUC is recommending that eight codes be carrier-priced in 2005, until the RUC has further opportunity to review data for these services. The RUC will not be submitting

Terry Kay
May 27, 2004
Page Two

relative value recommendations for several of the transplantation donor codes as we understand that CMS is still considering whether to include these services on the Medicare Physician Payment Schedule. In addition, the RUC is unable to provide recommendations for flow cytometry and In Situ Hybridization services at this time. The summary table in the attached binder, and in the enclosed diskette, specifically identifies the services to be reviewed at the September 2004 RUC meeting. We will send any new information to CMS immediately following the meeting.

Also included in this binder, and on the enclosed CD-ROM, are physician time data for each of the CPT codes reviewed at the September 2003, February 2004, and April 2004 RUC meetings. We will be sending you a comprehensive revision to the entire RUC database for physician time by June 30. 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 more than 2,000 existing CPT codes. Included in these recommendations are the PEAC refinements for all of the radiology services. The PEAC has identified less than 200 CPT codes that have not yet been reviewed and refined. The RUC will review these services at our September 2004 and February 2005 meetings and submit these refinement recommendations to you in Spring 2005.

Cost estimates for medical supplies and equipment not listed on "CMS's Labor, Supply, and Equipment List for the Year 2004" are based on provided source(s) as noted, such as manufacturer's catalogue prices and may not reflect the wholesale prices, quantity or cash discounts, prices for used equipment or any other factors which may alter the cost estimates.

Excision of Lesions

In CPT 2003, the CPT Editorial Panel modified the reporting of the excision of benign and malignant lesion CPT codes 11400-11446 and 11600-11646 utilizing the size of the actual skin removed, rather than the size of the lesion only. The RUC then reviewed a proposal from the specialties who perform these services to adjust the work relative values for work neutrality only. CMS agreed with this approach and published the RUC's recommendations in the Final Rule for the 2003 Physician Payment Schedule.

However, in *Proposed Rule* for the 2004 MFS, CMS indicated that they believe the work relative values for the excision of benign and malignant lesions of the same size should be

Terry Kay
May 27, 2004
Page Three

equivalent. CMS proposed to utilize a weighted average approach for each code pair to establish new equivalent work relative value units. The RUC and several specialties commented in opposition to this proposal and requested CMS to seek additional input on this issue. In the *Final Rule* for the 2004 MFS, CMS agreed to postpone consideration of this issue until the specialties had opportunity to survey these codes and present data to the RUC.

The specialties provided an update to the RUC at the January 2004 meeting. The specialties indicated that they plan to survey a representative number of codes from each family of codes to offer evidence that there is a difference in physician work between the excision of benign and malignant lesions. The RUC extensively discussed this issue and raised a number of issues including whether pathology is known prior to the excision and if coding changes would be appropriate to change benign/malignant to superficial/deep. The RUC approved a methodology where the societies would survey one benign and malignant code from each of the three anatomic families (six codes total) to answer the question whether there is a difference in physician work.

After discussions at the January 2004 RUC meeting, specialty society Advisors from the specialties of dermatology, general surgery, otolaryngology, plastic surgery, and podiatry agreed to survey one code from each of the six benign/malignant excision code families. Common vignettes and a common reference list were developed. All six codes were surveyed by dermatology, general surgery, and plastic surgery societies. The two codes that reference *feet* (11423 and 11623) were surveyed by podiatry (utilizing an anatomical variation to the vignette). The four codes that reference *scalp* and *face* (11423, 11443, 11623, and 11643) were surveyed by otolaryngology. The survey data, presented as Attachments A and B, clearly show that for each anatomical benign/malignant code pair, the total time, intra-time, and estimated work-RVU for excising a malignant lesion is *greater* when compared with excising a similar diameter benign lesion. The survey vignettes are shown in Attachment C. The reference table is shown in Attachment D.

We believe that the results of these surveys respond to CMS' request to prove that there is a difference in physician work for excising benign and malignant lesions with similar diameters. **The RUC submits the attached survey results to CMS as substantiation to reaffirm the RUC's previous work-relative value recommendations from the April 2002 meeting.**

The RUC did consider comments from the American Academy of Family Physicians regarding a request to further clarify the CPT descriptors for these services. The RUC understands that there may be inconsistent payment policies regarding whether one must wait for a pathology report prior to submitting claims for these services. The RUC suggests that specialties pursue this issue with the CPT Editorial Panel if they believe it to be necessary. The CPT Editorial Panel did discuss this issue at their May 2004 meeting and understands

Terry Kay
May 27, 2004
Page Four

that representatives from Dermatology will submit language to the Panel to clarify the guidelines for these services.

Analysis of Spine Infusion Pumps

The Medicare Physician Payment Schedule has assigned relative values for CPT Code 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* and CPT Code 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* for only the professional component. For reasons unknown, the technical component and the global service are carrier priced (Status C). The RUC reviewed these services in April 1995 for work and in March 2003 for practice expense inputs (previous recommendations are attached). **The RUC requests that CMS consider the RUC's previous recommendations (attached) in establishing relative value units for all components of CPT codes 62367 and 62368.**

On a personal note, I would like to congratulate you on your recent promotion to Deputy Director of Office of Clinical Standards and Quality. The quality of staff that CMS sends to our RUC meetings, and those with whom directly liaison with on RBRVS issues, is exceptional, and you have always been a valued member of that team. We will miss interacting with you on physician payment issues, but look forward to your continued contributions in the coverage area.

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

Sincerely,

A handwritten signature in cursive script, appearing to read "William Rich, MD".

William Rich, MD

cc: Ken Simon, MD
Rick Ensor
Edith L Hambrick MD
Marc Hartstein
Carolyn Mullen
Pam West, PT
Sherry Smith
Patrick Gallagher
RUC Members

April 5, 2004

William L. Rich III, MD, FACS
Chair, AMA/Relative Value Update Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Re: Excision of Benign and Malignant Lesions

Dear Dr. Rich:

The undersigned RUC Specialty Advisors are pleased to present the results of a survey for physician work for six of the 36 codes in the excision of benign/malignant lesion family of codes (CPT codes 11400-11646). Below is a very brief chronological presentation of CPT, RUC, and CMS activities, relative to these codes, since November 2001. This is followed by our recommendation to the RUC.

November 2001

At the November 2001 CPT meeting, the Editorial Panel modified the reporting of the excision of benign and malignant lesion CPT codes 11400-11446 and 11600-11646. Code selection was changed from measuring the lesion to measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (i.e., lesion diameter plus the most narrow margins required equal the excised diameter).

April 2002

At the April 2002 RUC meeting, societies representing the specialties of dermatology, family practice, general surgery, and plastic surgery proposed adjustments to the work-RVUs for CPT codes 11400-11646 to account for expected changes in reporting. A mathematical model was presented to the RUC that: 1) Estimated 30% of benign lesions and 50% of malignant lesions would be reported with the next higher code as a result of the change in descriptors; 2) Maintained the relative ratio between codes within each family; and 3) Maintained budget neutrality within each family. The RUC agreed with this proposal and recommended to CMS the following work-RVUs for codes 11400-11646:

11400	0.85	11420	0.98	11440	1.06	11600	1.31	11620	1.19	11640	1.35
11401	1.23	11421	1.42	11441	1.48	11601	1.80	11621	1.76	11641	2.16
11402	1.51	11422	1.63	11442	1.72	11602	1.95	11622	2.09	11642	2.59
11403	1.79	11423	2.01	11443	2.29	11603	2.19	11623	2.61	11643	3.10
11404	2.06	11424	2.43	11444	3.14	11604	2.40	11624	3.06	11644	4.03
11406	2.76	11426	3.78	11446	4.49	11606	3.43	11626	4.30	11646	5.95

December 2002

In the December 31, 2002 *Final Rule*, CMS indicated that they agreed with the RUC work-RVU recommendations for codes 11400-11646.

August 2003

In the August 15, 2003 *Proposed Rule*, CMS reversed its December 2002 decision and indicated that they believed the work-RVUs for the excision of benign and malignant lesions of the same size should be equivalent. CMS proposed to utilize a weighted average approach for each code pair to establish new equivalent work-RVUs.

December 2003

After the September 2003 RUC meeting, a comment letter was sent by the RUC to CMS that indicated that despite the former opinion of both the CPT Editorial Panel and the RUC, CMS staff continued to view the physician work in the excision of benign and malignant lesions to be equivalent. The RUC urged CMS to delay finalizing their proposed work-RVU changes until the RUC had the opportunity to provide further recommendations related to these services.

November 2003

In the November 7, 2003 *Final Rule*, CMS indicated that "...*We still believe that the physician work for these services is sufficiently similar not to warrant differences in the work RVUs. However, we will maintain the 2003 work RVUs as interim values for 2004 to allow opportunity for the specialty to resurvey these services.*"

January – April 2004 (Current)

After discussions at the January 2004 RUC meeting, society Advisors from the specialties of dermatology, general surgery, otolaryngology, plastic surgery, and podiatry agreed to survey one code from each of the six benign/malignant excision code families. Common vignettes and a common reference list were developed during conference calls (that included AMA staff). All six codes were surveyed by dermatology, general surgery, and plastic surgery societies. The two codes that reference *feet* (11423 and 11623) were surveyed by podiatry (utilizing an anatomical variation to the vignette). The four codes that reference *scalp* and *face* (11423, 11443, 11623, and 11643) were surveyed by otolaryngology. The survey data, presented as Attachments A and B, clearly show that for each anatomical benign/malignant code pair, the total time, intra-time, and estimated work-RVU for excising a malignant lesion is *greater* when compared with excising a similar diameter benign lesion. The survey vignettes are shown in Attachment C. The reference table is shown in Attachment D.

We believe that the results of these surveys respond to CMS' request to prove that there is a difference in physician work for excising benign and malignant lesions with similar diameters. **We recommend that the RUC submit the attached survey results to CMS as substantiation to reaffirm the RUC's previous work-RVU recommendations from the April 2002 meeting.** Advisors from each of the specialty societies that participated in this survey process look forward to discussing the survey results with the RUC at the upcoming April 2004 meeting.

Sincerely,

Thomas G. Olsen, MD
RUC Advisor, AAD

Charles P. Shoemaker, MD, FACS
RUC Advisor, ASGS

James C. Denny III, MD, FACS
RUC Advisor, AAOHNS

Marc Lenet, DPM
HCPAC Advisor, APMA

Charles D. Mabry, MD, FACS
RUC Advisor, ACS

Keith E. Brandt, MD, FACS
RUC Advisor, ASPS

Attachments

Attachment A1: Cover for Data Summary Tables

The first table (page 1) compares Harvard data and the Survey data. The second table (page 2) compares the survey summary data for all specialties and by specialty category.

COLUMN DEFINITIONS

Column	Header	Description of Column
A	Data Source	Source is either Harvard or RUC, as indicated.
B	CPT	CPT code number
C	Svy Resp	Number of completed surveys
D	IWPUT	intra-work per unit time (i.e., intensity)
E	RVW-min	Minimum RVW.
F	RVW-25th	25th percentile RVW
G	RVW-med	Median RVW
H	RVW-75th	75th percentile RVW
I	RVW-max	Maximum RVW
J	Total Time	Total Harvard or RUC physician time in minutes.
K	PRE-eval	Median pre-service evaluation time in minutes
L	PRE-posit	Median pre-service positioning time in minutes
M	PRE-s,d,w	Median pres.-service scrub, dress, wait time in minutes
N	INTRA-min	Minimum intra-service time in minutes.
O	INTRA-25th	25th percentile intra-service time in minutes
P	INTRA-med	Median intra-service time in minutes
Q	INTRA-75th	75th percentile intra-service time in minutes
R	INTRA-max	Maximum intra-service time in minutes
S	POST-Im-SD	Median immediate same day post-service time in minutes.
T	OV-13	Median number of postop office visits at level 99213
U	OV-12	Median number of postop office visits at level 99212

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	Data	Svy			RVW					TOTAL	PRE			INTRA					POST	OV	OV
2	Source	CPT	Resp	IWPUT	min	25th	med	75th	max	TIME	eval	posit	s,d,w	min	25th	med	75th	max	Im-SD	-13	-12
3	Hvd	11403		0.034			1.79			57	7					31			7		1
4	Hvd	11603		0.041			2.19			61	9					33			9		1
5	RUC	11403	63	0.050	1.01	1.95	2.15	2.40	4.50	70	15	5	5	5	15	20	30	60	10		1
6	RUC	11603	63	0.048	1.50	2.38	2.70	3.50	6.32	85	20	5	5	5	20	30	35	75	10		1
7	Hvd	11423		0.041			2.01			54	6					32			6		1
8	Hvd	11623		0.049			2.61			64	9					36			9		1
9	RUC	11423	101	0.028	0.30	2.10	2.37	3.08	4.50	82	17	5	10	5	20	25	30	90	10		2
10	RUC	11623	100	0.046	1.92	2.84	3.33	4.26	7.00	100	25	5	10	3	25	30	45	120	15		2
11	Hvd	11443		0.039			2.29			67	7					40			7		1
12	Hvd	11643		0.046			3.10			83	11					47			11		1
13	RUC	11443	71	0.050	1.76	2.43	2.75	3.75	6.00	88	18	5	10	5	20	30	40	90	10		1
14	RUC	11643	71	0.049	1.80	3.30	3.90	5.38	8.00	110	25	5	10	10	26	40	55	120	15		2
15																					

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	Data	Svy			RVW					TOTAL	PRE			INTRA					POST	OV	OV
2	Source	CPT	Resp	IWPUT	min	25th	med	75th	max	TIME	eval	posit	s,d,w	min	25th	med	75th	max	Im-SD	-13	-12
16	SURVEY DETAILS: TOTAL and by SPECIALTY CATEGORY																				
17	total	11403	63	0.050	1.01	1.95	2.15	2.40	4.50	70	15	5	5	5	15	20	30	60	10		1
18	DERM	11403	25	0.050			2.15			70	15	5	5			20			10		1
19	SURG	11403	38	0.048			2.11			70	15	5	5			20			10		1
20																					
21	total	11603	63	0.048	1.50	2.38	2.70	3.50	6.32	85	20	5	5	5	20	30	35	75	10		1
22	DERM	11603	25	0.028			2.50			85	25	5	5			25			10		2
23	SURG	11603	38	0.056			2.98			90	20	5	10			30			10		1
24																					
25	total	11423	101	0.028	0.30	2.10	2.37	3.08	4.50	82	17	5	10	5	20	25	30	90	10		2
26	DERM	11423	27	0.033			2.40			76	15	5	6			25			10		2
27	POD	11423	19	0.015			2.31			97	20	5	12			30			15		2
28	SURG	11423	55	0.046			2.39			82	17	5	10			25			10		1
29																					
30	total	11623	100	0.046	1.92	2.84	3.33	4.26	7.00	100	25	5	10	3	25	30	45	120	15		2
31	DERM	11623	28	0.063			3.28			92	25	5	7			30			10	1	1
32	POD	11623	19	0.032			2.93			118	30	5	12			38			18	1	1
33	SURG	11623	53	0.068			3.50			97	22	5	10			30			15		1
34																					
35	total	11443	71	0.050	1.76	2.43	2.75	3.75	6.00	88	18	5	10	5	20	30	40	90	10		1
36	DERM	11443	20	0.039			2.50			74	13	5	6			25			10		2
37	SURG	11443	51	0.053			3.00			95	20	5	10			30			15		1
38																					
39	total	11643	71	0.049	1.80	3.30	3.90	5.38	8.00	110	25	5	10	10	26	40	55	120	15		2
40	DERM	11643	19	0.084			3.80			90	20	5	10			30			10	1	1
41	SURG	11643	52	0.063			4.05			110	25	5	10			40			15		1

Attachment D: Complexity / Intensity Comparison

CPT Code: 11403

Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm

KEY REFERENCE SERVICE(S):

CPT	Descriptor	RVW	Glob
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	1.70	010
12031	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less	2.15	010

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

	SVY	REF 1	SVY	REF 2
CPT Code	11403	12001	11403	12031
MFS RVW	1.79	1.70	1.79	2.15
Harvard Total Time	57	36	57	45
Survey Median RVW	2.15		2.15	
Survey Total Time	70		70	

INTENSITY/COMPLEXITY MEASURES (MEAN)

Respondents who chose key reference code	14	14	10	10
--	----	----	----	----

TIME SEGMENTS

Pre-service	1.75	1.55	2.70	2.70
Intra-service	1.92	1.64	2.90	2.70
Post-service	1.33	1.36	2.50	2.50

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.00	1.27	3.10	2.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	1.36	2.40	2.30
Urgency of medical decision making	1.67	1.82	2.70	2.80

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.25	1.91	2.90	2.80
Physical effort required	1.67	1.64	2.90	2.80

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	1.75	1.64	2.60	2.50
Outcome depends on the skill and judgment of physician	2.08	1.91	3.10	3.00
Estimated risk of malpractice suit with poor outcome	2.08	1.91	2.80	2.80

Attachment D: Complexity / Intensity Comparison

CPT Code: 11423

Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm

KEY REFERENCE SERVICE(S):

CPT	Descriptor	RVW	Glob
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	1.70	010

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

	SVY	REF 1
CPT Code	11423	12001
MFS RVW	2.01	1.70
Harvard Total Time	54	36
Survey Median RVW	2.37	
Survey Total Time	82	

INTENSITY/COMPLEXITY MEASURES (MEAN)

Respondents who chose key reference code	17	17
--	----	----

TIME SEGMENTS

Pre-service	2.53	2.12
Intra-service	2.82	2.53
Post-service	2.47	2.24

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.76	2.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.88	2.25
Urgency of medical decision making	2.50	2.25

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.06	2.81
Physical effort required	2.56	2.38

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.88	2.56
Outcome depends on the skill and judgment of physician	3.06	2.63
Estimated risk of malpractice suit with poor outcome	2.75	2.25

Attachment D: Complexity / Intensity Comparison

CPT Code: 11443

Descriptor: Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm

KEY REFERENCE SERVICE(S):

CPT	Descriptor	RVW	Glob
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	1.70	010

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

	SVY	REF 1
CPT Code	11443	12001
MFS RVW	2.29	1.70
Harvard Total Time	67	36
Survey Median RVW	2.75	
Survey Total Time	88	

INTENSITY/COMPLEXITY MEASURES (MEAN)

Respondents who chose key reference code	17	17
--	----	----

TIME SEGMENTS

Pre-service	3.06	2.59
Intra-service	3.24	3.12
Post-service	2.65	2.59

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.31	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.65	2.24
Urgency of medical decision making	2.41	2.29

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.35	3.12
Physical effort required	2.88	2.88

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.59	2.88
Outcome depends on the skill and judgment of physician	3.65	3.24
Estimated risk of malpractice suit with poor outcome	3.47	2.76

Attachment D: Complexity / Intensity Comparison

CPT Code: 11603

Descriptor: Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm

KEY REFERENCE SERVICE(S):

CPT	Descriptor	RVW	Glob
12031	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less	2.15	010
23075	Excision, soft tissue tumor, shoulder area; subcutaneous	2.39	010

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

	SVY	REF 1	SVY	REF 2
CPT Code	11603	12031	11603	23075
MFS RVW	2.19	2.15	2.19	2.39
Harvard Total Time	61	45	61	92
Survey Median RVW	2.70		2.70	
Survey Total Time	85		85	

INTENSITY/COMPLEXITY MEASURES (MEAN)

Respondents who chose key reference code	10	10	10	10
--	----	----	----	----

TIME SEGMENTS

Pre-service	3.44	3.44	3.40	2.90
Intra-service	3.56	3.44	3.50	3.10
Post-service	3.78	3.56	2.90	2.70

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.22	3.60	2.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	2.89	3.50	2.90
Urgency of medical decision making	3.56	3.22	3.40	2.70

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.56	3.33	3.40	2.90
Physical effort required	3.33	3.11	3.10	2.80

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.89	3.22	3.70	2.90
Outcome depends on the skill and judgment of physician	4.22	3.78	3.50	3.00
Estimated risk of malpractice suit with poor outcome	4.11	3.44	3.60	2.90

Attachment D: Complexity / Intensity Comparison

CPT Code: 11623

Descriptor: Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm

KEY REFERENCE SERVICE(S):

CPT	Descriptor	RVW	Glob
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	1.70	010
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	4.32	010

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

	SVY	REF 1	SVY	REF 2
CPT Code	11623	12001	11623	13121
MFS RVW	2.61	1.70	2.61	4.32
Harvard Total Time	64	36	64	114
Survey Median RVW	3.33		3.33	
Survey Total Time	100		100	

INTENSITY/COMPLEXITY MEASURES (MEAN)

Respondents who chose key reference code	12	12	12	12
--	----	----	----	----

TIME SEGMENTS

Pre-service	3.58	3.17	3.00	2.55
Intra-service	4.17	3.83	3.00	2.91
Post-service	3.25	3.00	2.36	2.27

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.25	2.91	2.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.17	2.75	2.55	2.18
Urgency of medical decision making	3.67	3.17	2.82	2.45

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.00	3.92	3.09	2.82
Physical effort required	3.58	3.58	2.91	2.73

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.08	3.58	3.10	2.64
Outcome depends on the skill and judgment of physician	4.42	4.08	3.18	2.82
Estimated risk of malpractice suit with poor outcome	4.00	3.33	3.00	2.73

Attachment D: Complexity / Intensity Comparison

CPT Code: 11643

Descriptor: Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm

KEY REFERENCE SERVICE(S):

CPT	Descriptor	RVW	Glob
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	3.78	010
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	6.32	010

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

	SVY	REF 1	SVY	REF 2
CPT Code	11643	13131	11643	13152
MFS RVW	3.10	3.78	3.10	6.32
Harvard Total Time		94		138
Survey Median RVW	3.90		3.90	
Survey Total Time	110		110	

INTENSITY/COMPLEXITY MEASURES (MEAN)

Respondents who chose key reference code	12	12	12	12
--	----	----	----	----

TIME SEGMENTS

Pre-service	3.67	2.92	3.56	3.22
Intra-service	3.83	3.75	3.67	3.44
Post-service	3.33	2.92	3.38	2.78

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.58	3.00	3.67	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.42	2.50	3.11	2.33
Urgency of medical decision making	3.42	2.75	3.33	3.22

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.75	3.75	3.89	3.67
Physical effort required	3.42	3.42	3.44	3.33

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.00	3.08	3.78	3.33
Outcome depends on the skill and judgment of physician	4.17	3.92	4.11	3.78
Estimated risk of malpractice suit with poor outcome	3.92	3.33	4.11	3.44

Attachment D: Survey Reference List

CPT	CPT Long Descriptor	MFS RVW	Global Period
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	0.17	XXX
11101	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)	0.41	ZZZ
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.	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 patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.	0.45	XXX
11900	Injection, intralesional; up to and including seven lesions	0.52	0
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion	0.60	10
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	0.67	0
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	0.67	XXX
17340	Cryotherapy (CO2 slush, liquid N2) for acne	0.76	10
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	0.77	10
11901	Injection, intralesional; more than seven lesions	0.80	0
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	0.81	0
11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter, 0.6 to 1.0 cm	0.85	0
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.	0.88	XXX

Attachment D: Survey Reference List

CPT	CPT Long Descriptor	MFS RVW	Global Period
99214	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.	1.10	XXX
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	1.17	10
10080	Incision and drainage of pilonidal cyst; simple	1.17	10
10040	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	1.18	10
69540	Excision aural polyp	1.20	10
10120	Incision and removal of foreign body, subcutaneous tissues; simple	1.22	10
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.	1.34	XXX
67800	Excision of chalazion; single	1.38	10
11313	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm	1.62	0
41100	Biopsy of tongue; anterior two-thirds	1.63	10
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	1.70	10
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	1.76	10
68110	Excision of lesion, conjunctiva; up to 1 cm	1.77	10
11750	Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;	1.86	10
67801	Excision of chalazion; multiple, same lid	1.88	10
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; 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 45 minutes face-to-face with the patient and/or family.	2.00	XXX
21550	Biopsy, soft tissue of neck or thorax	2.06	10
21920	Biopsy, soft tissue of back or flank; superficial	2.06	10
12031	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less	2.15	10
12004	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm	2.24	10
23065	Biopsy, soft tissue of shoulder area; superficial	2.27	10
27323	Biopsy, soft tissue of thigh or knee area; superficial	2.28	10
40812	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	2.31	10

Attachment D: Survey Reference List

CPT	CPT Long Descriptor	MFS RVW	Global Period
68115	Excision of lesion, conjunctiva; over 1 cm	2.36	10
12041	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less	2.37	10
23075	Excision, soft tissue tumor, shoulder area; subcutaneous	2.39	10
57130	Excision of vaginal septum	2.43	10
10081	Incision and drainage of pilonidal cyst; complicated	2.45	10
12014	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm	2.46	10
12051	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	2.47	10
11770	Excision of pilonidal cyst or sinus; simple	2.61	10
57135	Excision of vaginal cyst or tumor	2.67	10
10121	Incision and removal of foreign body, subcutaneous tissues; complicated	2.69	10
23031	Incision and drainage, shoulder area; infected bursa	2.74	10
27040	Biopsy, soft tissue of pelvis and hip area; superficial	2.87	10
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm	3.12	10
12044	Layer closure of wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm	3.14	10
19101	Biopsy of breast; open, incisional	3.18	10
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	3.30	10
12035	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm	3.42	10
12054	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm	3.45	10
38500	Biopsy or excision of lymph node(s); open, superficial	3.74	10
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	3.78	10
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	3.80	10
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm	3.91	10
12007	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm	4.11	10
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	4.32	10
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm	4.44	10
12017	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm	4.70	10
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	5.94	10
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	6.32	10



American Academy of Dermatology Association

May 13, 2004

William Rich, M.D.
Chair, RVS Update Committee (RUC)
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Dr. Rich:

The undersigned specialty societies request that the recommendations by the Centers for Medicare and Medicaid Services regarding the work relative value units (work-RVUs) for excision of benign and malignant skin lesions, codes 11400-11446 and 11600-11646 be placed for discussion on the January 04 RUC agenda. The CMS recommendations are counter to those put forward by the RUC in response to changes in the code descriptors as approved by the CPT Editorial Panel in 2001.

At its November 2001 meeting, the CPT Editorial Panel approved a proposal to change the descriptors for the excision of skin lesion codes. The revised descriptors approved by the Editorial Panel base code selection on the size of the lesion plus the narrowest margin required to adequately excise the lesion. The Editorial Panel made this change to recognize the increased physician work when certain tumors require much wider margins of excision than tumors of similar clinical size but different pathology. A certain percentage of procedures are expected to upshift to the next higher code because of this descriptor change.

In 2002 the RUC recognized that in order to maintain work and budget neutrality, a readjustment in the work-RVUs of these codes is indicated. The excision codes have an established relativity within families. At that time, it was felt that a new, standard RUC survey would potentially disrupt this relativity within families and would not maintain budget neutrality. Representatives from the Centers for Medicare and Medicaid Services (CMS) shared these concerns. Accordingly, a mathematical model that maintained current relativity and work/budget neutrality based on projections of the upshift in code selection was presented and agreed to by all of the specialties with significant utilization patterns for these codes.

The model assumed that the relative ratio between codes within each family is correct and should be maintained. It also assumed that the total work-RVUs for each family should be budget neutral. The model maintained the relativity within families and the total work-RVUs for each family remained budget neutral. It was proposed that actual CMS data, gathered after the new code descriptors were in use, could be used to further refine the work-RVUs, if necessary. However, to date there has been no report issued from CMS to indicate that these assumptions were incorrect. CMS now indicates in the 04 MFS Final Rule that physician work value for these codes must be demonstrated by survey of these codes.

We respectfully request that this issue be placed on the AMA RUC agenda for the January 04 meeting. Thank you for your time and consideration of this request. Because of the busy agenda at the January RUC meeting, it may be useful to also schedule a prefacilitation meeting with CMS and those societies that have commented on this issue. If you or RUC staff have any questions about this matter, please contact Norma Border at the American Academy of Dermatology at 847 240 1814 or nborder@aad.org

Sincerely,

Daniel M. Siegel, M.D.
American Academy of Dermatology

Neil H. Brooks, M.D.
American Academy of Family Physicians

John O. Gage, MD, FACS
American College of Surgeons

John W. Derr, Jr., MD
American Society of Plastic Surgeons

Excerpt from the RUC Comment Letter on the 08/15/2003 Proposed Rule:

Excision of Benign and Malignant Lesions

In *CPT 2003*, the CPT Editorial Panel modified the reporting of the excision of benign and malignant lesion CPT codes 11400-11446 and 11600-11646 utilizing the size of the actual skin removed, rather than the size of the lesion only. The RUC then reviewed a proposal from the specialties who perform these services to adjust the work relative values for work neutrality only. CMS agreed with this approach and published the RUC's recommendations in the Final Rule for the 2003 Physician Payment Schedule.

However, in this Proposed Rule, CMS has indicated that they believe the work relative values for the excision of benign and malignant lesions of the same size should be equivalent. CMS has proposed to utilize a weighted average approach for each code pair to establish new equivalent work relative value units.

The RUC understands that despite the former opinion of both the CPT Editorial Panel and our committee, CMS staff continue to view the physician work in the excision of benign and malignant lesions to be equivalent. We urge CMS to delay finalizing this proposal until the RUC has the opportunity to provide further recommendations related to these services. There are a number of issues that should be addressed related to this proposal. For example, the physician time for each of these code pairs of excision of benign and malignant lesions currently varies, with total physician time for excision of malignant lesion code 18% higher on average than the similar excision of benign lesion code.

Excerpt from the RUC Comment Letter on the 11/7/2003 Final Rule:

Excision of Benign and Malignant Lesions

In *CPT 2003*, the CPT Editorial Panel modified the reporting of the excision of benign and malignant lesion CPT codes 11400-11446 and 11600-11646 utilizing the size of the actual skin removed, rather than the size of the lesion only. The RUC then reviewed a proposal from the specialties who perform these services to adjust the work relative values for work neutrality only. CMS agreed with this approach and published the RUC's recommendations in the Final Rule for the 2003 Physician Payment Schedule.

However, in this Proposed Rule, CMS has indicated that they believe the work relative values for the excision of benign and malignant lesions of the same size should be equivalent. CMS has proposed to utilize a weighted average approach for each code pair to establish new equivalent work relative value units.

In our comments on the *Proposed Rule*, we urged CMS to delay finalizing this proposal until the RUC has the opportunity to provide further recommendations related to these services. CMS has agreed to not act unilaterally on this issue and to, instead, engage the affected specialties through the CPT and RUC processes. We support this decision and have scheduled a discussion of this issue on our January/February 2004 meeting agenda.

outdated because they were based on old data; for example, 1990 decennial census data and 1996 through 1998 malpractice premiums, the most recent data available when the GPCIs for 2001 through 2003 were established. The calculation of the proposed 2004 through 2007 GPCIs will be based upon the same data sources and methodology, but the 2004 through 2007 GPCIs will utilize more current data: 2000 decennial census data, 2000 HUD fair market rental (FMR) data for residential rents, and 1999 through 2003 malpractice premium data. This should address the criticism of the 2001 through 2003 GPCIs being out of date.

a. Proposed Work Geographic Practice Cost Indices

We have not yet received the 2000 decennial census data that will be utilized for the revision of the work GPCIs. For this reason, revisions to the work GPCIs will be included in the proposed rule for calendar year 2005.

b. Proposed Practice Expense Geographic Practice Cost Indices

We have not yet received the 2000 decennial census data that will be utilized for the revision of the majority of the practice expense GPCI. We have obtained 2000 HUD fair market rental (FMR) data for residential rents that is utilized for a portion of the practice expense revision. Since we have not received the primary data upon which practice expense GPCIs are calculated and since the office rent component of the practice expense GPCI has not proven to be a substantially variable component in past GPCI updates and accounts for only approximately 12.0 percent of the total GPCI calculation (phased in over a two year period), we have decided not to revise the practice expense GPCIs now based on our limited data. For these reasons, revisions to the practice expense GPCIs will be included in the proposed rule for calendar year 2005.

c. Proposed Malpractice Geographic Practice Cost Indices

The malpractice GPCI is the most volatile of the three indexes with relatively large variations existing between localities. Malpractice premium data for a \$1 million to \$3 million mature "claims made" policy were collected, with mandatory patient compensation funds considered.

However, due to the recent concerns regarding the escalating cost of professional liability insurance, especially in 2002 and 2003, we will be collecting more recent malpractice premium data. We propose using actual 1999 through 2002 malpractice premium data and projecting the malpractice premium rates for 2003. The methodology for forecasting 2003 medical malpractice premiums will consist of calculating the geometric mean rate of growth between 1999 through 2002 and applying that rate to the 2002 premium. We will also obtain a national aggregate malpractice premium series with which to benchmark the 2003 forecast. At this point, we are still collecting the 2002 malpractice premium data and are thus unable to project 2003 malpractice premium data in this proposed rule. We are proposing to base the malpractice GPCIs upon actual 2001 and 2002 malpractice premium data and projected 2003 malpractice premium data by January 1, 2004. These revised malpractice GPCIs will be published in this year's final physician fee schedule regulation. They will be considered interim and subject to public comment.

9. Payment Localities

We are also interested in receiving comments on the composition of the current Medicare physician payment localities (89 separate payment localities) to which the GPCIs are applied. For additional information regarding the composition of the 89 Medicare physician payment localities please refer to both the July 2, 1996 proposed rule (61 FR 34615) and the November 22, 1996 final rule (61 FR 59494) for the Medicare physician fee schedule.

C. Coding Issues

1. Payment Policy for CPT Tracking Codes

In the November 1, 2001 final rule (66 FR 55269), we stated that carriers have discretion for coverage and payment of services described by CPT tracking codes; also known as CPT Category III codes, unless we have made a national coverage determination (NCD). (These CPT Category III codes are distinct from the HCPCS Level III codes used by local claims processors which are to be discontinued under HIPAA implementation.) We have received several requests to create national

payment amounts for some CPT tracking codes even if there has been no NCD with respect to the services. After review of these requests, we are proposing to change our policy regarding payment for CPT tracking codes.

We propose to create national payment policy and determine national payment amounts for CPT tracking codes when there is a significant programmatic need for us to do so. Such a need could arise, for example, if we receive requests from carrier medical directors that we establish a national payment amount because of carrier inability to do so. This policy change would not change the contractor's discretion over coverage for the CPT tracking codes, but would establish a payment level if the contractor finds that coverage is warranted. Carriers do not need to establish a payment amount for a tracking code until they receive a claim for the code.

2. Excision of Benign and Malignant Lesions

In the CPT 2003 book, the definitions for excision of benign lesions (CPT codes 11400 through 11446 inclusive) and excision of malignant lesions (CPT codes 11600 through 11646 inclusive) were substantively changed. Starting in 2003, these codes are to be reported based on the excised diameter (actual skin removed) rather than on the size of the lesion. We have reviewed the new code descriptors and are proposing to make the work RVUs the same for removal of all skin lesions with the same excised diameters that are from the same area of the body, whether the lesions are benign or malignant. For example, the work RVUs for the removal of benign skin lesions from the trunk, arms or legs with excised diameter 1.1-2.0 cm, CPT code 11402, would be the same as the work RVUs for CPT code 11602, which is the removal of malignant skin lesions from trunk, arms or legs with excised diameter of 1.1-2.0 cm. Therefore, to retain budget neutrality within each code pair, the total work RVUs associated with each code pair will be constant both before and after the work adjustment. We will accomplish this by dividing the total 2003 work RVUs (2003 work RVUs for a given code pair multiplied by 2002 utilization) by the total 2002 utilization for the given code pair. For example:

CPT code	2002 utilization	2003 work RVU	Total work RVUs
11400	69,041	0.65	58,885

CPT code	2002 utilization	2003 work RVU	Total work RVUs
11600	13,756	x 1.31 =	18,036
Total	82,809		76,721

76,721 divided by 82,809 = 0.93 work RVU.

The proposed work RVUs for these
codes follow:

The proposed work RVUs for these codes follow:

TABLE 3

*CPT CODE	Description	2003 work RVU	Proposed Work RVU
11400	Exc tr-ext b9+marg 0.5 < cm	0.85	0.93
11401	Exc tr-ext b9+marg 0.6-1 cm	1.23	1.44
11402	Exc tr-ext b9+marg 1.1-2 cm	1.51	1.72
11403	Exc tr-ext b9+marg 2.1-3 cm	1.79	1.97
11404	Exc tr-ext b9+marg 3.1-4cm	2.06	2.21
11406	Exc tr-ext b9+marg > 4.0 cm	2.76	3.03
11420	Exc h-f-nk-sp b9+marg 0.5 <	0.98	1.01
11421	Exc h-f-nk-sp b9+marg 0.6-1	1.42	1.55
11422	Exc h-f-nk-sp b9+marg 1.1-2	1.63	1.84
11423	Exc h-f-nk-sp b9+marg 2.1-3	2.01	2.28
11424	Exc h-f-nk-sp b9+marg 3.1-4	2.43	2.72
11426	Exc h-f-nk-sp b9+marg > 4 cm	3.78	4.03
11440	Exc face-mm b9+marg 0.5 < cm	1.06	1.16
11441	Exc face-mm b9+marg 0.6-1 cm	1.48	1.89
11442	Exc face-mm b9+marg 1.1-2 cm	1.72	2.31
11443	Exc face-mm b9+marg 2.1-3 cm	2.29	2.86
11444	Exc face-mm b9+marg 3.1-4 cm	3.14	3.78
11446	Exc face-mm b9+marg > 4 cm	4.49	5.57
11600	Exc tr-ext mlg+marg 0.5 < cm	1.31	0.93
11601	Exc tr-ext mlg+marg 0.6-1 cm	1.80	1.44
11602	Exc tr-ext mlg+marg 1.1-2 cm	1.95	1.72
11603	Exc tr-ext mlg+marg 2.1-3 cm	2.19	1.97
11604	Exc tr-ext mlg+marg 3.1-4 cm	2.40	2.21
11606	Exc tr-ext mlg+marg > 4 cm	3.43	3.03
11620	Exc h-f-nk-sp mlg+marg 0.5 <	1.19	1.01
11621	Exc h-f-nk-sp mlg+marg 0.6-1	1.76	1.55
11622	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	1.84
11623	Exc h-f-nk-sp mlg+marg 2.1-3	2.61	2.28
11624	Exc h-f-nk-sp mlg+marg 3.1-4	3.06	2.72
11626	Exc h-f-nk-sp mlg+mar > 4 cm	4.30	4.03
11640	Exc face-mm malig+marg 0.5 <	1.35	1.16
11641	Exc face-mm malig+marg 0.6-1	2.16	1.89
11642	Exc face-mm malig+marg 1.1-2	2.59	2.31
11643	Exc face-mm malig+marg 2.1-3	3.10	2.86
11644	Exc face-mm malig+marg 3.1-4	4.03	3.78
11646	Exc face-mm mlg+marg > 4 cm	5.95	5.57

C. Coding Issues

1. Payment Policy for CPT Tracking Codes

The November 1, 2001 final rule (66 FR 55269) included a discussion of CPT Category III codes (also known as CPT tracking codes) and stated that carriers have discretion for coverage and payment of services described by these CPT tracking codes unless we have made a national coverage determination (NCD). We have received requests to create national payment amounts for some CPT tracking codes even if there has been no NCD. Based on these requests, we proposed to change our policy regarding payment for CPT tracking codes and create national payment policy and determine national payment amounts for CPT tracking codes when there is a significant programmatic need for us to do so. This policy change would not change the contractor's discretion over coverage for the CPT tracking codes, but could establish a payment level to be used if the contractor finds that coverage is warranted. In addition, carriers would not be required to establish a payment amount for a tracking code until they receive a claim for the code.

Comment: Several commenters expressed concerns about this proposal. They believe that establishing a national payment rate for these codes risks premature creation of payment levels of reimbursement and creates an expectation for the future value of the code. The commenters also stated that establishment of a national price could also subvert the RUC process because such pricing could influence subsequent RUC valuation or our acceptance of the RUC's recommendations. Other commenters were supportive of the proposal, with some suggesting that we work with the specialty societies and the RUC in determining appropriate payment rates. One commenter suggested that an alternative to the proposal would be to use the existing refinement panel process because these refinement panels are multispecialty and feature the relevant specialty expertise. One commenter also requested we establish RVUs for specific tracking codes in the final rule.

Response: We understand the reservations and concerns of the commenters. As we indicated in the proposed rule, we would determine national payment amounts for CPT tracking codes only when there is a significant programmatic need for us to do so. If there is a need to establish payment amounts for a tracking code, we would appreciate the assistance of the relevant specialty societies and the

RUC and such pricing would be subject to public comment. However, in some instances, interim values might need to be established if timing does not permit us to obtain prior input from the medical community.

Final Decision

We will finalize our proposal to create national payment policies and determine national payment amounts for CPT tracking codes when there is a significant programmatic need for us to do so. We note that, as discussed in the August 15, 2003 proposed rule, this policy change would not change the contractor's discretion over coverage for CPT tracking codes, but would establish a payment level if the contractor finds that coverage is warranted.

2. Excision of Benign and Malignant Lesions

The definitions for excision of benign lesions (CPT codes 11400 through 11446 inclusive) and excision of malignant lesions (CPT codes 11600 through 11646 inclusive) were substantively changed for 2003. These codes are now reported based on the excised diameter (actual skin removed) rather than on the size of the lesion. Based on these changes to the code descriptors, we proposed to make the work RVUs the same for removal of all skin lesions with the same excised diameters that are from the same area of the body, whether the lesions are benign or malignant. For example, the work RVUs for the removal of benign skin lesions from the trunk, arms or legs with excised diameter 1.1–2.0 cm (CPT code 11402) would be the same as the work RVUs for CPT code 11602, which is the removal of malignant skin lesions from trunk, arms or legs with excised diameter of 1.1–2.0 cm.

Comment: The specialty society representing dermatology objected to this proposal and contended that the excision of malignant lesions generally goes deeper and is more time-consuming than the excision of benign lesions and that malignant lesion excision also requires greater skill and embodies greater risk. The society stated that this proposal ignores a multi-specialty effort by a CPT Integumentary Workgroup, the CPT Editorial Panel and the RUC to revise the code descriptors and to assign work RVUs to these services. This view was supported by a joint comment from the heads of several surgical specialties. The RUC also urged us to delay finalizing this proposal until the RUC has the opportunity to provide further recommendations related to these services. In addition, the specialty societies representing podiatry, general

surgery, colon and rectal surgery, osteopathy, ophthalmology, plastic surgery, otolaryngology as well as the AMA, the Mayo Foundation and individual physicians also urged us to withdraw this proposal. Medical Group Management Association requested the policy rationale for equating the work RVUs for the benign and malignant code pairs. The specialty society representing family physicians agreed with and supported our position that there is no difference in physician work involved in excising a benign or malignant lesion. However, the commenter did not support our proposal to implement such RVU changes unilaterally and stated that we should utilize the CPT and RUC process.

Response and Final Decision: We still believe that the physician work for these services is sufficiently similar not to warrant differences in the work RVUs. However, we will maintain the 2003 work RVUs as interim values for 2004 to allow opportunity for the specialty to resurvey these services. Note: That due to the adjustments to work RVUs to match the MEI weights, the work RVUs in Addendum B may differ from the values in 2003.

3. Create G Codes for Monitoring Heart Rhythms

As explained in the August 15, 2003 proposed rule, technological advances have made cardiac telemetry equipment, typically used in hospitals, available in the home setting. Coverage of this technology is currently at the discretion of the local Medicare contractors because there is no national coverage determination for this service. We proposed to establish new HCPCS codes to specifically describe this service along with proposed RVUs and PE inputs for payment as follows:

GXXX1—Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; includes recording, monitoring, receipt of transmissions, analysis, and physician review and interpretation. (global)

We proposed 0.52 physician work RVUs and 0.24 multipractice RVUs for this service and proposed crosswalking the practice expense inputs from CPT Code 93268 Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission physician review and interpretation.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Excisions of Lesions: Wide Margins

CPT requested the review of 36 revised excision of benign and malignant lesion codes based on the revisions to the descriptors to include the margins of the lesions. The Dermatology, Family Physician, General Surgery and Plastic Surgery specialty societies chose not to survey these revised codes, rather they proposed increases based on the frequency that would maintain the 2002 family RVU ratio for the first 5 codes in each family remain work neutral. However, the last code in the family will remain the same. This rationale is derived from the estimation that with the inclusion of the lesion's margins, codes that previously described larger lesion sizes will now be more appropriately coded using a higher level code. For example, the specialty societies estimated that for benign lesion types, the frequency for higher level codes would increase by 30 percent. For malignant codes, the specialty societies estimated that the frequency for code usage for the next higher level code would increase by about 50 percent. Since the description of the last code in the family is inclusive of margins at a certain level and higher, the society determined that by holding the work value for the last code in the family the same, the family will remain work neutral. The RUC agreed with this rationale. **The RUC recommends the following work relative values for codes 11400-11646:**

CPT 11400	0.85	CPT 11420	0.98	CPT 11440	1.06
CPT 11401	1.23	CPT 11421	1.42	CPT 11441	1.48
CPT 11402	1.51	CPT 11422	1.63	CPT 11442	1.72
CPT 11403	1.79	CPT 11423	2.01	CPT 11443	2.29
CPT 11404	2.06	CPT 11424	2.43	CPT 11444	3.14
CPT 11406	2.76	CPT 11426	3.78	CPT 11446	4.49
CPT 11600	1.31	CPT 11620	1.19	CPT 11640	1.35
CPT 11601	1.80	CPT 11621	1.76	CPT 11641	2.16
CPT 11602	1.95	CPT 11622	2.09	CPT 11642	2.59
CPT 11603	2.19	CPT 11623	2.61	CPT 11643	3.10
CPT 11604	2.40	CPT 11624	3.06	CPT 11644	4.03
CPT 11606	3.43	CPT 11626	4.30	CPT 11646	5.95

Practice Expenses

No changes to the practice expense inputs were recommended.

Integumentary System

Excision – Benign Lesions

Excision (including simple closure) of benign lesions of skin or subcutaneous tissues (eg, neoplasm, cicatricial, fibrous, inflammatory, congenital, cystic lesions), includes local anesthesia. See appropriate size and body area below. For shave removal, see 11300 et seq., and for electrosurgical and other methods see 17000 et seq.

Excision is defined as full-thickness (through the dermis) removal of ~~the a following lesions~~, including margins, and includes simple (non-layered) closure when performed. Report separately each benign lesion excised. Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter). The margins refer to the most narrow margin required to adequately excise the lesion, based on the physician's judgment. The measurement of lesion plus margin is made prior to excision. The excised diameter is the same whether the surgical defect is repaired in a linear fashion, or reconstructed, eg with a skin graft.

The closure of defects created by incision, excision, or trauma may require intermediate or complex closure. Repair by intermediate or complex closure should be reported separately. For excision of benign lesions requiring more than simple closure, ie, requiring intermediate or complex closure, report 11400-11466 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see 11400-14300, 15000-15261, 15570-15770. See page 53 for definition of intermediate or complex closure.

~~(For excision of benign lesions requiring more than simple closure, i.e., requiring intermediate or complex closure, report 11400-11446 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see 14000-14300, 15000-15261, 15570-15770)~~

~~(For electrosurgical and other methods, see 17000 et seq)~~

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲11400	E1	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion <u>excised</u> diameter 0.5 cm or less	010	0.91
▲11401	E2	lesion <u>excised</u> diameter 0.6 to 1.0 cm	010	1.32
▲11402	E3	lesion <u>excised</u> diameter 1.1 to 2.0 cm	010	1.61
▲11403	E4	lesion <u>excised</u> diameter 2.1 to 3.0 cm	010	1.92
▲11404	E5	lesion <u>excised</u> diameter 3.1 to 4.0 cm	010	2.20
▲11406	E6	lesion <u>excised</u> diameter over 4.0 cm (For unusual or complicated excision, add modifier –22)	010	2.76
▲11420	E7	Excision, benign lesion <u>including margins</u> , except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion <u>excised</u> diameter 0.5 cm or less	010	1.06
▲11421	E8	lesion <u>excised</u> diameter 0.6 to 1.0 cm	010	1.53
▲11422	E9	lesion <u>excised</u> diameter 1.1 to 2.0 cm	010	1.76
▲11423	E10	lesion <u>excised</u> diameter 2.1 to 3.0 cm	010	2.17
▲11424	E11	lesion <u>excised</u> diameter 3.1 to 4.0 cm	010	2.62
▲11426	E12	lesion <u>excised</u> diameter over 4.0 cm (For unusual or complicated excision, add modifier –22)	010	3.78

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲11440	E13	Excision, other benign lesion <u>including margins</u> (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion excised diameter 0.5 cm or less	010	1.15
▲11441	E14	lesion excised diameter 0.6 to 1.0 cm	010	1.61
▲11442	E15	lesion excised diameter 1.1 to 2.0 cm	010	1.87
▲11443	E16	lesion excised diameter 2.1 to 3.0 cm	010	2.49
▲11444	E17	lesion excised diameter 3.1 to 4.0 cm	010	3.42
▲11446	E18	lesion excised diameter over 4.0 cm (For unusual or complicated excision, add modifier '-22') (For eyelids involving more than skin, see also 67800 et seq)	010	4.49

Integumentary System

Excision – Malignant Lesions

Excision (including simple closure) of malignant lesions of skin ~~or subcutaneous tissues~~ (eg, basal cell carcinoma, squamous cell carcinoma, melanoma), ~~including local anesthesia each lesion.~~ (See appropriate size and body area below.) For ~~removal~~ destruction of malignant lesions of skin ~~by any method other than excision, as defined above,~~ see destruction codes 17000-17999-17260-17286.

Excision is defined as full-thickness (through the dermis) removal of ~~the a~~ the following lesions; including margins, and includes simple (non-layered) closure when performed. Report separately each malignant lesion excised. Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter). The margins refer to the most narrow margin required to adequately excise the

lesion, based on the physician's judgment. The measurement of lesion plus margin is made prior to excision. Note that the excised diameter is the same whether the surgical defect is repaired in a linear fashion, or reconstructed, eg with a skin graft.

The closure of defects created by incision, excision, or trauma may require intermediate or complex closure. Repair by intermediate or complex closure should be reported separately. For excision of malignant lesions requiring more than simple closure, ie, requiring intermediate or complex closure, report 11600-11646 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see 14000-14300, 15000-15261, 15570-15770. See page 53 for definition of intermediate or complex closure.

When frozen section pathology shows the margins of excision were not adequate, an additional excision may be necessary for complete tumor removal. Use only one code to report the additional excision and re-excision(s) to achieve wider margins at the same operative session is reported with one malignant excision code based on the final widest excised diameter required for complete tumor removal at the same operative session..

To report a re-excision procedure performed to widen margins at a subsequent operative session, see codes 11600-11646, as appropriate. Append the modifier '-58' if the re-excision procedure is performed during the postoperative period of the primary excision procedure.

~~(For excision of malignant lesions requiring more than simple closure, ie, requiring intermediate or complex closure, report 11600-11646 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see 14000-14300, 15000-15261, 15570-15770)~~

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 11600	E19	Excision, malignant lesion <u>including margins</u> , trunk, arms or legs; <u>lesion excised</u> diameter 0.5 cm or less	010	1.41
▲ 11601	E20	<u>lesion excised</u> diameter 0.6 to 1.0 cm	010	1.93
▲ 11602	E21	<u>lesion excised</u> diameter 1.1 to 2.0 cm	010	2.09

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲11603	E22	lesion excised diameter 2.1 to 3.0 cm	010	2.35
▲11604	E23	lesion excised diameter 3.1 to 4.0 cm	010	2.58
▲11606	E24	lesion excised diameter over 4.0 cm	010	3.43
▲11620	E25	Excision, malignant lesion <u>including margins</u> , scalp, neck, hands, feet, genitalia; lesion excised diameter 0.5 cm or less	010	1.34
▲11621	E26	lesion excised diameter 0.6 to 1.0 cm	010	1.97
▲11622	E27	lesion excised diameter 1.1 to 2.0 cm	010	2.34
▲11623	E28	lesion excised diameter 2.1 to 3.0 cm	010	2.93
▲11624	E29	lesion excised diameter 3.1 to 4.0 cm	010	3.43
▲11626	E30	lesion excised diameter over 4.0 cm	010	4.30
▲11640	E31	Excision, malignant lesion <u>including margins</u> , face, ears, eyelids, nose, lips; lesion excised diameter 0.5 cm or less	010	1.53
▲11641	E32	lesion excised diameter 0.6 to 1.0 cm	010	2.44

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲11642	E33	lesion <u>excised</u> diameter 1.1 to 2.0 cm	010	2.93
▲11643	E34	lesion <u>excised</u> diameter 2.1 to 3.0 cm	010	3.50
▲11644	E35	lesion <u>excised</u> diameter 3.1 to 4.0 cm	010	4.55
▲11646	E36	lesion <u>excised</u> diameter over 4.0 cm (For eyelids involving more than skin, see also 67800 et seq)	010	5.95

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	PROPOSAL: Maintain 2002 family RVW RATIO for FIRST 5 codes - Do not change RVW for LAST code,																		
2	Estimate upcoded frequency (30%-benign, 50%-malignant), Calc recommended RVW as family budget neutral (ie, Col G total = Col I total)																		
3				RVW	ratio	RVW	w-RVUs	w-RVUs	w-RVUs	2000 Actual Freq (total & -modifiers)					2003 Estimated "upcoded" Frequency				
4	CPT	Lesion Type	Lesion Size	2002 RVW	Maintain Ratio in 2002 MFS	2003 Recom'd RVW	2002 workRVUs = 2002 RVW x 2000 freq	2003 Est workRVUs = 2002 RVW x upcode freq	2003 Est workRVUs = Rec'd RVW x upcode freq	2000 FRQ (Total)	FRQ (blank, -22,-52) @100%	FRQ -51 @50%	FRQ -54 @70%	FRQ -55 @20%	Estimated 2003 "upcoded" FRQ (Total)	FRQ (blank, -22,-52) @100%	FRQ -51 @50%	FRQ -54 @70%	FRQ -55 @20%
5	11400	Benign-trunk, arms or legs	0.5 cm or less	0.91	0.6	0.85	49,932	34,952	32,673	63,686	46,054	17,632	0	0	44,580	32,238	12,342	0	0
6	11401	Benign-trunk, arms or legs	0.6 to 1.0 cm	1.32	0.8	1.23	115,098	102,297	95,626	102,767	71,624	31,143	0	0	91,043	63,953	27,090	0	0
7	11402	Benign-trunk, arms or legs	1.1 to 2.0 cm	1.61	1.0	1.51	150,218	147,268	137,663	108,549	78,057	30,492	0	0	106,814	76,127	30,687	0	0
8	11403	Benign-trunk, arms or legs	2.1 to 3.0 cm	1.92	1.2	1.79	82,046	111,175	103,924	48,173	37,292	10,881	0	0	66,286	49,522	16,764	0	0
9	11404	Benign-trunk, arms or legs	3.1 to 4.0 cm	2.20	1.4	2.06	36,975	54,086	50,559	19,056	14,558	4,498	0	0	27,791	21,378	6,413	0	0
10	11406	Benign-trunk, arms or legs	over 4.0 cm	2.76		2.76	52,396	66,312	66,312	20,415	17,553	2,862	0	0	26,132	21,920	4,211	0	0
11							486,665	516,091	486,757	362,646	265,138	97,508	0	0	362,646	265,138	97,508	0	0
12																			
13	11420	Benign-scalp, neck, hands, feet, genitalia	0.5 cm or less	1.06	0.7	0.98	36,869	25,809	23,953	39,803	29,762	10,041	0	0	27,862	20,833	7,029	0	0
14	11421	Benign-scalp, neck, hands, feet, genitalia	0.6 to 1.0 cm	1.53	1.0	1.42	65,352	61,711	57,275	49,048	36,379	12,669	0	0	46,275	34,394	11,881	0	0
15	11422	Benign-scalp, neck, hands, feet, genitalia	1.1 to 2.0 cm	1.76	1.2	1.63	73,112	73,731	68,430	47,434	35,648	11,786	0	0	47,918	35,867	12,051	0	0
16	11423	Benign-scalp, neck, hands, feet, genitalia	2.1 to 3.0 cm	2.17	1.4	2.01	36,981	52,930	49,125	19,077	15,007	4,070	0	0	27,584	21,199	6,385	0	0
17	11424	Benign-scalp, neck, hands, feet, genitalia	3.1 to 4.0 cm	2.62	1.7	2.43	14,482	23,532	21,841	6,131	4,924	1,207	0	0	10,015	7,949	2,066	0	0
18	11426	Benign-scalp, neck, hands, feet, genitalia	over 4.0 cm	3.78		3.78	17,309	23,577	23,577	4,851	4,307	544	0	0	6,690	5,784	906	0	0
19							244,105	261,290	244,200	166,344	126,027	40,317	0	0	166,344	126,027	40,317	0	0
20																			
21	11440	Benign-face, ears, eyelids, nose, lips, muc	0.5 cm or less	1.15	0.7	1.06	79,422	55,596	51,037	80,654	57,460	23,165	29	0	56,458	40,222	16,216	20	0
22	11441	Benign-face, ears, eyelids, nose, lips, muc	0.6 to 1.0 cm	1.61	1.0	1.48	113,623	112,893	103,637	81,490	59,652	21,828	10	0	81,239	58,994	22,229	16	0
23	11442	Benign-face, ears, eyelids, nose, lips, muc	1.1 to 2.0 cm	1.87	1.2	1.72	90,086	102,652	94,236	55,926	40,423	15,503	0	0	63,595	46,192	17,401	3	0
24	11443	Benign-face, ears, eyelids, nose, lips, muc	2.1 to 3.0 cm	2.49	1.5	2.29	34,208	59,932	55,018	15,561	11,915	3,646	0	0	27,671	20,467	7,203	0	0
25	11444	Benign-face, ears, eyelids, nose, lips, muc	3.1 to 4.0 cm	3.42	2.1	3.14	13,288	23,397	21,479	4,268	3,503	765	0	0	7,656	6,027	1,629	0	0
26	11446	Benign-face, ears, eyelids, nose, lips, muc	over 4.0 cm	4.49		4.49	12,734	17,967	17,967	3,032	2,640	392	0	0	4,312	3,691	622	0	0
27							343,361	372,437	343,375	240,931	175,593	65,299	39	0	240,931	175,593	65,299	39	0
28																			
29	11600	Malignant-trunk, arms or legs	0.5 cm or less	1.41	0.7	1.31	14,400	7,200	6,704	12,167	8,258	3,909	0	0	6,084	4,129	1,955	0	0
30	11601	Malignant-trunk, arms or legs	0.6 to 1.0 cm	1.93	0.9	1.80	83,904	51,807	48,238	53,347	33,600	19,747	0	0	32,757	20,929	11,828	0	0
31	11602	Malignant-trunk, arms or legs	1.1 to 2.0 cm	2.09	1.0	1.95	148,887	119,874	111,614	87,548	54,928	32,620	0	0	70,448	44,264	26,184	0	0
32	11603	Malignant-trunk, arms or legs	2.1 to 3.0 cm	2.35	1.1	2.19	73,866	120,638	112,326	35,648	27,217	8,431	0	0	61,598	41,073	20,526	0	0
33	11604	Malignant-trunk, arms or legs	3.1 to 4.0 cm	2.58	1.2	2.40	32,966	57,031	53,101	14,545	11,010	3,535	0	0	25,097	19,114	5,983	0	0
34	11606	Malignant-trunk, arms or legs	over 4.0 cm	3.43		3.43	43,853	65,766	65,766	14,187	11,383	2,804	0	0	21,460	16,888	4,572	0	0
35							397,876	422,315	397,749	217,442	146,396	71,046	0	0	217,442				
36																			
37	11620	Malignant-scalp, neck, hands, feet, genital	0.5 cm or less	1.34	0.6	1.19	7,970	3,985	3,553	7,169	4,727	2,442	0	0	3,585	2,364	1,221	0	0
38	11621	Malignant-scalp, neck, hands, feet, genital	0.6 to 1.0 cm	1.97	0.8	1.76	45,561	28,639	25,531	28,565	17,690	10,875	0	0	17,867	11,209	6,659	0	0
39	11622	Malignant-scalp, neck, hands, feet, genital	1.1 to 2.0 cm	2.34	1.0	2.09	81,330	67,724	60,373	39,755	29,758	9,997	0	0	34,160	23,724	10,436	0	0
40	11623	Malignant-scalp, neck, hands, feet, genital	2.1 to 3.0 cm	2.93	1.3	2.61	38,688	70,262	62,635	14,966	11,442	3,524	0	0	27,361	20,600	6,761	0	0
41	11624	Malignant-scalp, neck, hands, feet, genital	3.1 to 4.0 cm	3.43	1.5	3.06	16,346	30,818	27,473	5,492	4,039	1,453	0	0	10,229	7,741	2,489	0	0
42	11626	Malignant-scalp, neck, hands, feet, genital	over 4.0 cm	4.30		4.30	16,071	26,317	26,317	4,411	3,064	1,347	0	0	7,157	5,084	2,074	0	0
43							205,966	227,746	205,881	100,358	70,720	29,638	0	0	100,358				
44																			
45	11640	Malignant-face, ears, eyelids, nose, lips, n	0.5 cm or less	1.53	0.6	1.35	57,074	28,537	25,262	44,494	30,113	14,381	0	0	22,247	15,057	7,191	0	0
46	11641	Malignant-face, ears, eyelids, nose, lips, n	0.6 to 1.0 cm	2.44	1.0	2.16	247,279	169,150	149,739	118,298	84,397	33,889	0	12	81,396	57,255	24,135	0	6
47	11642	Malignant-face, ears, eyelids, nose, lips, n	1.1 to 2.0 cm	2.93	1.2	2.59	298,796	297,867	263,685	115,687	88,269	27,418	0	0	116,993	86,333	30,654	0	6
48	11643	Malignant-face, ears, eyelids, nose, lips, n	2.1 to 3.0 cm	3.50	1.4	3.10	107,909	232,416	205,745	35,439	26,223	9,216	0	0	75,563	57,246	18,317	0	0
49	11644	Malignant-face, ears, eyelids, nose, lips, n	3.1 to 4.0 cm	4.55	1.9	4.03	45,457	92,869	82,212	11,605	8,376	3,229	0	0	23,522	17,300	6,223	0	0
50	11646	Malignant-face, ears, eyelids, nose, lips, n	over 4.0 cm	5.95		5.95	38,532	68,254	68,254	7,375	5,577	1,798	0	0	13,178	9,765	3,413	0	0
51							795,046	889,092	794,898	332,898	242,955	89,931	0	12	332,898				



AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Office of Governmental Affairs
1101 Vermont Avenue, N.W.
Suite 606
Washington, DC 20005
(202) 289-2222
FAX (202) 371-0384
mail@ASAwash.org

April 1, 2004

William Rich, MD
Chairman
AMA/Specialty Society RVS Update Committee
515 North State Street
Chicago, IL 60610

Re:

CPT Code 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

CPT Code 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

Dear Dr. Rich,

The above referenced codes breakdown into a professional component and a technical component. The RBRVS assigned RVUs to only the professional component; the technical component and the global service are Carrier priced (Status C). The American Society of Anesthesiologists and the American Academy of Pain Medicine request the RUC encourage CMS to classify all components as Status A (Active code) and to assign RVUs for all components. These services are most often performed in the office setting where the physician owns the equipment, provides the supplies and employs the clinical labor staff. We are unclear as to why the technical and global components are carrier priced.

When these codes came to the RUC in 1995, the RUC accepted the presenting society's recommended work values and the RBRVS uses those same values for the work for the professional component. Code 62367-26 has 0.48 work RVUs and code 62368-26 has 0.75 work RVUs. The RVUw's are still valid and we request they be assigned to the global component. The PE inputs accepted for codes 62367 and 62368 by the PEAC in March 2003 can be used to calculate the practice expense RVUs.

We are most appreciative of both the RUC's and CMS's consideration of this request.

Sincerely,

James D. Grant, MD
American Society of Anesthesiologists
RUC Advisor

Eduardo M. Fraifeld, MD
American Academy of Pain Medicine
RUC Advisor

AMA SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATIONS
APRIL 1995

INFUSION THERAPY - TAB 8

The CPT Editorial Panel added eight new codes to describe procedures using implantable drug pumps to provide continuous intrathecal medications for patients with severe intractable pain or spasticity. After a development period of ten years, the FDA approved treatment using implantable pumps. There was considerable discussion at the RUC meetings regarding the nature of these coding changes, particularly whether the new codes describe new procedures or could be considered as included in the existing codes 63750 and 63780. The RUC was also provided with diagrams, which are attached to the recommendations.

Codes 63750 [Insertion subarachnoid catheter with reservoir and/or pump for intermittent or continuous infusion of drug, including laminectomy] and 63780 [Insertion or replacement, subarachnoid or epidural catheter, with reservoir and/or pump for drug infusion, without laminectomy] sound very similar to the new CPT codes 62350 [Implantation, revision or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantable pump; without laminectomy] and 62362 [Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming] however, codes 63750 and 63780 are used to describe the work involved in implanting cancer patients with a catheter system to alleviate severe pain, not chronic pain or spasticity. The existing codes 63750 and 63780 provide a short-term means for controlling pain until the patient dies of cancer, whereas the new codes apply to the constant delivery of medicine into the intrathecal space. The operation to place the intrathecal catheter is very complex because the system is permanent and must remain in place for the duration of the patients' life.

The family of codes has been divided into two groups to separately describe implanting a device to provide medicine and implanting a catheter. This grouping recognizes that the permanent placement of a complete drug infusion system would only occur at the initiation of treatment.

Code 62350 [Implantation, revision or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantable pump; without laminectomy] involves the placement of an implantable reservoir for the delivery of drugs designed to alleviate chronic pain or spasticity. The physician work is similar to code 63650 [Percutaneous implantation of neurostimulator electrodes; epidural]. The RUC recommends 6.25 RVUs for this code.

Code 62351 [Implantation, revision or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantable pump;

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

with laminectomy] is the same as code 62350 but requires a laminectomy. The RUC compared the work involved in this service to code 63655 [Laminectomy for implantation of neurostimulator electrodes; epidural], and recommends 9.25 RVUs.

Code 62355 [Removal of previously implanted intrathecal or epidural catheter] is done when a problem such as infection develops. Until now, there was no way for the physician to report removal of a previously implanted catheter. The RUC determined that the work of 62355 most closely approximated the work of CPT code 63688 [Revision or removal of implanted spinal neurostimulator pulse generator or receiver] and, therefore, lowered the specialty's recommendation by 0.8 RVUs, reducing the recommended RVUs from 5.60 to 4.80 RVUs.

Code 62360 [Implantation or replacement of a device for intrathecal or epidural drug infusion; subcutaneous reservoir] is a new code for the implantation of a reservoir. The surgeon implants the reservoir after the intrathecal catheter has been placed, and connects the reservoir to the catheter. Although placement of a subcutaneous reservoir is similar to CPT code 63685 [Incision and subcutaneous placement of spinal neurostimulator or receiver, direct or inductive coupling], less physician work is required to place the smaller subcutaneous reservoir. The RUC recommends 2.00 RVUs.

Code 62361 [Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump] is similar to placement of a spinal neurostimulator (code 63685). The RUC determined that the work of code 62361 was comparable to code 36530 [Insertion of an implantable intravenous infusion pump] and reduced the specialty recommendation from 7.00 to 4.80 RVUs.

The RUC found that the work of code 62362 [Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming] was most comparable to that of code 63685, and lowered the specialty society recommendation from 7.14 RVUs to 6.29 RVUs. The RUC considered the work involved in code 62365 [Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion] to be comparable to that of code 36532, which has 3.23 RVUs. Code 36532 has a 10 day global period, however, and 62365 has a 90 day global period. Therefore, the RUC lowered the specialty recommendation from 5.20 RVUs to 4.77 RVUs.

Codes 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] and 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] are done postoperatively and involve the overall evaluation of the implanted pump to make sure that it is working correctly. The RUC recommends 0.48 RVUs for code 62367 and 0.75 RVUs for code 62368.

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
62274	L1	Injection of diagnostic or therapeutic anesthetic or <u>antispasmodic</u> substance (including narcotics); subarachnoid or subdural, single	000	1.78 (No Change)
62288*	L11	Injection of substance other than anesthetic, <u>antispasmodic</u> , contrast, or neurolytic solutions; subarachnoid (separate procedure)	000	1.74 (No Change)
<u>CATHETER IMPLANTATION</u>				
(For percutaneous placement of intrathecal or epidural catheter, see codes 62274-62284, 62288, 62289, 62298)				
•62350	L2	Implantation, revision or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantable infusion pump; without laminectomy	090	6.25
•62351	L3		090	9.25
•62355	L4	Removal of previously implanted intrathecal or epidural catheter	090	4.80

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

RESERVOIR/PUMP IMPLANTATION				
•62360	L5	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	090	2.00
•62361	L6		090	4.80
•62362	L7	without programming	090	6.29
•62365	L8	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	090	4.77
•62367	L9	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming	XXX	0.48
•62368	L10		XXX	0.75
		(To report pump refill, use 96530)		
63750	L12	Insertion, subarachnoid catheter with reservoir and/or pump for intermittent or continuous infusion of drug, including laminectomy (63750 has been deleted. To report, see 63XX2 and 63XX4, 63XX5 or 63XX6)	090	N/A
63780	L13	Insertion or replacement, subarachnoid or epidural catheter, with reservoir and/or pump for drug infusion, without laminectomy (63780 has been deleted. To report, see 63XX1 and 63XX4, 63XX5 or 63XX6)	090	N/A

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

AMA/Specialty Society RVS Update Process Summary of Recommendation

Tracking Number: L9

Global Period: XXX

Recommended RVW: 0.48

CPT Descriptor: Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming

Vignette Used in Survey: A 65-year-old male presents for an electronic analysis of an implanted infusion pump that delivers opiates and has successfully controlled his pain due to prostate cancer and metastases to multiple bone sites in the lower body and resultant bilateral leg and pelvic bone pain (rated 8/10). Because of the multiple sites of bone involvement and lack of response to chemotherapy, no radiation therapy or further chemotherapy is planned. His expected survival time is nine months from his cancer.

The electronic analysis of the implanted pump device, which determines the rate of infusion and the amount of morphine solution remaining in the pump reservoir, indicates a satisfactory infusion rate and residual volume; so no reprogramming is needed.

Description of Pre-Service Work: Review of patient medical chart with special attention to patient's response to drug delivery via implanted infusion pump.

Description of Intra-Service Work: Electronic analysis is performed to determine reservoir status, alarm status, and the drug prescription status. Because the electronic analysis of the implanted pump device indicates a satisfactory infusion rate and residual volume; no reprogramming is needed.

Description of Post-Service Work: Communication with the patient, family, and other health care professionals (including written and telephone reports and orders) on the day of the analysis are considered part of the post-operative work for this procedure.

Key REFERENCE SERVICE(S):

1995 RVW	CPT Descriptor	Harvard Time (minutes)				Phase Spec Global	On MPC Tbl?
		Pre-	Intra-	Hosp- Post-	Off- Post		
0.45	63690 Electronic analysis of implanted neurostimulator pulse generator system (may include rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling impedance and patient compliance measurements); without reprogramming of pulse generator.	0	19t	0	0	3/ns XXX	yes
(new)* .48	L9 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming	0	20	0	0	RUC/ns XXX	n/a

*Specialty recommended RVW

Relationship to Key Reference Service(s) and/or other Rationale for RVW Recommendation (Include all applicable elements of work in rationale: time; technical skill & physical effort; mental effort and judgment; and stress):

L9 can be compared to electronic analysis of a neurostimulator without reprogramming. This is also the same RVW as 93731 electronic analysis of a dual chamber pacemaker without reprogramming. (.45)

FREQUENCY INFORMATION

How was this service previously reported? CPT code 96530 may have been used for refilling and maintenance of an implantable pump or reservoir, however, this code is included in the section for chemotherapy, and thus is inappropriate for spasticity and pain management. Equally important, 96530 was not intended to describe the new generation of pumps requiring analyses to check the reservoir status, the alarm status, and drug prescription status. Depending upon the results of these analyses, the physician may change the patient's dosage, reprogram the pump, and refill the pump.

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

Estimate the number of times this service might be provided nationally in a one-year period? The Health Care Financing Administration has only recently (3/4/94) expanded its national Medicare coverage policy on infusion pumps to specifically include coverage for implantable infusion pumps used to administer antispasmodic drugs intrathecally to treat chronic intractable spasticity and to administer opioid drugs for chronic intractable pain. Consequently, Medicare frequency data is not available. [Attachment A presents data about the incidence of the disease(s) that this procedure is designed to treat.]

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

SURVEY DATA:

Specialty(s): American Association of Neurological Surgeons

Median Intra-Service Time: 20 Low: 5 High: 60

Median Pre-Service Time: n/a Median Post-Service Time: n/a

Length of Hospital Stay: 0 Number of ICU Days: 0

Number & Level of Post-Hospital Visits: n/a

Number of Times Provided in Past 12 months (Median): 30 in Past 5 years: 101

Sample Size: 160 Response Rate (%): 46 (29%) MEDIAN RVW: 0.48

25th pctl RVW: 0.45 75th pctl RVW: 0.98 Low: 0.38 High: 2.00

62368

AMA/Specialty Society RVS Update Process Summary of Recommendation

Tracking Number: L10

Global Period: XXX

Recommended RVW: 0.75

CPT Descriptor: Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming

Vignette Used in Survey: A 65-year-old male presents for an electronic analysis of an implanted infusion pump that delivers opiates to control pain because he has begun to experience increasing pain after several months of good control, that has become quite severe (rated 6/10). The patient has prostate cancer and metastases to multiple bone sites in the lower body and resultant bilateral leg and pelvic bone pain. Because of the multiple sites of bone involvement and lack of response to chemotherapy, no radiation therapy or further chemotherapy is planned. His expected survival time is nine months from his cancer.

Analysis of the pump function via external electronic analysis verifies the infusion rate. The pump is then reprogrammed to increase the rate of infusion and control the increased level of pain.

Description of Pre-Service Work: Review of patient medical chart with special attention to patient's response to drug delivery via implanted infusion pump.

Description of Intra-Service Work: Electronic analysis is performed to determine reservoir status, alarm status, and the drug prescription status. Electronic analysis of the pump function verifies the infusion rate. The pump is then reprogrammed to increase the rate of infusion and control the increased level of pain.

Description of Post-Service Work: Communication with the patient, family, and other health care professionals (including written and telephone reports and orders) on the day of the analysis and reprogramming are considered part of the post-operative work for this procedure.

Key REFERENCE SERVICE(S):

1995 RVW	CPT Descriptor	Harvard Time: (minutes)				Phase Spec Global	On MPC Tbl?
		Pre-	Intra-	Hosp- Post	Off- Post		
0.65	63691 Electronic analysis of implanted neurostimulator pulse generator system (may include rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); with reprogramming of pulse generator	0	27	0	0	3/ns XXX	yes
(new)* 0.75	L10 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	30	0	0	RUC/ ns XXX	n/a

*Specialty recommended RVW

Relationship to Key Reference Service(s) and/or other Rationale for RVW Recommendation (Include all applicable elements of work in rationale: time; technical skill & physical effort; mental effort and judgment; and stress):

L10 RVW falls between the .65 RVW for reprogramming a neurostimulator pulse generator and .92 for reprogramming a dual chamber pacemaker.

FREQUENCY INFORMATION

How was this service previously reported? CPT code 96530 may have been used for refilling and maintenance of an implantable pump or reservoir, however, this code is included in the section for chemotherapy, and thus is inappropriate for spasticity and pain management. Equally important, 96530 was not intended to describe the new generation of pumps requiring analyses to check the reservoir status, the alarm status, and drug prescription status. Depending upon the results of these analyses, the physician may change the patient's dosage, reprogram the pump, and refill the pump.

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

Estimate the number of times this service might be provided nationally in a one-year period? The Health Care Financing Administration has only recently (3/4/94) expanded its national Medicare coverage policy on infusion pumps to specifically include coverage for implantable infusion pumps used to administer antispasmodic drugs intrathecally to treat chronic intractable spasticity and to administer opioid drugs for chronic intractable pain. Consequently, Medicare frequency data is not available. [Attachment A presents data about the incidence of the disease(s) that this procedure is designed to treat.]

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

SURVEY DATA:

Specialty(s): American Association of Neurological Surgeons

Median Intra-Service Time: 30 Low: 10 High: 65

Median Pre-Service Time: n/a Median Post-Service Time: n/a

Length of Hospital Stay: 0 Number of ICU Days: 0

Number & Level of Post-Hospital Visits: n/a

Number of Times Provided in Past 12 months (Median): 50 in Past 5 years: 120

Sample Size: 160 Response Rate (%): 45 (28%) MEDIAN RVW: 0.75

25th pct RVW: 0.65 75th pct RVW: 1.13 Low: 0.48 High: 3.00



AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Office of Governmental Affairs
1101 Vermont Avenue, N.W.
Suite 606
Washington, DC 20005
(202) 289-2222
FAX (202) 371 0384
mail@ASAwash.org

February 21, 2003

Mr. Todd Klemp
American Medical Association
515 North State Street
Chicago, IL 60610

Re: Practice Expense Refinements

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 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming

Dear Todd,

The American Society of Anesthesiologists offers revised Direct Practice Expense Inputs for the above referenced codes. These inputs represent the opinion of a consensus panel that worked to update the existing data so that they more accurately reflect the clinical labor, supplies and equipment required to provide these services in the office setting.

We appreciate the opportunity to work with the PEAC on this matter. Please contact us if you have any questions or if you need any further information.

Sincerely,

Neal H. Cohen, M.D.
American Society of Anesthesiologists
PEAC Advisor

520 N. Northwest Highway, Park Ridge, IL 60068-2573
Telephone: (847) 825-5586 . Fax: (847) 825-1692 . E-mail: mail@ASAhq.org

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

CPT Long Descriptor:

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 - electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming

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

Geographic Practice Setting %: Rural _____ Suburban _____ Urban _____

Type of Practice %: _____ Solo Practice
33% Single Specialty Group
_____ Multispecialty Group
67% Medical School Faculty Practice Plan

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

A Consensus Committee developed these recommendations. The Consensus Committee consisted of anesthesiologists from different geographic locales and from varying sized groups who were familiar with these procedures.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Review records and complete forms required for patient's chart**

Intra-Service Clinical Labor Activities:

- **Obtain vital signs -- BP, pulse, respiration, temperature**
- **Assist the physician in performing the service**
 - **prepare and position the patient**
 - **educate patient in regard to pump operation**
 - **advise patient on appropriate cautions and concerns**
 - **assist with placement and operation of pump programmer to determine pump parameters such as reservoir status, alarm status and drug prescription status**
 - **if review of infusion rate, residual volume and patient's pain, symptoms and side effects indicates need for reprogramming (Code 62368) assist with reprogramming, evaluation and recording of new pump parameters**

Post-Service Clinical Labor Activities:

- **Place follow up call to patient to find out if the patient is experiencing any problems and to evaluate the patient's perception and evaluation of pump function**

	A	B	C	D	E	F
1						
2			62367		62368	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	
4	LOCATION		In Office	Out Office	In Office	Out Office
6	TOTAL CLINICAL LABOR TIME	1130 RN/LPN/MTA	29.0		39.0	
8	TOTAL PRE-SERV CLINICAL LABOR TIME	1130	3.0		3.0	
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	1130	23.0		33.0	
12	TOTAL POST-SERV CLINICAL LABOR TIME	1130	3.0		3.0	
13	PRE-SERVICE					
14	Start: Following visit when decision for surgery or procedure made					
15	Complete pre-service diagnostic & referral forms	1130	3		3	
16	Coordinate pre-surgery services					
17	Schedule space and equipment in facility					
18	Office visit before surgery/procedure: Review test and exam results					
19	Provide pre-service education/obtain consent					
20	Follow-up phone calls & prescriptions					
21	Other Clinical Activity (please specify)					
22	End: When patient enters office/facility for surgery/procedure					
23	SERVICE PERIOD					
24	Start: When patient enters office/facility for surgery/procedure					
25	Pre-service services					
26	Review charts					
27	Greet patient and provide gowning					
28	Obtain vital signs	1130	3		3	
29	Provide pre-service education/obtain consent					
30	Prepare room, equipment, supplies	1130	2		2	
31	Prepare and position patient/ monitor patient/ set up IV					
32	Sedate/apply anesthesia					
33	Intra-service					
34	Assist physician in performing procedure	1130	15		25	
35	Post-Service					
36	Monitor pt. following service/check tubes, monitors, drains					
37	Clean room/equipment by physician staff	1130	3		3	
38	Complete diagnostic forms, lab & X-ray requisitions					
39	Review/read X-ray, lab, and pathology reports					
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
41	Coordination of Care					
42	Discharge day management 99238 –12 minutes 99239 –15 minutes					
43	Other Clinical Activity (please specify)					
44	End: Patient leaves office					
45	POST-SERVICE Period					
46	Start: Patient leaves office/facility					
47	Conduct phone calls/call in prescriptions	1130	3		3	
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 36 minutes	36				
53	99214 53 minutes	53				
54	99215 63 minutes	63				
55	Other					
56						
57	Total Office Visit Time		0	0	0	0
58	Other Activity (please specify)					
59	End: with last office visit before end of global period					
60	MEDICAL SUPPLIES					
61	Minimum Supply Package for Vistsis (Multi-specialty)	1	1		1	

	A	B	C	D	E	F
2			62367		62368	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	
4	LOCATION		In Office	Out Office	In Office	Out Office
62						
63						
64						
65						
66						
67						
68	Equipment					
69	Programmers: Medtronic, CPI, Ventritex	E55012	23		33	
70	Exam table	E11001	23		33	
71						
72						

CPT 2005 RUC Recommendations

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue Tab		Tracking Number	RUC Date	RUC Tab	RUC S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
00561	XXX	N	Nov03	M	Anesthesia Procedures - Congenital Heart Infant Bypass	H2	Feb04	04	ASA	25.00	25.00			
00562	XXX	R	Nov03	M	Anesthesia Procedures - Congenital Heart Infant Bypass	H1	Feb04	04	ASA	20.00	20.00	Yes		
11004	000	N	Feb04	2	Tissue Debridement of Genitalia for Gangrene	T1	Apr04	05	AUA	10.75	8.80		Yes	
11005	000	N	Feb04	2	Tissue Debridement of Genitalia for Gangrene	T2	Apr04	05	ACS				Yes	Carrier Price-Sept04 RUC Meeting
11006	000	N	Feb04	2	Tissue Debridement of Genitalia for Gangrene	T3	Apr04	05	AUA	13.99	11.10		Yes	
11008	ZZZ	N	Feb04	2	Tissue Debridement of Genitalia for Gangrene	T4	Apr04	05	ACS				Yes	Carrier Price-Sept04 RUC Meeting
19160	090	R	Aug03	E	Mastectomy Revisions		Editorial			5.98	5.98	Yes	Yes	
19162	090	R	Aug03	E	Mastectomy Revisions		Editorial			13.51	13.51	Yes	Yes	
19296	000	N	Nov03	N	Placement of Breast Radiotherapy: Afterloading Balloon Catheter	I2	Feb04	05	ASTRO, ACR, ASBS	5.64	3.63		Yes	
19297	ZZZ	N	Nov03	N	Placement of Breast Radiotherapy: Afterloading Balloon Catheter	I1	Feb04	05	ASBS	3.75	1.72		Yes	
19298	000	N	Nov03	N	Placement of Breast Radiotherapy: Afterloading Balloon Catheter	I3	Feb04	05	ASTRO, ACR	11.00	6.00		Yes	
27412	090	N	Feb04	L	Osteochondral Procedures	V4	Apr04	08	AAOS	25.00	23.23		Yes	
27415	090	N	Feb04	L	Osteochondral Procedures	V5	Apr04	08	AAOS	20.00	18.49		Yes	

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
29866	090	N	Feb04	L	Osteochondral Procedures	V1	Apr04	08 AAOS	13.88	13.88		Yes
29867	090	N	Feb04	L	Osteochondral Procedures	V2	Apr04	08 AAOS	17.00	17.00		Yes
29868	090	N	Feb04	L	Osteochondral Procedures	V3	Apr04	08 AAOS	24.13	23.59		Yes
31545	000	N	Aug03	K	Laryngoscopic Excision of Microscopic Non-Neoplastic Lesions	C1	Feb04	06 AAO-HNS	6.30	6.30		Yes
31546	000	N	Aug03	K	Laryngoscopic Excision of Microscopic Non-Neoplastic Lesions	C2	Feb04	06 AAO-HNS	8.50	9.73		Yes
31620	ZZZ	N	Nov03	O	Bronchoscopy Stent Revisions, Endobronchial Ultrasound	J5	Apr04	09 ATS, ACCP	1.60	1.40		Yes
31630	000	R	Nov03	O	Bronchoscopy Stent Revisions, Endobronchial Ultrasound		Feb04	07 ATS, ACCP	3.81	3.81	Yes	Yes
31631	000	R	Nov03	O	Bronchoscopy Stent Revisions, Endobronchial Ultrasound	J1	Feb04	07 ATS, ACCP	4.36	4.36	Yes	Yes
31636	000	N	Nov03	O	Bronchoscopy Stent Revisions, Endobronchial Ultrasound	J2	Feb04	07 ATS, ACCP	4.30	4.30		Yes
31637	ZZZ	N	Nov03	O	Bronchoscopy Stent Revisions, Endobronchial Ultrasound	J3	Apr04	09 ATS, ACCP	1.58	1.58		Yes
31638	000	N	Nov03	O	Bronchoscopy Stent Revisions, Endobronchial Ultrasound	J4	Feb04	07 ATS, ACCP	4.88	4.88		Yes
32019	000	N	Feb04	M	Chronic Indwelling Pleural Catheter	W1	Apr04	10 STS	5.19	4.17		Yes
32850	XXX	R	Feb04	R	Lung Transplantation	X1	Apr04	11 ASTS				No RUC Recommendation
32855	XXX	N	Feb04	R	Lung Transplantation	X2	Apr04	11 ASTS				No RUC Recommendation

CPT Code	Global Period	Coding Change	CPT Date	CPT Issue Tab		Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
32856	XXX	N	Feb04	R	Lung Transplantation	X3	Apr04	11	ASTS						No RUC Recommendation
33930	XXX	R	Feb04	S	Heart-Lung, Heart Transplantation	Y1	Apr04	12	ASTS						No RUC Recommendation
33933	XXX	N	Feb04	S	Heart-Lung, Heart Transplantation	Y2	Apr04	12	ASTS						No RUC Recommendation
33940	XXX	R	Feb04	S	Heart-Lung, Heart Transplantation	Y3	Apr04	12	ASTS						No RUC Recommendation
33944	XXX	N	Feb04	S	Heart-Lung, Heart Transplantation	Y4	Apr04	12	ASTS						No RUC Recommendation
34803	090	N	Feb04	S1	Endovascular Graft for Abdominal Aortic Aneurysm	Z1	Apr04	18	SIR, ACR, SVS	24.00	24.00			Yes	
35161	090	D	Nov03	P	Aneurysm Repair		Deleted							Yes	
35162	090	D	Nov03	P	Aneurysm Repair		Deleted							Yes	
35582	090	D	Nov03	P	In Situ Vein Bypass		Deleted							Yes	
36475	000	N	Nov03	Q	Endovenous Ablation Therapy	K1	Feb04	08	SVS, ACR, SIR	8.40	6.72			Yes	
36476	ZZZ	N	Nov03	Q	Endovenous Ablation Therapy	K2	Feb04	08	SVS, ACR, SIR	5.17	3.38			Yes	
36478	000	N	Nov03	Q	Endovenous Ablation Therapy	K3	Feb04	08	SVS, ACR, SIR	8.40	6.72			Yes	

CPT Code	Global	Coding	CPT Code	CPT Issue	Tracking Number	RUC Date	RUC Tab	S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
36479	ZZZ	N	Nov03	Q	Endovenous Ablation Therapy	K4	Feb04	08	SVS, ACR, SIR	5.17	3.38		Yes	
36818	090	N	Feb04	O	Upper Arm Cephalic Vein Transposition	AA1	Apr04	17	SVS	11.72	11.52		Yes	
36819	090	R	Feb04	O	Upper Arm Cephalic Vein Transposition		Apr04	17	SVS	13.98	13.98	Yes	Yes	
37205	000	R	Feb04	Q	Carotid Stenting		Apr04	19	AANS/C NS, AAN, SIR, ASN, ACR, SVS, ACC	8.27	8.27	Yes	Yes	
37206	ZZZ	R	Feb04	Q	Carotid Stenting		Apr04	19	AANS/C NS, AAN, SIR, ASN, ACR, SVS, ACC	4.12	4.12	Yes	Yes	
37215	090	N	Feb04	Q	Carotid Stenting	AB1	Apr04	19	AANS/C NS, AAN, SIR, ASN, ACR, SVS, ACC	18.86	18.71		Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC Tab	S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
37216	090	N	Feb04	Q	Carotid Stenting	AB2	Apr04	19	AANS/C NS, AAN, SIR, ASN, ACR, SVS, ACC	18.13	17.98		Yes	
43257	000	N	May03	30	Endoscopic Anti-Reflux Procedures (STRETTA) for GERD	A1	Sep03	10	AGA, SAGES	7.00	5.50		Yes	
43644	090	N	Nov03	R	Gastric Restrictive Procedures	L2	Feb04	09	SAGES	27.83	27.83		Yes	
43645	090	N	Nov03	R	Gastric Restrictive Procedures	L3	Feb04	09	SAGES	29.96	29.96		Yes	
43845	090	N	Nov03	R	Gastric Restrictive Procedures	L1	Apr04	23	SAGES				Yes	Carrier Price-Sept04 RUC Meeting
43846	090	R	Aug03	L	Gastric Bypass for Obesity		Editorial			24.01	24.01	Yes	Yes	
44132	XXX	R	Feb04	T	Intestine Transplantation	AC1	Apr04	13	ASTS					No RUC Recommendation
44133	090	R	Feb04	T	Intestine Transplantation	AC2	Apr04	13	ASTS					No RUC Recommendation
44137	090	N	Feb04	T	Intestine Transplantation	AC6	Apr04	13	ASTS				Yes	Carrier Price
44715	XXX	N	Feb04	T	Intestine Transplantation	AC3	Apr04	13	ASTS					No RUC Recommendation
44720	XXX	N	Feb04	T	Intestine Transplantation	AC4	Apr04	13	ASTS	5.00	5.00		Yes	
44721	XXX	N	Feb04	T	Intestine Transplantation	AC5	Apr04	13	ASTS	7.00	7.00		Yes	
45391	000	N	Feb04	X	Proximal to Splenic Flexure Colonoscopy Aspiration-Biopsy	AD1	Apr04	24	AGA, ASGE	5.33	5.09		Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Issue Tab		Tracking Number	RUC Date	RUC Tab	S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
45392	000	N	Feb04	X	Proximal to Splenic Flexure Colonoscopy Aspiration-Biopsy	AD2	Apr04	24	AGA, ASGE	6.78	6.54			Yes	
46143	XXX	N	Feb04	V	Liver Transplantation	AE5	Apr04	14	ASTS						No RUC Recommendation
46947	090	N	Aug03	M	Stapling Hemorrhoidopexy	D1	Feb04	10	ASCoRS	5.20	5.20			Yes	
47133	XXX	R	Feb04	V	Liver Transplantation	AE1	Apr04	14	ASTS						No RUC Recommendation
47140	090	R	Feb04	V	Liver Transplantation	AE2	Apr04	14	ASTS	54.92	54.92	Yes	Yes		
47141	090	R	Feb04	V	Liver Transplantation	AE3	Apr04	14	ASTS	67.40	67.40	Yes	Yes		
47142	090	R	Feb04	V	Liver Transplantation	AE4	Apr04	14	ASTS	74.89	74.89	Yes	Yes		
47143	XXX	N	Feb04	V	Liver Transplantation	AE5	Apr04	14	ASTS						No RUC Recommendation
47144	XXX	N	Feb04	V	Liver Transplantation	AE6	Apr04	14	ASTS						No RUC Recommendation
47145	XXX	N	Feb04	V	Liver Transplantation	AE7	Apr04	14	ASTS						No RUC Recommendation
47146	XXX	N	Feb04	V	Liver Transplantation	AE8	Apr04	14	ASTS	6.00	6.00		Yes		
47147	XXX	N	Feb04	V	Liver Transplantation	AE9	Apr04	14	ASTS	7.00	7.00		Yes		
48550	XXX	R	Feb04	U	Pancreas Transplantation	AF1	Apr04	15	ASTS						No RUC Recommendation
48551	XXX	N	Feb04	U	Pancreas Transplantation	AF2	Apr04	15	ASTS						No RUC Recommendation
48552	XXX	N	Feb04	U	Pancreas Transplantation	AF3	Apr04	15	ASTS	4.30	4.30		Yes		
50300	XXX	R	Feb04	W	Kidney Transplantation	AG1	Apr04	16	ASTS						No RUC Recommendation

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
50320	090	R	Feb04	W	Kidney Transplantation	AG2	Apr04	16	ASTS	22.18	22.18	Yes	Yes		
50323	XXX	N	Feb04	W	Kidney Transplantation	AG3	Apr04	16	ASTS						No RUC Recommendation
50325	XXX	N	Feb04	W	Kidney Transplantation	AG4	Apr04	16	ASTS						No RUC Recommendation
50327	XXX	N	Feb04	W	Kidney Transplantation	AG5	Apr04	16	ASTS	4.04	4.00			Yes	
50328	XXX	N	Feb04	W	Kidney Transplantation	AG6	Apr04	16	ASTS	4.50	3.50			Yes	
50329	XXX	N	Feb04	W	Kidney Transplantation	AG7	Apr04	16	ASTS	4.30	3.34			Yes	
50360	090	R	Feb04	W	Kidney Transplantation		Apr04	16	ASTS	31.48	31.48	Yes	Yes		
50365	090	R	Feb04	W	Kidney Transplantation		Apr04	16	ASTS	36.75	36.75	Yes	Yes		
50391	000	N	Feb04	Z	Renal Pelvis - Ureter Therapeutic Agents Instillation	AH1	Apr04	6	AUA	2.50	1.96			Yes	
50547	090	R	Feb04	W	Kidney Transplantation	AG8	Apr04	16	ASTS	25.46	25.46	Yes	Yes		
50559	000	D	Aug03	N	Deletion of Urologic Endoscopic Insertion of Radioactive Element		Deleted							Yes	
50578	000	D	Aug03	N	Deletion of Urologic Endoscopic Insertion of Radioactive Element		Deleted							Yes	
50959	000	D	Aug03	N	Deletion of Urologic Endoscopic Insertion of Radioactive Element		Deleted							Yes	
50978	000	D	Aug03	N	Deletion of Urologic Endoscopic Insertion of Radioactive Element		Deleted							Yes	
52234	000	R	Feb04	EC-I	Cystourethroscopy - Resection of Small Tumor		Editorial			4.62	4.62	Yes	Yes		
52347	000	D	Nov03	T	Cystourethroscopy with Resection - Incision of Ducts		Deleted							Yes	

CPT Code	Global Coding	CPT Issue	CPT Change	Issue Date	Issue Tab	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
52402	000	N	Nov03	T	Cystourethrascopy with Resection - Incision of Ducts		Renum				5.27	5.27		Yes	
57267	ZZZ	N	Feb04	3	Pelvic Floor Defect Graft Repair	AI1	Apr04	29	ACOG		4.88	4.88		Yes	
57282	090	R	Aug03	O	Vaginal Extra and Intraperitoneal Colpopexy		Feb04	12	ACOG		8.85	8.85	Yes	Yes	
57283	090	N	Aug03	O	Vaginal Extra and Intraperitoneal Colpopexy	E1	Feb04	12	ACOG		14.00	14.00		Yes	
58356	010	N	Feb04	4	Endometrial Cryoablation Therapy	AJ1	Apr04	30	ACOG					Yes	Carrier Price-Sep04 RUC Meeting
58565	090	N	Feb04	A2	Hysteroscopic Fallopian Tube Cannulation and Placement of Permanent Implants	AK1	Apr04	31	ACOG		9.99	7.02		Yes	
58956	090	N	Nov03	V	BSO Omentectomy with TAH for Malignancy	M1	Feb04	11	ACOG		20.78	20.78		Yes	
61885	090	R	Feb04	V1	Neurostimulator Insertion-Replacement		Editorial				5.84	5.84	Yes	Yes	
63050	090	N	Feb04	6	Cervical Laminoplasty	AL1	Apr04	21	AANS/CNS, NASS		20.75	20.75		Yes	
63051	090	N	Feb04	6	Cervical Laminoplasty	AL2	Apr04	21	AANS/CNS, NASS		24.25	24.25		Yes	
63295	ZZZ	N	Feb04	7	Osteoplastic Laminectomy	AM1	Apr04	22	AANS/CNS, NASS		5.25	5.25		Yes	
63685	090	R	Feb04	V1	Neurostimulator Insertion-Replacement		Editorial				7.03	7.03	Yes	Yes	
64590	010	R	Feb04	V1	Neurostimulator Insertion-Replacement		Editorial				2.40	2.40	Yes	Yes	

CPT Code	Global Coding Period	CPT 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
66710	090	R	Feb04	8	Ciliary Endoscopic Ablation	AN1	Apr04	27	AAO	4.77	4.77	Yes	Yes	
66711	090	N	Feb04	8	Ciliary Endoscopic Ablation	AN2	Apr04	27	AAO	6.60	6.60		Yes	
75960	XXX	N	Feb04	Q	Carotid Stenting		Apr04	19	AANS/C NS, AAN, SIR, ASN, ACR, SVS, ACC	0.82	0.82	Yes	Yes	
76075	XXX	R	Feb04	D	Dual X-Ray Absorptionmetry for Vertebral Assessment		Apr04	B	ACR	0.30	0.30	Yes	Yes	
76076	XXX	R	Feb04	D	Dual X-Ray Absorptionmetry for Vertebral Assessment		Apr04	B	ACR	0.22	0.22	Yes	Yes	
76077	XXX	N	Feb04	D	Dual X-Ray Absorptionmetry for Vertebral Assessment	AO1	Apr04	B	ACR	0.17	0.17		Yes	
76510	XXX	N	Feb04	F	Ophthalmic Ultrasound	AP1	Apr04	28	AAO	1.59	1.55		Yes	
76511	XXX	R	Feb04	F	Ophthalmic Ultrasound	AP2	Apr04	28	AAO	0.94	0.94	Yes	Yes	
76512	XXX	R	Feb04	F	Ophthalmic Ultrasound	AP3	Apr04	28	AAO	0.98	0.94		Yes	
76513	XXX	R	Feb04	F	Ophthalmic Ultrasound		Apr04	28	AAO	0.66	0.66	Yes	Yes	
76514	XXX	R	Feb04	F	Ophthalmic Ultrasound		Apr04	28	AAO	0.17	0.17	Yes	Yes	
76820	XXX	N	Feb04	11	Doppler Velocimetry, Umbilical and Middle Cerebral Arteries	AQ1	Apr04	A	ACOG, ACR				Yes	Carrier Price-Sept04 RUC Meeting
76821	XXX	N	Feb04	11	Doppler Velocimetry, Umbilical and Middle Cerebral Arteries	AQ2	Apr04	A	ACOG, ACR				Yes	Carrier Price - Sep04 RUC Meeting

CPT Code	Global	Coding	CPT Issue	CPT Tab	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments		
76827	XXX	R	Feb04	11	Doppler Velocimetry, Umbilical and Middle Cerebral Arteries	Apr04	A	ACOG, ACR	0.58	0.58	Yes	Yes		
76828	XXX	R	Feb04	11	Doppler Velocimetry, Umbilical and Middle Cerebral Arteries	Apr04	A	ACOG, ACR	0.56	0.56	Yes	Yes		
77418	XXX	R	Nov03	24	Intensity Modulated Treatment Delivery	Editorial			0.00	0.00	Yes	Yes	Practice Expense Only	
77750	XXX	R	Feb04	15	Radiopharmaceutical Therapy	Apr04	D	ACR, SNM	4.90	4.90	Yes	Yes		
78267	XXX	R	Feb04	B1	H Pylori Detection (C 13 Urea) - Infrared Spectrometry	CLFS								
78268	XXX	R	Feb04	B1	H Pylori Detection (C 13 Urea) - Infrared Spectrometry	CLFS								
78464	XXX	R	Feb04	12	Attenuation Correction	Editorial			1.09	1.09	Yes	Yes		
78465	XXX	R	Feb04	12	Attenuation Correction	Editorial			1.46	1.46	Yes	Yes		
78810	XXX	D	Feb04	13	Position Emission Tomography and Computed Procedures	Apr04	C	ACR, SNM				Yes		
78811	XXX	N	Feb04	13	Position Emission Tomography and Computed Procedures	AR1	Apr04	C	ACR, SNM	1.80	1.54		Yes	
78812	XXX	N	Feb04	13	Position Emission Tomography and Computed Procedures	AR2	Apr04	C	ACR, SNM	2.00	1.93		Yes	
78813	XXX	N	Feb04	13	Position Emission Tomography and Computed Procedures	AR3	Apr04	C	ACR, SNM	2.10	2.00		Yes	
78814	XXX	N	Feb04	13	Position Emission Tomography and Computed Procedures	AR4	Apr04	C	ACR, SNM	2.40	2.20		Yes	

CPT Code	Global Coding	CPT Change	CPT Date	CPT Issue	Tracking Number	RUC Date	RUC Tab	S.S. Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
78815	XXX	N	Feb04	13	Position Emission Tomography and Computed Procedures	AR5	Apr04	C	ACR, SNM	2.73	2.44		Yes
78816	XXX	N	Feb04	13	Position Emission Tomography and Computed Procedures	AR6	Apr04	C	ACR, SNM	3.00	2.50		Yes
78990	XXX	D	Feb04	14	Position Emission Tomography and Computed Tomography		Apr04	C	ACR, SNM				Yes
79000	XXX	D	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM				Yes
79001	XXX	D	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM				Yes
79005	XXX	N	Feb04	15	Radiopharmaceutical Therapy	AS1	Apr04	D	ACR, SNM	1.80	1.80		Yes
79020	XXX	D	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM				Yes
79030	XXX	D	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM				Yes
79035	XXX	D	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM				Yes
79100	XXX	D	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM				Yes
79101	XXX	N	Feb04	15	Radiopharmaceutical Therapy	AS2	Apr04	D	ACR, SNM	2.10	1.96		Yes
79200	XXX	R	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM	1.99	1.99	Yes	Yes

CPT Code	Global	Coding	CPT	CPT	Issue	Tracking	RUC	RUC	S.S.	Specialty	RUC	Same	RVU	MFS	Comments
Code	Period	Change	Date	Tab		Number	Date	Tab		Rec	Rec	as last year?			
79300	XXX	R	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM	1.60	1.60	Yes	Yes		
79400	XXX	D	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM					Yes	
79420	XXX	D	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM					Yes	
79440	XXX	R	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM	1.99	1.99	Yes	Yes		
79445	XXX	N	Feb04	15	Radiopharmaceutical Therapy	AS3	Apr04	D	ACR, SNM	2.40	2.40			Yes	
79900	XXX	D	Feb04	14	Provision of Therapeutic Radiopharmaceuticals		Deleted							Yes	
79999	XXX	R	Feb04	15	Radiopharmaceutical Therapy		Apr04	D	ACR, SNM					Yes	Carrier Price
82045	XXX	N	Feb04	H	Albumin Cobalt Binding Test		CLFS								
82656	XXX	N	Feb04	21	Pancreatic Elastase		CLFS								
83009	XXX	N	Feb04	B1	H Pylori Detection (C 13 Urea) - Infrared Spectrometry		CLFS								
83013	XXX	R	Feb04	B1	H Pylori Detection (C 13 Urea) - Infrared Spectrometry		CLFS								
83014	XXX	R	Feb04	B1	H Pylori Detection (C 13 Urea) - Infrared Spectrometry		CLFS								
83630	XXX	N	Feb04	19	Fecal Lactoferrin		CLFS								
84163	XXX	N	Nov03	1	Pregnancy Associated Plasma Protein		CLFS								

CPT Code	Global	Coding Change	CPT Period	CPT Issue Date	CPT Tab	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
84165	XXX	R	Feb04	22	Protein Electrophoresis	AT1	Apr04	E	CAP		0.37	0.37	Yes	Yes	
84166	XXX	N	Feb04	22	Protein Electrophoresis	AT2	Apr04	E	CAP		0.37	0.37		Yes	
85046	XXX	R	Nov03	2	Reticulocyte Parameters		CLFS								
86064	XXX	N	Nov03	K	Flow Cytometry of B Cells, Natrual Killer (NK) Cells and Stem Cells		CLFS								
86334	XXX	R	Feb04	22	Protein Electrophoresis	AT3	Apr04	E	CAP		0.37	0.37	Yes	Yes	
86335	XXX	N	Feb04	22	Protein Electrophoresis	AT4	Apr04	E	CAP		0.37	0.37		Yes	
86379	XXX	N	Nov03	K	Flow Cytometry of B Cells, Natrual Killer (NK) Cells and Stem Cells		CLFS								
86587	XXX	N	Nov03	K	Flow Cytometry of B Cells, Natrual Killer (NK) Cells and Stem Cells		CLFS								
87807	XXX	N	Feb04	23	Infectious Agent Antigen Detection by Immunoassay with Direct Optical Observation		CLFS								
88180	XXX	D	Feb04	A3	Flow Cytometry		Apr04	F	CAP					Yes	
88184	XXX	N	Feb04	A3	Flow Cytometry	AU1	Apr04	F	CAP					Yes	No RUC Recommendation-Sept04 RUC Meeting
88185	XXX	N	Feb04	A3	Flow Cytometry	AU2	Apr04	F	CAP					Yes	No RUC Recommendation-Sept04 RUC Meeting
88187	XXX	N	Feb04	A3	Flow Cytometry	AU3	Apr04	F	CAP					Yes	No RUC Recommendation-Sept04 RUC Meeting
88188	XXX	N	Feb04	A3	Flow Cytometry	AU4	Apr04	F	CAP					Yes	No RUC Recommendation-Sept04 RUC Meeting

CPT Code	Global Period	Coding Change	CPT Date	CPT Issue Tab		Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
88189	XXX	N	Feb04	A3	Flow Cytometry	AU5	Apr04	F	CAP				Yes	No RUC Recommendation-Sept04 RUC Meeting
88360	XXX	N	Feb04	25	In Situ Hybridization (e.g. FISH) Procedures	AV2	Apr04	G	CAP, ASC				Yes	No RUC Recommendation-Sep04 RUC Meeting
88361	XXX	R	Feb04	25	In Situ Hybridization (e.g. FISH) Procedures	AV1	Apr04	G	CAP, ASC				Yes	No RUC Recommendation-Sep04 RUC Meeting
88365	XXX	R	Feb04	25	In Situ Hybridization (e.g. FISH) Procedures	AV3	Apr04	G	CAP, ASC				Yes	No RUC Recommendation-Sep04 RUC Meeting
88367	XXX	N	Feb04	25	In Situ Hybridization (e.g. FISH) Procedures	AV4	Apr04	G	CAP, ASC				Yes	No RUC Recommendation-Sep04 RUC Meeting
88368	XXX	N	Feb04	25	In Situ Hybridization (e.g. FISH) Procedures	AV5	Apr04	G	CAP, ASC				Yes	No RUC Recommendation-Sep04 RUC Meeting
89346	XXX	N	Feb04	H	Reproductive Medicine Laboratory Procedures		CLFS							
90465	XXX	N	Nov03	F	Pediatric Specific Immunization Administration	N5	Feb04	13	AAP	0.17	0.17		Yes	
90466	XXX	N	Nov03	F	Pediatric Specific Immunization Administration	N6	Feb04	13	AAP	0.15	0.15		Yes	
90467	XXX	N	Nov03	F	Pediatric Specific Immunization Administration	N7	Feb04	13	AAP	0.17	0.17		Yes	
90468	XXX	N	Nov03	F	Pediatric Specific Immunization Administration	N8	Feb04	13	AAP	0.15	0.15		Yes	
90471	XXX	R	Nov03	F	Pediatric Specific Immunization Administration	N1	Feb04	13	AAP	0.17	0.17		Yes	
90472	XXX	R	Nov03	F	Pediatric Specific Immunization Administration	N2	Feb04	13	AAP	0.15	0.15		Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC Tab	S.S. Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
90473	XXX	R	Nov03	F	Pediatric Specific Immunization Administration	N3	Feb04	13	AAP	0.17	0.17	Yes	
90474	XXX	R	Nov03	F	Pediatric Specific Immunization Administration	N4	Feb04	13	AAP	0.15	0.15	Yes	
90656	XXX	N	Aug03	EC11	Vaccines		Vaccine						
90700	XXX	R	Aug03	EC11	Vaccines		Vaccine						
91032	000	D	Nov03	6	Gastroesophageal Reflux Procedures and Esophagus - GE Junction Impedance Test		Feb04	14	ASGE, AGA			Yes	
91033	000	D	Nov03	6	Gastroesophageal Reflux Procedures and Esophagus - GE Junction Impedance Test		Feb04	14	ASGE, AGA			Yes	
91034	000	N	Nov03	6	Gastroesophageal Reflux Procedures and Esophagus - GE Junction Impedance Test	O1	Feb04	14	ASGE, AGA	1.30	0.97	Yes	
91035	000	N	Nov03	6	Gastroesophageal Reflux Procedures and Esophagus - GE Junction Impedance Test	O2	Feb04	14	ASGE, AGA	1.50	1.59	Yes	
91037	000	N	Nov03	6	Gastroesophageal Reflux Procedures and Esophagus - GE Junction Impedance Test	O3	Feb04	14	ASGE, AGA	1.50	0.97	Yes	
91038	000	N	Nov03	6	Gastroesophageal Reflux Procedures and Esophagus - GE Junction Impedance Test	O4	Feb04	14	ASGE, AGA	1.95	1.10	Yes	
91040	000	N	Feb04	28	Esophageal Balloon Provocation	AX1	Apr04	26	AGA	0.97	0.97	Yes	
91065	XXX	R	Feb04	B1	H Pylori Detection (C 13 Urea) - Infrared Spectrometry		Editorial			0.20	0.20	Yes	Yes
91120	000	N	Feb04	27	Rectal Barostat Sensation Test	AW1	Apr04	25	AGA	0.97	0.97	Yes	
93741	XXX	R	May03	M	ECG Vest	B2	Feb04	15	ACC	0.80	0.80	Yes	Yes

CPT Code	Global Period	Coding Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC Tab	S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
93742	XXX	R	May03	M	ECG Vest	B3	Feb04	15	ACC	0.91	0.91	Yes	Yes	
93745	XXX	N	May03	M	ECG Vest	B1	Feb04	15	ACC				Yes	No RUC Recommendation
93890	XXX	N	Nov03	G	Intracranial Artery Transcranial Doppler Studies	P1	Feb04	16	SVS, AAN	1.00	1.00		Yes	
93892	XXX	N	Nov03	G	Intracranial Artery Transcranial Doppler Studies	P2	Feb04	16	SVS, AAN	1.15	1.15		Yes	
93893	XXX	N	Nov03	G	Intracranial Artery Transcranial Doppler Studies	P3	Feb04	16	SVS, AAN	1.15	1.15		Yes	
94060	XXX	R	May04	8	Bronchospasm		Editorial			0.31	0.31	Yes	Yes	
94070	XXX	R	May04	8	Bronchospasm		Editorial			0.60	0.60	Yes	Yes	
94452	XXX	N	Nov03	10	High Altitude Hypoxia Simulation Test	Q1	Feb04	17	ATS, ACCP	0.40	0.31		Yes	
94453	XXX	N	Nov03	10	High Altitude Hypoxia Simulation Test	Q2	Feb04	17	ATS, ACCP	0.40	0.40		Yes	
95115	000	R	Feb04	H1	Allergy and Immunology		Editorial			0.00	0.00	Yes	Yes	Practice Expense Only
95120	000	R	Feb04	H1	Allergy and Immunology		Editorial			0.06	0.06	Yes	Yes	
95144	000	R	Feb04	H1	Allergy and Immunology		Editorial			0.06	0.06	Yes	Yes	
95145	000	R	Feb04	H1	Allergy and Immunology		Editorial			0.06	0.06	Yes	Yes	
95928	XXX	N	Nov03	14	Central Motor Evoked Potential Study	R1	Feb04	18	AAN, ACNS, AAEM	1.50	1.50		Yes	

CPT Code	Global	Coding	CPT Change	CPT Date	Issue Tab	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
95929	XXX	N	Nov03	14	Central Motor Evoked Potential Study	R2	Feb04	18	AAN, ACNS, AAEM	1.50	1.50			Yes	
95971	XXX	R	Feb04	K1	Complex Deep Brain Neurostimulator Generator - Transmitter Electronic Analysis	BA1	Apr04	20	AANS/C NS, AAN, ASA	0.78	0.78	Yes		Yes	
95972	XXX	R	Feb04	K1	Complex Deep Brain Neurostimulator Generator - Transmitter Electronic Analysis	BA2	Apr04	20	AANS/C NS, AAN, ASA	1.50	1.50	Yes		Yes	
95973	ZZZ	R	Feb04	K1	Complex Deep Brain Neurostimulator Generator - Transmitter Electronic Analysis	BA3	Apr04	20	AANS/C NS, AAN, ASA	0.92	0.92	Yes		Yes	
95978	XXX	N	Feb04	K1	Complex Deep Brain Neurostimulator Generator - Transmitter Electronic Analysis	BA4	Apr04	20	AANS/C NS, AAN, ASA	3.50	3.50			Yes	
95979	ZZZ	N	Feb04	K1	Complex Deep Brain Neurostimulator Generator - Transmitter Electronic Analysis	BA5	Apr04	20	AANS/C NS, AAN, ASA	1.75	1.64			Yes	
96111	XXX	R	Nov03	16	Developmental Testing Revision					2.60	2.60	Yes		Yes	
99293	XXX	R	Nov03	L	Neonate Definition Editorial Revision					15.98	15.98	Yes		Yes	
99294	XXX	R	Nov03	L	Neonate Definition Editorial Revision					7.99	7.99	Yes		Yes	

CPT Code	Global Coding	CPT Change	CPT Date	CPT Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
99295	XXX	R	Nov03	L	Neonate Definition Revision	Editorial				18.46	18.46	Yes	Yes	
99296	XXX	R	Nov03	L	Neonate Definition Revision	Editorial				7.99	7.99	Yes	Yes	

Specialty and Acronym

Society

Acronym

AMA CPT Editorial Panel	AMA/CPT
AMA Staff	AMA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology	AAD
American Academy of Facial Plastic and Reconstructive Surgery	AAFPRS
American Academy of Family Physicians	AAFP
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
American Academy of Pediatrics	AAP
American Academy of Pharmaceutical Physicians	AAPP
American Academy of Physical Medicine and Rehabilitation	AAPMR
American Academy of Physician Assistants	AAPA
American Academy of Sleep Medicine	AASM
American Association of Clinical Endocrinologists	AACE
American Association of Electrodiagnostic Medicine	AAEM
American Association of Hip and Knee Surgeons	AAHKS
American Association of Neurological Surgeons	AANS
American Association of Neurological Surgeons	ASNS
American Association of Plastic Surgeons	AAPS
American Burn Association	ABA
American Chiropractic Association	ACA
American Clinical Neurophysiology Society	ACNS
American College of Cardiology	ACC
American College of Chest Physicians	ACCP

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

<u>Society</u>	<u>Acronym</u>
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society for Therapeutic Radiology and Oncology	ASTRO
American Society of Abdominal Surgeons	ASAS
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Cataract and Refractive Surgery	ASCaRS
American Society of Clinical Oncology	ASCO
American Society of Clinical Pathology	ASCP
American Society of Colon and Rectal Surgeons	ASCoRS
American Society of Cytopathology	ASC
American Society of General Surgeons	ASGS
American Society of Hematology	ASH
American Society of Maxillofacial Surgeons	ASMS
American Society of Neuroradiology	ASNR
American Society of Neuroradiology	ASNR
American Society of Plastic Surgeons	ASPS
American Society of Transplant Surgeons	ASTS
American Speech, Language, and Hearing Association	ASHA
American Thoracic Society	ATS
American Urological Association	AUA
Association Military Surgeons of the U.S.	AMSUS
Centers for Medicare and Medicaid Services	CMS
CMD	CMD
College of American Pathologists	CAP
Congress of Neurological Surgeons	CNS
Consultants	Abt
Consultants	CMS
Consultants	consultant
Consultants	PPRC

Society**Acronym**

Contact Lens Society of America	CLSA
Former PEAC Members	AAO-HNS
Former PEAC Members	AAOS
Former PEAC Members	ACC
Former PEAC Members	ACOG
Former PEAC Members	ACR _h
Former PEAC Members	ACS
Former PEAC Members	ANA
Former PEAC Members	ASC
Former PEAC Members	ASCO
Former PEAC Members	RPA
Former RUC Members	AACAP
Former RUC Members	AAFP
Former RUC Members	AAN
Former RUC Members	AANS
Former RUC Members	AAO
Former RUC Members	AAO-HNS
Former RUC Members	AAOS
Former RUC Members	AAP
Former RUC Members	AAPA
Former RUC Members	ACC
Former RUC Members	ACEP
Former RUC Members	ACH _r
Former RUC Members	ACOG
Former RUC Members	ACP
Former RUC Members	ACR
Former RUC Members	AGA
Former RUC Members	AGS
Former RUC Members	AMA
Former RUC Members	AOA
Former RUC Members	APSA
Former RUC Members	ASA

<u>Society</u>	<u>Acronym</u>
Former RUC Members	ASCO
Former RUC Members	ASPS
Former RUC Members	ASTRO
Former RUC Members	ATS
Former RUC Members	AUA
Former RUC Members	CAP
Former RUC Members	CPT
Former RUC Members	SNM
Former RUC Members	STS
Former RUC Members	SVS
International Observer	observer
International Spinal Injection Society	ISIS
Joint Council of Allergy, Asthma and Immunology	JCAAI
Medical Group Management Association	MGMA
MedPAC	MedPAC
National Association of Social Workers	NASW
North American Spine Society	NASS
PEAC Chairman	Chairman
Practice Expense Advisory Committee (PEAC)	PEAC
Radiological Society of North America	RSNA
Renal Physicians Association	RPA
RUC Chairman	Chairman
RUC Chairman - Home Address	Chairman
Society for Vascular Surgery	SVS
Society of American Gastrointestinal Endoscopic Surgeons	SAGES
Society of Critical Care Medicine	SCCM
Society of Interventional Radiology	SIR
Society of Nuclear Medicine	SNM
Society of Thoracic Surgeons	STS
The American Society for Aesthetic Plastic Surgery	ASAPS
The Endocrine Society	TES
The Triological Society	TTS

AMA/Specialty Society RVS Update Committee Recommendation

CPT Code	Tracking Number	Pre-Evaluation Time	Pre-Positioning Time	Pre-scrub, dress, wait time	Intra-service time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time
00561	H2	45			300	30													375
11004	T1	30	15	20	90	30													185
11006	T2	30	15	20	120	30													215
19296	I2	30	10	15	30	15						0.5							118
19297	I1	5			30	5													40
19298	I3	30	15	15	60	30						0.5							168
27412	V4	45	15	15	180	30			1	1		1			2	3			469
27415	V5	45	15	15	120	30			1	1		1			2	3			409
29866	V1	45	15	15	100	20						0.5			3	2			304
29867	V2	45	15	15	120	30				1		1			2	3			390
29868	V3	45	15	15	180	30			1	1		1			2	3			469
31545	C1	40	10	10	60	15						0.5							153
31546	C2	40	10	10	90	20						0.5							188
31620	J5				20														20
31630	J	20	15	15	45	30													125
31631	J1	20	10	15	45	30													120
31636	J2	15	15	15	45	25													115
31637	J3				30														30
31638	J4	20	15	15	60	30													140
32019	W1	15	10	15	30	20													90
34803	Z1	75	15	20	165	30			1	1		1			1	1			428
36475	K1	40	10	15	60	15						0.5							158
36476	K2				45														45
36478	K3	40	10	15	55	15						0.5							153
36479	K4				45														45
36818	AA1	35	10	15	90	30						0.5			1	1			236
37215	AB1	60	15	15	103	30				1		1				2			335
37216	AB2	60	15	15	97	30				1		1				2			329
43257		15	10	10	60							0.5							113
43644	L2	30	30	15	180	30			1	2		1			1	1	1		476
43645	L3	45	30	15	200	30			1	2		1			1	1	1		511

AMA/Specialty Society RVS Update Committee Recommendation

CPT Code	Tracking Number	Pre-Evaluation Time	Pre-Positioning Time	Pre-scrub, dress, wait time	Intra-service time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time
44720	AC4				50														50
44721	AC5				70														70
45391	AD1	25	5	5	55	20													110
45392	AD2	30	5	10	75	20													140
46947	D1	40	10	10	30	22						0.5			1	1			168
47146	AE8				60														60
47147	AE9				65														65
48552	AF3				50														50
50327	AG5				44														44
50328	AG6				45														45
50329	AG7				45														45
50391	AH1	13	7.5		30	10													61
52402		30			50	15													95
57267	AI1				45														45
57283	E1	60	12	15	95	30			1	1		1			1	1			335
58565	AK1	35	10	15	50	30						0.5			2				188
58956	M1	77.5	15	20	150	30			2	1	1	1				3			507
63050	AL1	55	25	15	150	30			2	1		1			1	2			440
63051	AL2	55	25	15	190	30			2	1		1			1	2			480
63295	AM1	10			45														55
66711	AN2	10	5	10	30	10						0.5			1	4			190
76077	AO1	1			5	1													7
76510	AP1	5			30	10													45
76511	AP2	5			15	10													30
76512	AP3	10			15	10													35
78811	AS1	10			20	10													40
78812	AS2	10			30	10													50
78813	AS3	15			30	10													55
78814	AS4	15			30	15													60
78815	AS5	15			35	15													65

AMA/Specialty Society RVS Update Committee Recommendation

CPT Code	Tracking Number	Pre-Evaluation Time	Pre-Positioning Time	Pre-scrub, dress, wait time	Intra-service time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time
78816	AS6	15			40	15													70
79005	AT1	20			15	10													45
79101	AT2	30			30	20													80
79445	AT3	30			45	20													95
84166		3			5	5													13
86335		4			6	5													15
90465	N5				7														7
90466	N6				7														7
90467	N7				7														7
90468	N8				7														7
90471	N1				7														7
90472	N2				7														7
90473	N3				7														7
90474	N4				7														7
91034	O1	15				16													31
91035	O2	15			20	16													51
91037	O3	15				16													31
91038	O4	15				26													41
91040	AY1	8	4	3	15	15													45
91120	AX1	7	4	4	15	15													45
93890	P1	10			15	10													35
93892	P2	10			20	10													40
93893	P3	10			20	10													40
94452	Q1	10			10	10													30
94453	Q2	5			6	12													23
95928	R1	15			60	15													90
95929	R2	15			60	15													90
95978	BB4	5			60	5													70
95979	BB5				30														30
97598	F2	15			40	15													70

AMA/Specialty Society RVS Update Committee Recommendation

CPT Code	Tracking Number	Pre-Evaluation Time	Pre-Positioning Time	Pre-scrub, dress, wait time	Intra-service time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time
97601		10			30	10													50
97605	G1	10			30	10													50
97606	G2	10			30	10													50
97810		3			15	3													21
97811					15														15
97813		3			15	3													21
97814					15														15

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2004

Anesthesia Procedures - Congenital Heart Infant Bypass

The CPT Editorial Panel created a new code 00561 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest, with pump oxygenator, under one year of age* to differentiate between the work involved in procedures normally performed on adults from those associated with surgical repair of congenital heart lesions in children less than one year of age. CPT code 00562 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator* (Base Unit = 20) was created more than 30 years ago. At that time, correction of these lesions occurred after the child grew for several years. Now complete repair is performed at the earliest possible time, frequently shortly after birth.

The RUC reviewed survey data from nearly 50 anesthesiologists who indicated that this new service described in 00561 is more intense than the service currently described in 00562. The survey responses on the intensity/complexity measures included a wide variance, with mental effort and judgment; technical skill and physical effort; and psychological stress all being at least 40% greater for the procedures performed on children under one year of age. Although the survey median was 27 base units, the specialty recommended the 25th percentile of 25 base units. The RUC agreed with this recommendation and the specialty's comparison to CPT codes 00563 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest* and 00566 *Anesthesia for direct coronary artery bypass grafting without pump oxygenator*. **The RUC recommends a base unit of 25 for CPT code 00561.**

The RUC discussed the issue of work neutrality and agreed that it could not be applied in this situation. The specialty estimates that the services currently reported under 00562 that will now be reported as 00561 will be less than 2% of the total utilization.

Practice Expense

The service is performed in a facility setting only and, therefore, no direct practice expense inputs are applicable.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
●00561	H2	with pump oxygenator, under one year of age <u>(Do not report 00561 in conjunction with 99100, 99116, and 99135)</u>	XXX	25 ASA Base Units
00562	H1	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator	XXX	20 ASA Base Units (No Change)

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

CPT Code:00561 Tracking Number: HH2 Global Period:XXX **Recommended Base Unit Value: 25**

CPT Descriptor: Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, under one year of age
(Do not report 00561 in conjunction with 99100, 99116, and 99135)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: This infant was noted to have trisomy 21 and a heart murmur at birth. Subsequent studies determined the presence of an atrioventricular (AV) canal defect. The patient was followed closely after starting digoxin and furosemide by mouth. At his six month check-up the infant was noted to have tachypnea and failure to gain weight. The oxygen saturation was noted to be 88 % (a decrease from previous measurements), and radiologic examination of the chest noted signs consistent with cardiac failure. The repair of the congenital heart defect under cardio-pulmonary bypass was scheduled.

Percentage of Survey Respondents who found Vignette to be Typical: 82.97%

Description of Pre-Service Work: The day prior to the scheduled surgery the infant was seen in the pre-anesthetic clinic. Prior to entering the examination room the medical chart was reviewed with special attention to the cardiology notes and laboratory investigations including the results of cardiac catheterizations and ultrasonic evaluations. The electrocardiogram demonstrated sinus tachycardia and ventricular hypertrophy. Increased lung markings were noted on the chest x-ray. A detailed history including prenatal care and birth history was completed. On questioning the parents were unaware of any defects in any other body system. Past history revealed no previous anesthetics or significant events. Family history and review of systems were unremarkable.

A small for age crying infant was noted on examination. He appeared cachectic and slightly dusky in color. The cry was weak. There were mild retractions noted throughout the thorax, and tachypnea with a respiratory rate of 45 breaths per minute was observed. There were no other associated defects noted that would indicate the presence of a congenital syndrome. Examination of the airway was normal for this age and condition. The auscultation of the lungs noted rhonci throughout and possibly some rales in the bases; however, the patient was not cooperative enough and did not stop crying long enough for a complete examination. As noted earlier intercostal and suprasternal retractions were observed as was an occasional inspiratory grunt. Examination of the heart noted a rate greater than 170 beats per minute. A loud 4/6 systolic murmur was evident throughout the precordium.

Blood was drawn for a complete blood count, electrolytes, and type and cross-match.

The process of anesthesia including intramuscular injection of anesthetic agents for induction, monitors, vascular access including peripheral and subclavian venous access and arterial access likely at the wrist were described. The maintenance of anesthesia and the plan to maintain endotracheal intubation into the post-operative period were discussed. The number of "tubes" entering and exiting the infant was mentioned as was the likelihood of generalized edema especially noticeable on the face post-operatively. The possibility of using nitric oxide for pulmonary vascular dilation was noted. Lastly, plans for pain management in the postoperative period were discussed with the parents. After discussing the total anesthetic plan the parents were given the opportunity to have any questions they may have answered.

The following morning the patient's chart was reviewed for additional information including the results of the previous day's blood tests. Both the complete blood count and electrolyte panel were normal for age. The anesthesiologist confirmed four units of blood were available in the operating room. The patient was examined with no interval changes noted. The parents were given the opportunity to again ask questions and all were answered to their satisfaction.

The operating room was prepared for administration of general anesthesia. This includes preparing the anesthesia machine, as well as medications and airway and monitoring equipment including preparation of pressure transducers for arterial and central venous pressure monitoring. A tower of intravenous medication pumps was prepared for the administration of cardio- and vaso-active medications as well as aprotinin for aid in hemostasis. The nitric oxide delivery equipment and airway circuit were assembled and checked.

A final chart review was performed to confirm the presence of required documentation and consent forms.

Description of Intra-Service Work: Ketamine and atropine doses were calculated based on weight and administered intramuscularly after sterile preparation into the deltoid muscle. Once the infant was noted to be under the influence of the anesthetic he was transferred to the operating room. Monitors were placed for five lead electrocardiogram, pulse oximetry and blood pressure. A saphenous vein was cannulated with a 20 gauge catheter and intravenous narcotic anesthesia and muscle relaxation were infused. Manual ventilation with 100% oxygen was begun. After appropriate demonstration of paralysis with a nerve blockade monitor, the trachea was intubated with the appropriate age calculated sized endotracheal tube. Auscultation of breath sounds and capnography confirmed the correct tube placement. The endotracheal tube was secured with waterproof tape so as not to be disturbed by placement of the transesophageal echo probe (separately reported).

A radial artery was cannulated with a 22 gauge catheter and a left subclavian 5 French double lumen central line was placed under sterile conditions (both reported separately). Both lines were connected to the pressure transducers after zeroing as recommended. Blood samples were drawn for blood gas analysis and activated clotting time (ACT). A 1 ml test dose of aprotinin was administered and after noting no adverse reaction the continuous infusion started. The remaining cardioactive infusion drugs were connected to the central line but not started.

Intravenous medications to prevent infection and inflammation were administered. Anesthesia charting was performed. Ventilation was adjusted as indicated by the blood gas results.

Surgery commenced and ventilation was momentarily stopped during sternotomy. Intermittent blood gas analysis and ACT were measured throughout the surgery. Narcotics and muscle relaxants were intermittently administered as necessary and blood pressure was titrated with inhaled isoflurane.

After the surgeons adequately dissected the great vessels, heparin was administered intravenously and the activated clotting time was measured to be over 400 seconds. Cardio-pulmonary bypass commenced soon after cannulation of the aorta and right atrium, and ventilation was discontinued. During bypass the anesthesiologist in conjunction with the perfusionist administered anesthetic agents and relaxants as appropriate. Surgical repair of the atrio-ventricular canal ensued with graft closure of the septal defects and suture repair of the valvular insufficiency. The anesthesiologist and the surgeon worked together to assure venting of air from the heart prior to release of the aortic cross-clamp. Near the anticipated end of bypass and after adequate re-warming, ventilation was restarted and inotropic cardiac support was begun with infusions of dopamine and dobutamine. Afterload reduction was produced by an infusion of milrinone. Heating the infant was partially accomplished with forced warm air mattress controlled by the anesthesiologist.

After discontinuing bypass, the pulmonary artery was cannulated by the surgeon and the pressure line was passed to the anesthesiologist for connection to a transducer. As is typically seen with AV canal repair in children less than one year of age, the pulmonary artery pressure was discovered to be high and inhaled nitric oxide gas was added to the inspiratory anesthetic circuit. Flows were adjusted to obtain the correct concentration as measured in the inspiratory limb. Once cardiac and pulmonary parameters were stabilized the heparin anticoagulation was reversed with intravenous protamine and the ACT was measured as normal. Blood gases were intermittently checked. Due to the

patient's weight and the effects of cardiopulmonary bypass on the coagulation system, coagulopathies are commonly seen after discontinuation from bypass.

After the conclusion of surgery a portable monitor and ventilation circuit were connected to the patient for transport of the baby to the intensive care unit. The nitric oxide circuit was tested to ensure adequate delivery of the vasodilator during transport. The infusion pumps delivering cardiovascular medications were checked for proper function prior to transport. On arrival to the intensive care unit, hemodynamic and respiratory monitors were transferred to the unit's system. Ventilation was transferred to a bedside ventilator and parameters adjusted to satisfaction. The continued administration of nitric oxide was confirmed. Vital signs were monitored.

Description of Post-Service Work: A full report was given to the physician assuming care and the assigned nurse. Finally, the anesthetic record was completed and filed. The anesthesiologist then met with the infant's family and discussed the course of the anesthetic and anticipated issues during the initial period of recovery. The anesthesiologist visited the patient on the first post-operative day to assess recovery from anesthesia and document adverse events associated with the procedure. An entry in the medical record was made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		01/2004			
Presenter(s):	James D. Grant, MD				
Specialty(s):	American Society of Anesthesiologists				
CPT Code:	00561				
Sample Size:	170	Resp n:	47	Resp %: 27.6%	
Sample Type:	Panel				
		Low	25 th pctl	Median*	75th pctl
Survey Base Unit Values:		23.00	25.00	27.00	30.00
Pre-Anesthesia Time:		15.00	30.00	45.00	73.00
Intra-op Anesthesia Time:		150.00	300.00	300.00	360.00
Post-Anesthesia Time:				30.00	

To calculate above and below time recommendations, tab here

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Base Unit Value</u>
00562	XXX	20

CPT Descriptor Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator

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

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

Number of respondents who choose Key Reference Code: 26

TIME ESTIMATES (Median)

New/Revised
CPT Code:
00561

Key Reference
CPT Code:
00562

Median Pre-Service Time	45.00	not available
Median Intra-Service Time	300.00	not available
Median Post-service Time	30.00	not available
Median Total Time	375.00	

Calculate total
reference time
tab here

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

The number of possible diagnosis and/or the number of management options that must be considered	4.50	3.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.35	3.69
Urgency of medical decision making	4.62	3.65

Technical Skill/Physical Effort (Mean)

Technical skill required	4.88	3.67
Physical effort required	4.42	3.63

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.77	3.65
Outcome depends on the skill and judgement of physician	4.81	3.81
Estimated risk of malpractice suit with poor outcome	4.38	3.23

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Anesthesia intensity/complexity	4.35	3.42
Intra-Op Anesthesia intensity/complexity	4.77	3.79
Post-Anesthesia intensity/complexity	3.76	3.14

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.*

The younger and smaller the patient, the greater the anesthesia risk and work. This fact has been acknowledged with the codes that describe anesthesia services for hernia repairs.

Code	Descriptor	Base Unit Value
00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified.	4
00832	Anesthesia for hernia repairs in lower abdomen; ventral and incisional hernias	6
00834	Anesthesia for hernia repairs in the lower abdomen not otherwise specified, under 1 year of age	5
00836	Anesthesia for hernia repairs in the lower abdomen not otherwise specified, infants less than 37 weeks gestational age at birth and less than 50 weeks gestational age at time of surgery	6

The same logic follows through to anesthesia for cardiac procedures. In order to maintain the integrity of the relative value system, the new code must have a base unit value higher than code 00562- Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator – 20 base units (which was the most frequently selected reference service in our survey) but less than code 00796 – Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient) – 30 base units (selected by 6 survey respondents to serve as their reference service and quite possibly the most complex and difficult anesthesia service that currently exists). Additionally, new code 0056X1 includes qualifying circumstances for extreme age, total body hypothermia and controlled hypotension; these services are not separately reportable and must be taken into account when valuing the service. All this supports assigning a value of 25 base units to the new code. This puts it on par with code 00563 – Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest and with code 00566 – Anesthesia for direct coronary artery bypass grafting without pump oxygenator. Both of these codes have 25 base units.

Almost 83 percent of our respondents agreed that the patient described in the survey was typical. Remarks made by those that did not agree,

- Typical patient would be younger and show evidence of CHF. This patient is very difficult to start an IV and art line. Fluid and blood component management would be an additional challenge given the small size of the patient.
- Our patients are typically younger (2-3 months of age) and presumably smaller (3-5 kg) with greater pvd, vascular reactivity.
- Patient is a bit younger with a bit more heart failure. Repair is performed utilizing deep hypothermic circulatory arrest.
- Younger (a neonate – not 6 months), more unstable. More likely to use circulatory arrest than as described.
- Less complex congenital lesion.
- Neonate or infant having bypass with AA. Deep hypothermic circulatory arrest.

Our recommended value of 25 base units matches the 25th percentile in our results. Both the median (27) and the mean (27.45) exceed the 25 units assigned to a cardiac anesthesia service with hypothermic circulatory arrest. Since hypothermic circulatory arrest is not typically used with new code 0056X1, we do not recommend a higher 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? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 00562 - Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator

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

Specialty Anesthesiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? <2,500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Anesthesiology	Frequency <2,500	Percentage	100.00%
--------------------------	------------------	------------	---------

Specialty	Frequency	Percentage
-----------	-----------	------------

Specialty	Frequency	Percentage
-----------	-----------	------------

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

Specialty Anesthesiology	Frequency <250	Percentage	100.00%
--------------------------	----------------	------------	---------

Specialty	Frequency	Percentage
-----------	-----------	------------

Specialty	Frequency	Percentage
-----------	-----------	------------

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 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 and the other two codes are recommended as carrier priced for 2005, and will be reviewed by the RUC in September 2004.

11004 and 11006

The RUC reviewed the typical patient scenario for these two 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. The RUC also 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.**

The RUC used the same building block approach 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 75th 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.

The RUC recommends the following physician time and relative work values:

CPT Code	Pre-Service Evaluation Time	Pre-Service Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	Recommended RVU
11004	30	15	20	90	30	8.80
11006	30	15	20	120	30	11.10

The RUC recommends that codes 11005 and 11008 be carrier priced for the year 2005.

Practice Expense for 11004 and 11006

The RUC agreed that these procedures are performed on an emergent basis in the facility setting only, and would not have any practice expense. The RUC recommends no practice expense inputs for these codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
11000		<i>Debridement of extensive eczematous or infected skin; up to 10% of body surface</i> <u>(For abdominal wall or genitalia debridement for necrotizing soft tissue infection, see code 11004-11006)</u>	000	0.60 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 11004	T1	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection of external genitalia and perineum	000	8.80
● 11005	T2	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure	000	Carrier Priced for 2005-Recommendations will be presented at September 2004 RUC Meeting
● 11006	T3	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure	000	11.10
+ ● 11008		<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 11008 in conjunction with 11004-11006)</u> <u>(Do not report 11008 in conjunction with 11000-11001; 11010-11044)</u> <u>(Report skin grafts or flaps separately when performed for closure at the same session as 11004-11008)</u> <u>(When orchiectomy is performed, use 54520)</u> <u>(When testicular transplantation is performed, use 54680)</u>	ZZZ	Carrier Priced for 2005-Recommendations will be presented at September 2004 RUC Meeting

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

Recommended Work Relative Value

CPT Code:11004 Tracking Number: Global Period: 000 Specialty Society RVU: **10.75** RUC RVU: **8.80**

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 and 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

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):		Jeffery A. Dann, M.D.				
Specialty(s):		American Urological Association				
CPT Code:		11004				
Sample Size:		985	Resp n: 43		Response: %	
Sample Type: Random						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		4.90	10.75	13.50	20.00	28.00
Pre-Service Evaluation Time:				30.0		
Pre-Service Positioning Time:				15.0		
Pre-Service Scrub, Dress, Wait Time:				20.0		
Intra-Service Time:		45.00	60.00	90.00	120.00	300.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		30.00				
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>
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: 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	0.0	133.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	0.0	92.00
Median Total Time	185.00	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

Psychological Stress (Mean)

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 25th 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**

Recommended Work Relative Value

CPT Code:11006 Tracking Number: Global Period: 000 Specialty Society RVU: **13.99** RUC RVU: **11.10**

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 fascitis (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

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Jeffery A. Dann, M.D.				
Specialty(s):	American Urological Association				
CPT Code:	11006				
Sample Size:	985	Resp n:	42	Response:	%
Sample Type:	Random				
		Low	25 th pctl	Median*	75th pctl
Survey RVW:		4.94	10.06	13.99	16.00
Pre-Service Evaluation Time:				30.0	
Pre-Service Positioning Time:				15.0	
Pre-Service Scrub, Dress, Wait Time:				20.0	
Intra-Service Time:		15.00	60.00	120.00	120.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	30.00				
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>
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	0.0	133.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	0.0	92.00
Median Total Time	215.00	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 IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

IWPUT for new/revised CPT code 1104X3 - 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	%
---------------	-------------	------------	---

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? 500

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

Specialty AUA	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

	A	B	C	D	E	F
1						
2			11004		11006	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Debridement of skin subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection of the external genitalia		Debridement of skin subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection of the external genitalia, perineum and abdominal wall, with or without fascial closure	
4	LOCATION		Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		N/A	0	N/A	0
6	TOTAL CLINICAL LABOR TIME		0.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	0.0	0.0	0.0
10	PRE-SERVICE					
11	Start: Following visit when decision for surgery or procedure made					
12	Complete pre-service diagnostic & referral forms					
13	Coordinate pre-surgery services					
14	Schedule space and equipment in facility					
15	Provide pre-service education/obtain consent					
16	Follow-up phone calls & prescriptions					
17	Other Clinical Activity (please specify)					
18	End: When patient enters office/facility for surgery/procedure					
19	SERVICE PERIOD					
20	Start: When patient enters office/facility for surgery/procedure					
21	Pre-service services					
22	Review charts					
23	Greet patient and provide gowning					
24	Obtain vital signs					
25	Provide pre-service education/obtain consent					
26	Prepare room, equipment, supplies					
27	Setup scope (non facility setting only)					
28	Prepare and position patient/ monitor patient/ set up IV					
29	Sedate/apply anesthesia					
30	Intra-service					
31	Assist physician in performing procedure					
32	Post-Service					
33	Monitor pt. following service/check tubes, monitors, drains					
34	Clean room/equipment by physician staff					
35	Clean Scope					
36	Clean Surgical Instrument Package					
37	Complete diagnostic forms, lab & X-ray requisitions					
38	Review/read X-ray, lab, and pathology reports					
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
40	Discharge day management 99238 –12 minutes 99239 –15 minutes					
41	Other Clinical Activity (please specify)					
42	End: Patient leaves office					
43	POST-SERVICE Period					
44	Start: Patient leaves office/facility					
45	Conduct phone calls/call in prescriptions					
46	Office visits:					
47	List Number and Level of Office Visits					
48	99211 16 minutes	16				
49	99212 27 minutes	27				
50	99213 36 minutes	36				
51	99214 53 minutes	53				
52	99215 63 minutes	63				
53	Other					
54						
55	Total Office Visit Time		0	0	0	0
56	Other Activity (please specify)					
57	End: with last office visit before end of global period					
58	MEDICAL SUPPLIES					
59	No Medical Supplies					
60	Equipment					
61	No Equipment					
62						

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2004

Placement of Breast Radiotherapy: Afterloading Balloon Catheter

For breast cancer patients, post-operative radiation can be delivered to the entire affected breast or, for appropriately selected patients, to the tissue immediately surrounding the resected tumor (partial breast irradiation). The specialty society believes that breast brachytherapy is the most widely accepted means of delivering partial breast irradiation. The availability of balloon catheters to facilitate breast brachytherapy has made this therapeutic modality widely available to more women. The CPT Editorial Panel created three new codes to report the procedures involving the surgical insertion of radiotherapy afterloading balloon catheter into the breast for the radioelement application.

19297

The RUC had a lengthy discussion of the pre and post service time of ZZZ global code 19297 *Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)*. The presenters and RUC members agreed that for this unique procedure additional time in patient consultation in both the pre-service and post-service time periods was warranted, but a much lower amount of time than was presented by the specialty. **The RUC recommends the pre-service and post-service time for 19297 to 5 each.**

In addition, the RUC agreed that the work of 19297 is similar to the neurological code 95975 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)* (work RVU = 1.70) and code 15101 *Split graft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU=1.72). 95975 and 15101 each have intra-service work intensities between 0.05 and 0.06, and the RUC believed this new family of codes had similar work intensities. The RUC then used a building block approach to justify and assign a relative value for 19297. The building block approach assumed a work intensity of 0.05 multiplied by the specialty's surveyed results for intra-service time, of 30 minutes. The physician work entailed in pre and post service time was then added for a total work relative value of 1.72. **The RUC recommends a relative work value of 1.72 for CPT Code 19297.**

19296

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

The RUC discussed at length, the physician work associated with code 19296 *Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; on date separate from partial mastectomy*. The RUC and the specialty society agreed that the surveyed results regarding the pre-service evaluation time survey were inaccurate, and should be 30 minutes instead of 45 minutes. **The RUC recommends that the pre-service evaluation physician time be 30 minutes for 19296.**

The RUC and specialty society, in addition, believed that the physician work intensity is less than what the specialty society survey results indicated. The RUC reviewed surgical codes 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* (work RVU = 3.69) and 43251 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* (work RVU = 3.69), in relation to 19296 and agreed that the work intensity was much lower than the two other surgical codes, yet slightly higher than 19297. The RUC believed that a work intensity of 0.055 is appropriate for 19296, and used a building block approach to value the code. This service is typically performed with conscious sedation. The RUC believed a relative value of 3.63 was more appropriate for the physician work, time, and intensity involved. **The RUC recommends a work RVU of 3.63 for CPT code 19296.**

19298

The RUC reviewed the work relative value of 19298 *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) a partial mastectomy, includes imaging guidance*. The RUC believed that the work intensity of 19298 slightly higher than 19296 with the use of brachytherapy catheters. With this in mind, the committee reviewed code 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 5.99). 52341 had been RUC reviewed recently, it is a 000 day global code, and had similar surveyed physician time and intensity. As in code 19296 the pre-service evaluation time was adjusted to reflect the true physician work time. **The RUC recommends a pre-service evaluation physician time for 19298 of 15 minutes.**

The RUC believed that the intensity of work and the physician time for 19298 is similar to code 52341, and that with the specialty society surveyed time which was slightly higher, the relative value for 19298 should be 6.00 relative work units. In addition, the RUC recognized that code 19298 would typically be performed with conscious sedation. **The RUC recommends a work RVU of 6.00 for CPT code 19298.**

<u>Building Block Analysis</u>	19297		RUC Rec = 1.72
	Survey Data	RUC Std.	RVW
	Time	Intensity	(=time x intensity)
Pre-service	5	0.0224	0.11
<u>Intra-service:</u>	30	0.050	1.50
Post-Service	5	0.0224	0.11

<u>Building Block Analysis</u>	19296		RUC Rec = 3.63
	Survey Data	RUC Std.	RVW
	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	40	0.0224	0.89
Pre-service scrub, dress, wait	15	0.0081	0.12
<u>Intra-service:</u>	30	0.0546	1.64
Immediate Post	15	0.0224	0.34
Post-Service Discharge Day	.5	1.28	0.64

<u>Building Block Analysis</u>	19298		RUC Rec = 6.00
	Survey Data	RUC Std.	RVW
	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	45	0.0224	1.01
Pre-service scrub, dress, wait	15	0.0081	0.12
<u>Intra-service:</u>	60	0.0593	3.56
Immediate Post	30	0.0224	0.67
Post-Service	.5	1.28	0.64

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

Discharge Day			
---------------	--	--	--

Practice Expense:

The practice expense inputs for the Placement of Breast Radiotherapy: Afterloading Balloon Catheter codes were assessed by the RUC separately with the specialty society. Changes were made to the specialty society's original PE recommendations to address issues involving clinical labor type, clinical labor time, supplies and equipment. The RUC's recommended direct practice expense inputs are attached to this report.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●19296	I2	Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	000	3.63
✚●19297	I1	Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure) <u>(Use 19297 in conjunction with 19160 or 19162)</u>	ZZZ	1.72
●19298	I3	Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) a partial mastectomy, includes imaging guidance	000	6.00

Discharge Day			
---------------	--	--	--

Practice Expense:

The practice expense inputs for the Placement of Breast Radiotherapy: Afterloading Balloon Catheter codes were assessed by the RUC separately with the specialty society. Changes were made to the specialty society's original PE recommendations to address issues involving clinical labor type, clinical labor time, supplies and equipment. The RUC's recommended direct practice expense inputs are attached to this report.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●19296	I2	Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	000	3.63
✚●19297	I1	Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure) (Use 19297 in conjunction with 19160 or 19162)	ZZZ	1.72
●19298	I3	Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) a partial mastectomy, includes imaging guidance	000	6.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 19296 Tracking No: I2 Global: 000 RUC Recommended RVW: 5.64 3.63

Descriptor: Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; on date separate from partial mastectomy

Vignette Used in Survey:

A 55 year-old woman who has recently undergone a lumpectomy for early stage (stage 0, I, or II) breast cancer. She had no prior history of breast cancer treated with a lumpectomy procedure and radiation in the same breast. At the conclusion of the patient's lumpectomy procedure, sutures were used to close the skin and subcutaneous tissue to maintain a skin spacing distance of 5-7 mm between the lumpectomy cavity and the skin surface for possible future placement of a radiotherapy afterloading balloon catheter. She now presents for placement of the balloon catheter into the breast, under imaging guidance, for interstitial radioelement application. [NOTE: When completing this survey, only consider the work related to and necessary for placement of the catheter during the 000-day global period. The work related to the previously performed lumpectomy and interstitial radioelement application would be reported separately.]

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Clinical Description Of Service:

Preoperative work:

- Review pathology report to reconfirm that the tissue margins are free of cancerous cells and that no positive lymph nodes were detected.
- Review planned procedure
- Write pre-operative orders for peri-operative medications
- Change into scrub clothes
- Review the elements of wound care for the catheter exit site and the scheduling of receiving radiation therapy via the implanted balloon catheter
- Examine the tissue margins surrounding the lumpectomy cavity
- Answer patient and family questions and obtain informed consent
- Verify that all necessary instruments and supplies are readily available in the OR
- Verify that the size and configuration of the balloon catheter are correct
- Monitor patient positioning and draping
- Scrub and gown

Intra-operative Work:

Under appropriate anesthesia, the lumpectomy site and the remaining breast tissue are examined, to ensure adequate tissue for the radiotherapy afterloading balloon catheter to be securely positioned. Confirm that the site is appropriate (not too close to the sternum or in the axillary tail of the breast). Confirm that the cavity has been kept open with only the subcutaneous and top skin layer closed. A skin spacing of 5-7 mm between the skin and lumpectomy cavity to protect the skin from radiation damage is confirmed. Using either a sterile ruler or imaging guidance, the size and shape of the lumpectomy cavity are evaluated to determine the appropriate technique for the implantation of the catheter. Prior to insertion, the selected balloon catheter is tested by inflating it with a saline solution. The symmetry and integrity of the balloon is assessed and the balloon is deflated. Next, a separate "stab-like" incision is made near the lumpectomy incision. Through this incision, a trocar is placed to create a separate pathway to the lumpectomy cavity. Fluid that may have accumulated in the cavity is drained. The catheter is then inserted into the lumpectomy cavity via this separate pathway. The balloon catheter is inflated with saline and contrast agent to allow the surrounding tissue to conform to the balloon element of the balloon. The surgeon monitors the amount of fluid during inflation to ensure that the balloon element is appropriately positioned in the lumpectomy cavity for the correct radiation dosimetry, previously supplied by the radiation oncologist. The 5-7 mm skin spacing between the cavity and skin is reconfirmed to ensure that it has remained intact. The surgeon confirms conformance of cavity to balloon

element of the radiotherapy afterloading balloon catheter. The surgeon verifies the placement and integrity of the radiotherapy afterloading balloon catheter after inflation with the saline and contrast agent. Having verified that the radiotherapy afterloading balloon element of the catheter is secure and appropriately placed, a stitch is placed on either side of the catheter, if the catheter was placed through the lumpectomy incision.

Postoperative work:

- Apply dressings
- Write postoperative note in patient's chart
- Dictate procedure report
- Dictate procedure outcome letter for referring physician and/or insurance company
- Consult with the family/patient regarding the procedure
- Review instructions for post-discharge wound care
- Prepare discharge records
- Discuss procedure outcome with referring physician(s)

SURVEY DATA

Presenter(s):	Eric Whitacre, MD (ACS) Richard Fine, MD (ASBS) Louis Potters, MD (ASTRO) Bibb Allen, MD (ACR)				
Specialty(s):	American College of Surgeons (ACS) American Society of Breast Surgeons (ASBS) American Society for Therapeutic Radiology and Oncology, Inc (ASTRO) American College of Radiology (ACR)				
CPT Code:	19296				
Sample Size:	328	Resp n:	71	Resp %:	22%
Sample Type:	Random				
	Low	25th pctl	Median	75th pctl	High
Survey RVW:	3.00	5.00	6.00	7.00	11.38
Pre-Service Evaluation Time:			30		
Pre-Service Positioning Time:			10		
Pre-Service Scrub, Dress, Wait Time:			15		
Intra-Service Time:	10	25	30	45	120
Post-Service	Total Min*	CPT code / # of visits			
Immed. Post-time:	15				
Critical Care time/visit(s):					
Other Hospital time/visit(s):					
Discharge Day Mgmt:	18	99238 x 0.5			
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(S):

CPT	Descriptor	'04 RVW	Glob
36561	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	5.97	010
77762	Intracavitary radiation source application; intermediate	5.72	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT 19296	Ref CPT 36561	Svy CPT 19296	Ref CPT 77762
Pre-service	55	35	70	Not Available
Intra-service	30	45	30	
Same Day Immediate Post-service	15	15		
Discharge day management	18	18	18	
Office visit		15		
TOTAL TIME	118	128	118	112 (PR)

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below	14	14	8	8
--	----	----	---	---

TIME SEGMENTS

Pre-service	3.50	3.23	3.25	3.13
Intra-service	3.71	3.54	3.63	3.38
Post-service	3.07	3.08	3.13	3.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.36	3.00	3.75	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.23	4.13	3.63
Urgency of medical decision making	3.43	3.46	3.38	3.38

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.71	3.54	3.50	3.13
Physical effort required	2.79	2.85	3.25	3.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.50	3.54	3.75	3.25
Outcome depends on the skill and judgment of physician	4.00	3.62	4.25	3.88
Estimated risk of malpractice suit with poor outcome	3.93	3.38	4.25	3.38

ADDITIONAL RATIONALE

The procedure for placing a radiotherapy afterloading balloon catheter (19296) is very similar to 36561 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older*. Total pre- and post-service work for the 10-day global code 36561 is also similar to code 19296. The consensus committee reviewing the survey results does not believe the survey respondents took into account the difference in global periods between the new code and the reference code when estimating an RVW – although they were instructed to do so. We also do not believe they considered imaging guidance, since most procedures report imaging guidance separately. Because the survey median RVW was inconsistent with the reference procedure, the consensus committee developed an RVW recommendation using the intraoperative intensity for 36561 (IWPUT=0.087) and the survey time data (see Table 1) and added the value for imaging guidance (76942, RVW=0.67) to calculate a **recommended RVW of 5.64 for 19296**. As a secondary check for the calculated value, the consensus committee compared the RVW for the new code with existing codes that are similar. Table 2 is sorted by RVW to show that the recommended value of 5.64 for 192XX1 places this code in reasonable relativity to other similar procedures in terms of total time, RVW, and IWPUT.

TABLE 1

RVW = 4.93 after subtracting time and visit information from 36561 (which does not include imaging guidance). THEN, add 0.67 RVWs for imaging guidance (76942) to calculate the **Recommended RVW of 5.64 for 19296.**

<u>Building Block Analysis</u>	19296		4.93	36561		RVW = 5.97
	Svy Data	RUC Std.	RVW	Svy Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	55	0.0224	1.23	25	0.0224	0.56
Pre-service scrub, dress, wait	15	0.0081	0.12	10	0.0081	0.08
Pre-service total			1.35			0.64
<u>Post-service:</u>	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
Immediate post	15	0.0224	0.34	15	0.0224	0.34
	Visit n	E/M RVW	(=n x RVW)	Visit n	E/M RVW	(=n x RVW)
Discharge 99238	0.5	1.28	0.64	0.5	1.28	0.64
99213		0.65	0.00		0.65	0.00
99212		0.43	0.00	1	0.43	0.43
99211		0.17	0.00		0.17	0.00
Post-service total			0.98			1.41
	Time	IWPUT	INTRA-RVW	Time	IWPUT	INTRA-RVW
<u>Intra-service:</u>	30	0.087	2.60	45	0.087	3.92

TABLE 2

CPT	Descriptor	GLOB	2004 RVW	IWPUT	TOT min	PRE min	INTRA min	SD min	HV -38	OV -13	OV -12
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	000	2.50	0.119	50	25	15	10			
19103	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	000	3.69	0.097	65	20	30	15			
19296	NEW	000	5.64	0.110	118	70	30	15	0.5		
36561	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	10	5.99	0.087	128	35	45	15	0.5		1
55859	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	90	12.50	0.094	249	50	90	40	0.5	3	

Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? **NO**
2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. **N/A**

FREQUENCY INFORMATION**How was this service previously reported?**

19499 Unlisted procedure, breast

PLUS

76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.Specialty: general surgery and radiology ~~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: general surgery and radiology

Frequency: Approximately 10-20% of patients undergoing 19160 or 19162 may also undergo radiotherapy, utilizing new codes 192XX1 or 19296.

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: general surgery and radiology

Frequency: Approximately 10-20% of patients undergoing 19160 or 19162 may also undergo radiotherapy, utilizing new codes 192XX1 or 19296.

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

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

CPT Code: 19297 **Tracking No:** I1Global: ZZZ **RUC Recommended RVW:** 3.75 1.72

Descriptor: Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)

(Use 19297 in conjunction with 19160 or 19162)

Vignette Used in Survey:

A 55 year-old female presents as a candidate for a lumpectomy, followed by accelerated partial breast irradiation to treat a newly diagnosed early stage (stage 0, I, or II) breast cancer. She has no prior history of breast cancer treated by lumpectomy and radiation in the same breast. At the conclusion of the patient's lumpectomy, surgical techniques are employed to maintain a skin spacing distance of 5-7 mm between the lumpectomy cavity and the skin surface. The surgeon's clinical judgment combined with immediate specimen evaluation indicate that the tissue margins surrounding the lumpectomy cavity were free of cancerous cells and a sentinel node biopsy or axillary dissection was negative in its findings. Using imaging guidance, a radiotherapy afterloading balloon catheter is placed into the breast for future interstitial radioelement application. [NOTE: When completing this survey, only consider the work related to and necessary for placement of the balloon catheter. The work related to the partial mastectomy would be reported separately.]

Percentage of Survey Respondents who found Vignette to be Typical: 98% of the respondents indicated vignette to be typical. One respondent indicated their patients would be older.

Clinical Description Of Service:

Additional Preoperative Work:

Additional pre-operative discussion with the patient includes the risks and benefits of placing a radiotherapy afterloading balloon catheter for irradiation of the breast, and obtaining consent. Prior to the procedure, the surgeon also confirms that the radiotherapy afterloading balloon catheter is available in the operating room and that the size and configuration of the balloon catheter are correct.

Additional Intra-operative Work:

After excision of the cancer of the breast and pathology confirmation that the tissue margins surrounding the lumpectomy cavity are free of cancerous cells and that no positive lymph nodes were detected, the remaining breast tissue is examined, to ensure adequate tissue for the radiotherapy afterloading balloon catheter to be securely positioned. A skin spacing of 5-7 mm between the skin and lumpectomy cavity to protect the skin from radiation damage is confirmed. Using either a sterile ruler or imaging guidance, the size and shape of the lumpectomy cavity are evaluated to determine the appropriate technique for the implantation of the catheter. Prior to insertion, the selected balloon catheter is tested by inflating it with a saline solution. The symmetry and integrity of the balloon is assessed and the balloon is deflated. Next, a separate "stab-like" incision is made near the lumpectomy incision. Through this incision, a trocar is placed to create a separate pathway to the lumpectomy cavity. The catheter is then inserted into the lumpectomy cavity via this separate pathway. The balloon catheter is inflated with saline and contrast agent to allow the surrounding tissue to conform to the balloon element of the balloon. The surgeon monitors the amount of fluid during inflation to ensure that the balloon element is appropriately positioned in the lumpectomy cavity for the correct radiation dosimetry, supplied by the radiation oncologist prior to surgery. The 5-7 mm skin spacing between the cavity and skin is reconfirmed to ensure that it has remained intact. The balloon catheter is deflated and withdrawn to allow

closure of the lumpectomy site without compromising the integrity of the catheter. After the lumpectomy site is closed, the radiotherapy afterloading balloon catheter is re-advanced and re-inflated to the previously pre-determined volume. Placement and integrity of the catheter is verified after inflation with saline and contrast agent. Having verified that the radiotherapy afterloading balloon element of the catheter is secure and appropriately placed, a stitch is placed on either side of the catheter, if the catheter was placed through the lumpectomy incision.

Additional Postoperative Work:

The additional catheter site is dressed. During recovery, additional wound care instructions are provided to the patient. Additional notes are added to the patient record.

SURVEY DATA

Presenter(s):	Eric Whitacre, MD (ACS) Richard Fine, MD (ASBS)				
Specialty(s):	American College of Surgeons (ACS) American Society of Breast Surgeons (ASBS)				
CPT Code:	19297				
Sample Size:	60	Resp n:	46	Resp %:	77%
Sample Type:	Random				
	Low	25th pctl	Median	75th pctl	High
Survey RVW:	2.33	5.00	5.97	6.00	8.00
Additional Pre-Service Time:			5		
Intra-Service Time:	15	25	30	40	70
Additional Post-Service Time:			5		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'04 RVW	Glob
36561	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	5.97	010

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

TIME ESTIMATES (MEDIAN)	Svy CPT 19297	Ref CPT 36561
Pre-service	5	35
Intra-service	30	45
Same Day Immediate Post-service	5	15
Critical care		
Other hospital visit		
Discharge day management		18
Office visit		15
TOTAL TIME	40	128

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below	24	24
--	----	----

TIME SEGMENTS

Pre-service	3.83	3.13
Intra-service	3.58	3.61
Post-service	2.91	2.77

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.83	2.87
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	2.74
Urgency of medical decision making	3.21	2.78

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.75	3.65
Physical effort required	2.67	2.70

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.17	3.30
Outcome depends on the skill and judgment of physician	4.04	3.57
Estimated risk of malpractice suit with poor outcome	3.75	3.39

ADDITIONAL RATIONALE

The procedure for placing a radiotherapy afterloading balloon catheter (19297) is very similar to 36561 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older*. Pre- and post-service work for the 10-day global code 36561 is greater than for the add-on code 19297. The consensus committee reviewing the survey results does not believe the survey respondents took into account the difference in global periods between the new code and the reference code when estimating an RVW – although they were instructed to do so. We also do not believe they considered imaging guidance, since most procedures report imaging guidance separately. Because the survey median RVW was inconsistent with the reference procedure, the consensus committee developed an RVW recommendation using the intraoperative intensity for 36561 (IWPUT=0.087) and the survey time data (see Table 1) and added the value for imaging guidance (76942, RVW=0.67) to calculate a **recommended RVW of 3.75 for 19297**. As an additional check, the consensus committee compared the recommended RVW for the new code with existing codes that are similar. Table 2 is sorted by RVW to show that the recommended value of 3.75 for 19297 places this code in reasonable relativity to other similar procedures in terms of total time, RVW, and IWPUT.

Table 1

RVW = 3.08 after subtracting time and visit information from 36561 (which does not include imaging guidance). THEN, add 0.67 RVWs for imaging guidance (76942) to calculate the Recommended RVW of 3.75 for 19297.

<u>Building Block Analysis</u>	19297		3.08	36561		RVW = 5.97
	Svy Data	RUC Std.	RVW	Svy Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	15	0.0224	0.34	25	0.0224	0.78
Pre-service scrub, dress, wait		0.0081	0.00	10	0.0081	0.08
Pre-service total			0.34			0.64
<u>Post-service:</u>	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
Immediate post	10	0.0224	0.22	15	0.0224	0.34
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)	Visit n	E/M RVW	(=n x RVW)
Discharge 99238		1.28	0.00	0.5	1.28	0.64
99212		0.43	0.00	1	0.43	0.43
Post-service total			0.22			1.41
	Time	IWPUT	INTRA-RVW	Time	IWPUT	INTRA-RVW
<u>Intra-service:</u>	30	0.087	2.52	45	0.087	3.92

Table 2

CPT	Descriptor	GLOB	2004 RVW	IWPUT	TOT min	PRE min	INTRA min	SD min	HV -38	OV -12
36218	Selective catheter placement, arterial system; additional 2nd order, 3rd order, and beyond, thoracic or brachiocephalic branch, within a vascular family	ZZZ	1.01	0.071	14		14			
37250	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel	ZZZ	2.10	0.091	23		23			
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	000	2.50	0.119	50	25	15	10		
19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker	ZZZ	2.93	0.049	60		60			
19103	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	000	3.69	0.097	65	20	30	15		
19297	Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; concurrent with partial mastectomy	ZZZ	3.75	0.106	55	15	30	10		
35685	Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit	ZZZ	4.04	0.090	45		45			
36561	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	10	5.99	0.087	128	35	45	15	0.5	1
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	ZZZ	6.32	0.071	88		88			
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system)	ZZZ	8.33	0.069	120		120			

Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? Yes
 2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. The primary procedure 19160 (Mastectomy, partial;) or 19162 (Mastectomy, partial; with axillary lymphadenectomy) would be reported in addition to this add-on code.
-

FREQUENCY INFORMATION

How was this service previously reported?

19499 Unlisted procedure, breast

PLUS

76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

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

Specialty: 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: general surgery

Frequency: Approximately 10-20% of patients undergoing 19160 or 19162 may also undergo radiotherapy

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: general surgery

Frequency: Approximately 10-20% of patients undergoing 19160 or 19162 may also undergo radiotherapy

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

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

CPT Code:19298 Tracking Number: I3 Global Period:000 RUC Recommended RVW: ~~11.00~~ 6.00

CPT Descriptor: Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) a partial mastectomy, includes imaging guidance

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old female, who is a candidate for a lumpectomy procedure followed by accelerated partial breast irradiation to treat a newly diagnosed early stage (stage 0, 1, or, stage II) breast cancer. Patient has no prior history of breast cancer treated with a lumpectomy procedure and radiation in the same breast. The surgical and radiation therapeutic alternatives have been fully discussed with the patient. After completion of the lumpectomy and pathological and pathological analysis of the surgical excisions specimen, it is determined that the patient is a candidate for interstitial tube and button type brachytherapy. The primary tumor margins are free of cancer cells and a sentinel node biopsy or axillary dissection is negative for cancer. The catheters are placed under imaging guidance. The brachytherapy applicator insertion is a separate procedure that may be performed immediately following the lumpectomy or delayed until a later date.

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

Description of Pre-Service Work: The physician presents to the patient a discussion of the elements of wound care for the brachytherapy catheters and explains the logistics of receiving radiation therapy via the implanted radiotherapy afterloading device according to the planned radiation protocol. The physician obtains informed consent from the patient for the insertion procedure.

The physician examines the breast and the tissue margins related to the lumpectomy cavity, reviews the radiological studies, and consults the pathology data to reconfirm that the tissue margins are free of cancer cells and that no positive lymph nodes were detected.

The physician confirms that the brachytherapy afterloading catheters and template (if used for insertion guidance) are available in the operating room for placement, and determines that the number, size and configuration of the brachytherapy afterloading devices are suitable for the application.

Patient is prepared in a sterile fashion for the brachytherapy afterloading catheter implantation, including sterile preparation of all equipment, set up of brachytherapy surgical tray and catheter equipment, positioning of patient on the table, and draping of the surgical area.

The anesthesia needs of the patient will be addressed in accordance with the individual patient clinical needs. The physician evaluates the remaining breast tissue, to ensure adequate tissue is present to accommodate the brachytherapy afterloading devices. The anatomy of the breast, the location of the lesion, the size and shape of the excision cavity, the relationship of the lesion to the nipple, chest wall, and skin, and other factors are considered. This evaluation can be aided by sterile ruler measurements, imaging guidance or both.

The interstitial tube and button catheter insertion requires the physician determine the volume of tissue that needs to be treated (implanted). This volume is dependant upon the size, shape, and location of the lesion in relation to the other breast anatomy. This method is suitable for asymmetrical excision cavities and accommodates a wide range of

anatomy variation. The physician plans for the number and relative positions of the individual tubes and the number of planes (or rows) of catheters that will be needed to create the volume implant.

The position of the patient's arm during the procedure and during treatment needs to be well defined because it is important to implant geometry. The physician measures and documents the arm position so it can be reproduced during the radiation treatment process.

The physician orients the implant catheters to ensure complete tumor coverage, protect normal tissue, and to create an optimal cosmetic result. The entrance and exit locations of the catheters on the skin, and the spacing between the planes and between the catheters are selected before the first catheter is implanted. Modifications are made during the implant procedure as needed. The entrance and exit sites are usually at some distance from the surgical incision. Since the radiation treatment distribution is significantly influenced by the catheter positions, it is essential that the treatment conceptualization and planning occur prior to the catheter placement procedure.

Description of Intra-Service Work: Once the distribution of catheters has been decided, the insertion process can begin. Hollow steel implant needles (or implant tubes with metal style) are used to insert the soft plastic catheters. The physician will use either a "freehand" or template guided technique. In the freehand technique the physician determines the proper location and spacing of the brachytherapy catheters by sterile ruler measurements or with the template guide pattern. The entrance and exit sites are marked on the skin with a sterile marking pencil. For the template technique the physician selects and marks the desired pattern on the template.

The physician selects the correct length needle, for each puncture site, that corresponds to the tissue distance that must be traversed from the entrance to the exit site. The physician punctures the skin directly with the sterile hollow stainless steel implant needles or a sharp blade may be needed to nick the skin to facilitate the entrance and exit. The physician then advances the needles through the skin and subcutaneous tissue as they are passed from the skin entrance to the exit site (usually tangential to the chest wall).

The deep plane of the implant, located at the base of the excision cavity, is implanted first. The physician checks the catheter distribution and spacing through the open excision cavity to ensure full and complete coverage of the tissue, at the deep margin of the excision cavity, is obtained. The most superficial plane is optimally 5mm or more beneath the skin. The physician determines the number of catheters in each plane based upon the width of the region to be treated and the spacing interval between the catheters.

The physician inserts the needles with clinical or image guidance or both. Once the needle or row of needles is in position the physician replaces them in the tissue with a series of brachytherapy tube catheters. The fine end of the brachytherapy tube catheter has a "thin leader-end" that is threaded through one end of the hollow needles and it exits at the opposite end, external to the patient. The physician pulls the needle and catheter assembly out as a unit so that the needle is removed and the brachytherapy tube catheter is left in situ, in its place.

The catheter has a "button" or sphere end-piece that prevents it from being pulled through and out with the needle. After the catheter and end-piece are in position near the skin the physician threads a second fixing button or sphere over the opposite or leader end of the tube of the interstitial catheter, so that the apparatus is fixed in the breast tissue on both sides. The physician must check that individual buttons or spheres are placed snugly but not tightly onto the skin to allow for postoperative edema in order to avoid pressure injury of the skin.

The physician inserts each catheter (typically 5-10 catheters per plane and 2-4 planes per implant) individually. A series of rows or planes must be created to give a 3-dimensional volume to the implanted region to achieve a proper treatment distribution that corresponds to the distribution of the disease and avoids important normal tissue structures. The inter-catheter and the inter-plane spacing must be monitored as the insertion proceeds.

The brachytherapy tube and button catheters have some degree of rigidity to ensure that the radiation source passes smoothly and safely through the catheter array during treatment. The physician must check that each catheter is patent by passing a non-radioactive dummy cable through the length of the catheter. The physician confirms the

position of the catheters within or around the target volume and the lumpectomy cavity by visual inspection, palpation, or by image guidance.

The proximal or leader ends of the brachytherapy tube and button interstitial catheters project externally from the skin. The cuts them individually to length and the excess length is removed and discarded. The projecting catheter ends must be prepared to accept the HDR afterloader connection tubing. In addition, the physician removes with a wire stripper type device the "internal stiffening-leader" from the individual brachytherapy catheters. These leaders are used to prevent the brachytherapy catheters from stretching during the pulling maneuver of the catheter insertion process.

After the catheters are correctly positioned the dressing is applied. Care must be taken not to bend or kink the catheters so special padding must be positioned by the physician. The cover sterile dressing is placed over the brachytherapy tube, button catheters and protection padding.

After the brachytherapy devices insertion has been completed, the patient is moved to the recovery area.

Description of Post-Service Work: The physician monitors the patient during recovery and instructs the patient on wound care and to not change the dressing until the first visit with the radiation oncologist at the radiation treatment facility. The radiation oncologist will perform the high dose rate treatment application (coded separately). The physician will supervise removal of the brachytherapy implant devices after the radiation treatment course is completed.

Appropriate follow-up appointments are scheduled.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2004				
Presenter(s):		Louis Potters, MD, ASTRO RUC Advisor Bibb Allen, MD, ACR RUC Advisor				
Specialty(s):		Radiation Oncology Radiology				
CPT Code:		19298				
Sample Size: 268		Resp n: 25		Resp %: 9.3%		
Sample Type: Random						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		4.50	11.00	12.45	13.50	16.00
Pre-Service Evaluation Time:				30.00		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				15.00		
Intra-Service Time:		5.00	45.00	60.00	120.00	150.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		30.00				
Critical Care time/visit(s):		0.00	99291x 0 99292x 0			
Other Hospital time/visit(s):		0.00	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:		18.00	99238x 0.50 99239x 0.00			
Office time/visit(s):		0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			

To calculate above and below time recommendations, tab here

**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>
55859	090	12.45

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

<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: 17**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 19298	Key Reference CPT Code: 55859
Median Pre-Service Time	60	50.00
Median Intra-Service Time	60.00	90.00
Median Immediate Post-service Time	30.00	40.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	18.00	0.00
Median Office Visit Time	0.00	69.00
Median Total Time	168.00	249.00

Calculate total
reference time
tab here

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

The number of possible diagnosis and/or the number of management options that must be considered	4.48	4.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.28	3.76
Urgency of medical decision making	3.44	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.84	4.24
Physical effort required	4.32	4.18

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.36	4.38
Outcome depends on the skill and judgement of physician	4.68	4.50
Estimated risk of malpractice suit with poor outcome	4.48	4.25

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.08	3.76
Intra-Service intensity/complexity	4.64	4.24
Post-Service intensity/complexity	3.63	3.50

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 Society of Therapeutic Radiology and Oncology and The American College of Radiology conducted a national survey to develop the inputs for this procedure. It was noted the intensity/complexity of tube and button type breast brachytherapy (19298) was found to be higher than for an analogous service, prostate brachytherapy (55859). The median time however, was less for 19xx3 than for 55859. The specialty society's review committee held several conference calls where the intensity/complexity measures and clinical times were reviewed and discussed. The panel members with many years of experience in breast and prostate brachytherapy found the times to be clearly paradoxical. Breast brachytherapy consistently is more complex and requires more time and assessment of each catheter at both the insertion and exit point relative to the parallel catheter as compared to prostate brachytherapy where needles are parallel based on a template/grid and without need of exiting. Further, we believe that imaging time to assess and change catheter placement was neglected in the surveys. Breast brachytherapy is uniformly considered by our experts to be more technically difficult. Therefore, the specialty society recommendation is 11.00 RVUs, which reflects the 25th percentile of the returned surveys.

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) Unlisted procedure

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

Specialty Radiation Oncology

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? 5000

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? 3,000 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

	A	B	C	D	E	F	G	H	I
1		staff, supply, equip		19296		19297		19298	
				Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; on date separate from partial mastectomy.		Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; concurrent with partial mastectomy.		Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) a partial mastectomy, includes imaging guidance.	
2		CODE	DESC						
3	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
4	GLOBAL PERIOD			000	000	N/A	ZZZ	000	000
5	TOTAL TIME - RN/LPN/MTA	L037D	RN/LPN/MTA	22	21		0	29	21
6	TOTAL TIME - RN/Diag Med Sonographer	L051B	RN/DMS	47	0		0	156	0
7	PRE-service time	L037D	RN/LPN/MTA	0	18		0	0	18
8	SERVICE time - RN/LPN/MTA	L037D	RN/LPN/MTA	19	0		0	26	0
9	SERVICE time - RN/Diag Med Sonog	L05B	RN/DMS	47	0		0	156	0
10	POST-service time	L037D	RN/LPN/MTA	3	3		0	3	3
11	PRE-SERVICE - BEFORE ADMISSION								
12	Start: Following decision for surgery visit								
13	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA						
14	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5				5
15	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5				5
16	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5				5
17	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3				3
19	End: When pt enters site for service								
20	SERVICE PERIOD - ADMISSION TO DISCHARGE								
21	Start: When pt enters site for procedure								
22	Pre-service services								
23	Review charts	L037D	RN/LPN/MTA	2				3	
24	Greet patient and provide gowning	L037D	RN/LPN/MTA	3				3	
25	Obtain vital signs	L037D	RN/LPN/MTA	3				5	
26	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5				5	
27	Prepare room, equipment, supplies	L051B	RN/DMS	2				5	
29	Prepare and position pt/ monitor pt/ set up IV	L051B	RN/DMS	2				6	
30	Sedate/apply anesthesia	L051B	RN/DMS	2				2	
31	Intra-service								
32	Assist MD/insert sterile tube/button catheters	L051B	RN/DMS					60	
33	For conscious sedation monitoring	L051A	RN/DMS	30				60	
34	Post-Service								
35	Monitor pt. - check tubes, monitors, drains	L051A	RN/DMS	3				15	
36	Clean room/equipment by physician staff	L051B	RN/DMS	3				3	
39	Complete diag forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	3					
40	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3				10	
42	Dischg day mgmt output=6" 99238=12" 99239=15"	L037D	RN/LPN/MTA						
43	Other Clinical Activity: Process images, complete data sheet, present images and data to the interpreting physician	L051B	RN/DMS	5				5	
44	End: Patient leaves office/facility								
45	POST-SERVICE Period - AFTER DISCHARGE								
46	Start: Patient leaves office/facility								
47	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3			3	3
58	End: last office visit - end of global period								

	A	B	C	D	E	F	G	H	I
1		staff, supply, equip		19296		19297		19298	
				Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; on date separate from partial mastectomy		Placement of a radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following a partial mastectomy, includes imaging guidance; concurrent with partial mastectomy		Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) a partial mastectomy, includes imaging guidance	
2		CODE	DESC						
3	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
59	MEDICAL SUPPLIES								
60	Procedure-related supply items:								
61	pack, minimum multi-specialty visit	SA048	pack	1				1	
62	Conscious Sedation Package	SA044	pack					1	
63	Aquasonic Gel	SJ062	oz	8				8	
64	basin (irrigation)	SJ009	item	1				1	
65	cap, surgical	SB001	item	2				2	
66	drape, sterile, fenestrated 16in x 29in	SB011	item	1				1	
67	drape-towel, sterile OR blue (2 pk uou)	SB020	item	2				2	
68	dressings, 3inx4in (Telfa, Release)	SG035	item	1				1	
69									
70	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1				1	
71	gloves, sterile	SB024	pair	2				2	
72	gown, staff, impervious	SB027	item	2				2	
73	implant trocar, stainless steel (NEW) (No Code Assigned)		item					10	
74	kit, RTS applicator (MammoSite) (NEW)		item	1					
75	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	20				20	
76	mask, surgical	SB033	item	2				2	
77									
78	pack, implant catheter, tube and button (NEW) (No Code Assigned)		item					30	
79	povidone swabsticks (3 pack uou)	SJ043	item	1				1	
80	shoe covers, surgical	SB039	pair	2				2	
81	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item	1				1	
82	suture, nylon, 3-0 to 6-0, c	SF036	item	1				1	
83	swab-pad, alcohol	SJ053	item	2				2	
84	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	1				1	
85	tape, surgical paper 1in (Micropore)	SG079	inch	6				6	
86	Guidance-related supply items:								
87	cover-condom, transducer or ultrasound probe	SB005	item	1				1	
88	paper, photo printing (8.5 x 11)	SK058	item	5				5	
89	disinfectant spray (Transeptic)	SM012	ml	10				10	
90	sanitizing cloth-wipe (patient)	SM021	item	2				2	
91	Equipment								
92	Power Table	E11003		X				X	
93	surgical lamp	E30009		X				X	
94	Sony Color Video Printer	E52010		X				X	
95	stretcher (recovery)							X	
96	ultrasound room, general (NEW)			X				X	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Osteochondral Procedures

CPT transferred three category III codes (0012T, 0013T, and 0014T) and two associated codes, to category I status due to the fact that these procedures are performed often and with sufficient clinical follow-up and efficacy to warrant a category I CPT code. These codes describe various osteochondral allograft implantations and transplantation procedures of the knee.

29866, 29867, 29868, 27412 & 27415

The RUC reviewed the survey results for 29X6 *Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the sutograft)*, 29867 *Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the sutograft) osteochondral allograft (eg, mosaicplasty)*, and 29868 *Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the sutograft) meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral*, 27412 *Autologous chondrocyte implantation, knee* and 27415 *Osteochondral allograft, knee, open* and agreed that the pre-service time for entire family of codes should be consistent. The RUC reviewed codes 29873 *Arthroscopy, knee, surgical; with lateral release* and 29883 *Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)* to validate the pre-service time. Both of these codes (29873 and 29883) have RUC survey data and the pre-service times are both 75 minutes total. **After extensive discussion the RUC felt that the pre-service time should total 75 minutes each for the family of codes (evaluation = 45 minutes, positioning = 15 minutes and scrub/dress/wait = 15 minutes).**

The RUC agreed that the post-service time for 29866, 29867, 29868 were appropriate as surveyed. However, 27412 and 27415 were modified to include two 99212 and three 99213 office visits. Reference code 29883 includes two 99212 and two 99213 office visits and the RUC agreed that an additional 99213 for these services is warranted.

The RUC recommends a work RVU of 13.88 for 29866 (25th percentile survey value) and a work RVU of 17.00 for 29867 (median survey value). The RUC recommends a work RVU of 23.59 for 29868, which reflects only the adjustment in pre-service time.

The RUC recommends a work RVU of 23.23 for 27412 and 18.49 for 27415. The RUC notes that these values are similar to the specialty's survey 25th percentile. The RUC agreed with the specialty society that CPT codes 27227 *Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation* (Work RVU=23.41), (90 minutes pre-service, 180 minutes intra-service, 6 hospital visits and 4 office visits) and 27284 *Arthrodesis, hip joint (including obtaining graft);* (Work RVU=23.41), (80 minutes pre-service, 180 minutes intra-service, 4 hospital visits and 3 office visits) are appropriate reference services for 27412. The RUC also considered the following reference services for 27415: 28705 *Arthrodesis; pantalar* (Work RVU=18.77), (75 minutes pre-service, 180 minutes intra-service, 2 hospital visits and 4 office visits) and 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (Work RVU=18.46), (60 minutes pre-service, 150 minutes intra-service, 2 hospital visits and 5 office visits).

The RUC agreed that the survey median intra-time and the original IWPUT were appropriate. Additionally, the RUC believed the specialties survey results did not fully account for the physicians pre-service and post-service work levels. The RUC modified the physician time and recommends the following:

CPT Code	Pre-Service Time			Intra-Service	IWPUT	Post-Office Visits	Recommended RVU
	Evaluation	Positioning	Scrub/Dress/Wait				
29866	45	15	15	100 minutes	.087	99212 x 3, 99213 x 2	13.88
29867	45	15	15	120 minutes	.081	99212 x 2, 99213 x 3	17.00
29868	45	15	15	180 minutes	.087	99212 x 2, 99213 x 3	23.59
27412	45	15	15	180 minutes	.085	99212 x 2, 99213 x 3	23.23
27415	45	15	15	120 minutes	.088	99212 x 2, 99213 x 3	18.49

Practice Expense Inputs

The standard practice expense inputs for 090 day global period codes were used and adjusted for the new office visit level as described above.

Issue #1

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 29866	V1	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft) <u>(Do not report 29866 in conjunction with 29870, 29871, 29874, 29875, 29877, 29884 when performed at the same session and/or 29879, 29885-29887 when performed in the same compartment)</u>	090	13.88
0012T		Arthroscopy, knee, surgical, implantation of osteochondral graft(s) for treatment of articular surface defect; autografts <u>(0012T has been deleted. To report, use 29866)</u>	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 29867	V2	<p>osteochondral allograft (eg, mosaicplasty)</p> <p><u>(Do not report code 29867 in conjunction with 27570, 29870, 29871, 29874, 29875, 29877, 29884 when performed at the same session and/or 29879, 29885-29887 when performed in the same compartment)</u></p> <p><u>(Do not report 29867 in conjunction with code 27415)</u></p>	090	17.00
0013T		<p>Arthroscopy, knee, surgical, implantation of osteochondral graft(s) for treatment of articular surface defect; allografts</p> <p><u>(0013T has been deleted. To report, see 29867, 27415)</u></p>	XXX	N/A
● 29868	V3	<p>meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral</p> <p><u>(Do not report 29868 in conjunction with 29870, 29871, 29874, 29875, 29880, 29883, 29884 when performed at the same session or 29881, 29882 when performed in the same compartment)</u></p>	090	23.59
0014T		<p>Meniscal transplantation, medial or lateral, knee (any method)</p> <p><u>(0014T has been deleted. To report, use 29868)</u></p>	XXX	N/A

Issue #2

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 27412	V4	Autologous chondrocyte implantation, knee (Do not report 27412 conjunction with 20926, 27331, 27570)	090	23.23
● 27415	V5	Osteochondral allograft, knee, open (For arthroscopic implant of osteochondral allograft, use 29867)	090	18.49
29870		Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure) (For surgical arthroscopy of the knee with implantation of osteochondral graft for treatment of articular surface defect, see Category III codes 0012T, 0013T) (For meniscal transplantation, medial or lateral, knee, use Category III code 0014T) (For surgical arthroscopy of the knee with implantation of osteochondral graft for treatment of articular surface defect, see 29866, 29867) (For open autologous chondrocyte implantation of the knee, use 27412) (For open osteochondral allograft of the knee, use 27415) (For meniscal transplantation, medial or lateral, knee, use code 29868)	090	5.06 (No Change)
29871		Arthroscopy, knee, surgical; for infection, lavage and drainage (For implantation of osteochondral graft for treatment of articular surface defect, see 27412, 27415, 29866, 29867)	090	6.54 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
29883		<i>with meniscus repair (medial AND lateral)</i> (For meniscal transplantation, medial or lateral, knee, use 29868)	090	11.03 (No Change)

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

Recommended Work Relative Value

CPT Code:29866 Tracking Number: V1 Global Period: 090

Specialty Society RVU: **13.88** RUC RVU: **13.88**

CPT Descriptor: Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38-year-old female presents with medial right knee pain that began four months ago after a fall. She has pain that is worse with activity and associated with giving-way episodes. She denies locking, but has increased pain with stair climbing. She has been treated with NSAIDs with only partial relief of her pain and no relief of her mechanical symptoms. Physical therapy has improved her pain with stair climbing, but has failed to return her knee to normal function. She has increase symptoms in flexion, which interferes with activities of daily living and she can no longer exercise because of the pain. She has normal limb alignment, joint effusion, and some medial joint line tenderness. Her extension is full, but she flexes to only 115 degrees with some pain on flexion and rotation. She has no evidence of instability. There is some patellofemoral crepitus, but no pain with compression of the patellofemoral joint. Imaging studies revealed an isolated osteochondral defect of the medial femoral condyle with an otherwise normal knee. Arthroscopically, she undergoes an autogenous osteochondral transplant to repair the 1.5cm² full thickness cartilage defect of the weight-bearing surface of the medial femoral condyle.

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: Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging and laboratory studies, with special attention to review of MRI, if available; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and or patient's family) to explain operative risks and benefits and to obtain informed consent. The physician marks the operative site. Preoperative work also includes pre-operative scrubbing; positioning the patient, using a mechanical leg holder to support the upper thigh and facilitate movement and exposure of the knee; positioning of a fluoroscopic C-arm used during the intraoperative period, supervising prepping and personally draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary (i.e., drill guide devices and internal fixation devices for fastening grafts) are present and available in the operative suite; applying the tourniquet on the upper thigh, if appropriate; and securing the "well leg" on a knee support attached to the operating table thereby holding it out of the way in elevation and abduction.

Description of Intra-Service Work: The index lesion is defined arthroscopically and the articular cartilage is resected back normal articular cartilage. A measuring guide is used to determine the size of the articular cartilage lesion and the number of grafts necessary for the "best fit" into the articular cartilage defect. Multiple cylindrical grafts are then harvested from the far periphery of the femoral trochlea or the medial or lateral walls of the intercondylar notch. The grafts are harvested with a tubular chisel driven into the donor site at a precise right angle to the joint surface. Care must be taken during harvesting to ensure complete extraction of a 4, 6 or 8 mm diameter by 15-25mm depth cylindrical grafts with well-fixed cartilaginous caps. The grafts are delivered through a transfer tube with a guarded impaction device. A recipient tunnel is created with the appropriate sized drill guide and certain systems employ a dilator is used to create a conical tunnel. The graft is then inserted with a plunger to match the surface of the graft to the surrounding native articular cartilage. This step-by-step sequence is then repeated until the lesion filled with autogenous grafts. The knee is then taken through a range of motion to insure stable graft placement. The knee is then drained and the portals and incisions are closed.

Description of Post-Service Work: - Monitoring patient stabilization in the recovery room.

- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- Patient's vital signs are checked.
- Circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative prescriptions and medications are written and reviewed
- Preparation of discharge records
- Post-discharge office visits for this procedure for 90 days - - Close monitoring of the postoperative effusion and pain dominates the early period and motion and strength then become the focus of post-op care.
- Assessment of circulation, sensation and motor function of the operated extremity
- Assessment of surgical wounds; Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation of laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress..

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Dale Blasier, MD (AAOS) William Beach, MD (AANA)				
Specialty(s):	AAOS; AANA				
CPT Code:	29866				
Sample Size:	70	Resp n:	32	Response: 45.71 %	
Sample Type:	Random				
		Low	25 th pctl	Median*	75 th pctl
Survey RVW:		11.00	13.88	15.00	20.00
Pre-Service Evaluation Time:				45.0	
Pre-Service Positioning Time:				15.0	
Pre-Service Scrub, Dress, Wait Time:				15.0	
Intra-Service Time:		60.00	90.00	100.00	120.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	20.00				
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:	18.0	99238x 0.50	99239x 0.00		
Office time/visit(s):	91.0	99211x 0.0	12x 3.0	13x 2.0	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>
29888	090	13.88

CPT Descriptor Arthroscopically-aided anterior cruciate ligament repair/augmentation or reconstruction

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
27446	090	15.82

CPT Descriptor Arthroplasty, knee, condyle and plateau; medial OR lateral compartment

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 29866	Key Reference CPT Code: 29888
-----------------------------------	--

Median Pre-Service Time	75.00	41.00
Median Intra-Service Time	100.00	127.00
Median Immediate Post-service Time	20.00	22.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	27.00
Median Discharge Day Management Time	18.0	0.00
Median Office Visit Time	91.0	47.00
Median Total Time	304.00	264.00

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	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.71
Urgency of medical decision making	3.00	3.14

Technical Skill/Physical Effort (Mean)

Technical skill required	3.86	3.29
Physical effort required	3.57	3.43

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.14	2.14
Outcome depends on the skill and judgment of physician	4.57	4.29
Estimated risk of malpractice suit with poor outcome	3.29	3.29

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.71	4.14
Intra-Service intensity/complexity	4.43	4.14
Post-Service intensity/complexity	3.29	3.43

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.*

The consensus committee reviewing the survey results for 29866 believe that the survey median RVW 15.00 results in an intensity that is inconsistent with the reference code. Instead, the survey 25th percentile RVW 13.88 is recommended for 29866(IWPUT=0.087). This value is the same as the primary reference code 29888 and reflects a greater intensity for 29866 vs 29888. As a second reference, we offer 27446 which has a work RVU of 15.82, total time of 271 minutes, and IWPUT of 0.091

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: No

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

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are 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) 0012T Arthroscopy, knee, surgical, implantation of osteochondral graft(s) for treatment of articular surface defect; autografts

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1250

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

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? 28

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. Surgical

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

Recommended Work Relative Value

CPT Code:29867 Tracking Number: V2 Global Period: 090

Specialty Society RVU: **17.00** RUC RVU: **17.00**

CPT Descriptor: Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old man presents with a several year history of pain and locking in his right knee. He states that he had previously injured the knee while playing sports and reports frequent knee pain with vigorous activities and weather changes, severe enough to limit his activities and requiring NSAIDs. He has had occasional giving-way episodes, locking with certain activities, and has had previous surgical treatment for a medial femoral condyle osteochondral injury. He has a large effusion with mild pain on palpation of the medial joint line. Range of motion of the knee is full except in terminal flexion. Flexion and rotation cause pain over the medial joint line. There is normal stability and a normal weight bearing line. Imaging studies revealed intact menisci and ligamentous structures and an osteochondral defect of the medial femoral condyle. Arthroscopically, he undergoes a resurfacing of the medial femoral osteochondral defect of his knee utilizing a fresh-frozen osteochondral allograft.

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: Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging and laboratory studies, with special attention to review of MRI, if available; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and or patient's family) to explain operative risks and benefits and to obtain informed consent. The physician marks the operative site. Preoperative work also includes pre-operative scrubbing; positioning the patient, using a mechanical leg holder to support the upper thigh and facilitate movement and exposure of the knee; positioning of a fluoroscopic C-arm used during the intraoperative period, supervising prepping and personally draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary (i.e., drill guide devices and internal fixation devices for fastening grafts) are present and available in the operative suite; applying the tourniquet on the upper thigh, if appropriate; and securing the "well leg" on a knee support attached to the operating table thereby holding it out of the way in elevation and abduction.

Description of Intra-Service Work: The articular lesion is often defined arthroscopically and a complete evaluation of the joint is performed to rule out associated pathology. Appropriate debridement of the lesion is confirmed and/or completed. The defect is carefully sized and marked. The defect is then prepared for graft implantation (cylindrical lesions can be prepared with a dowel technique whereas non-cylindrical lesions require manual recipient site preparation). The previously thawed osteochondral allograft is tediously prepared in a cylindrical or geographic shape. Multiple modifications of the allograft tissue are often required to obtain an appropriate fit to the articular surface defect. Once the graft is appropriately fashioned and placed, it is stabilized with resorbable or non-resorbable fixation. The knee is then brought through a range of motion to assure proper fixation and alignment of the osteochondral graft with the native medial femoral condyle. The arthrotomy is repaired.

Description of Post-Service Work: Postoperative work begins after skin closure in the operating room and includes application of sterile dressings, and immobilizing splint, and a Continuous Passive Motion (CPM) apparatus, as necessary. Postoperative work also includes monitoring patient stabilization in the recovery room, with special attention to monitoring of neurovascular status and function of the foot; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including continued monitoring of neurovascular function; adjustments to the splint and CPM apparatus; care

and removal of drain; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging reports, if needed; direct patient physiotherapy and assess physiotherapy progress; and pain medication adjustments. Careful monitoring of the physical therapy regimen is very important

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):		Dale Blasier, MD (AAOS) William Beach, MD (AANA)			
Specialty(s):		AAOS; AANA			
CPT Code:		29867			
Sample Size: 70		Resp n: 24		Response: 34.28 %	
Sample Type: Random					
		Low	25 th pctl	Median*	75 th pctl
Survey RVW:		11.00	14.50	17.00	23.25
Pre-Service Evaluation Time:				45.0	
Pre-Service Positioning Time:				15.0	
Pre-Service Scrub, Dress, Wait Time:				15.0	
Intra-Service Time:		75.00	105.00	120.00	150.00
Post-Service		Total Min**	CPT code / # of visits		
Immed. Post-time:		30.00			
Critical Care time/visit(s):		0.0	99291x 0.0	99292x 0.0	
Other Hospital time/visit(s):		30.0	99231x 0.0	99232x 1.0	99233x 0.0
Discharge Day Mgmt:		36.0	99238x 1.00	99239x 0.00	
Office time/visit(s):		99.0	99211x 0.0	12x 2.0	13x 3.0
			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>
27487	090	25.23

CPT Descriptor Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
27446	090	15.82

CPT Descriptor Arthroplasty, knee, condyle and plateau; medial OR lateral compartment

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

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

Number of respondents who choose Key Reference Code: 7 % of respondents: 29.1 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 29867	Key Reference CPT Code: 27487
Median Pre-Service Time	75.00	60.00
Median Intra-Service Time	120.00	200.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	95.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	99.0	92.00
Median Total Time	390.00	513.00

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	4.14	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	5.00
Urgency of medical decision making	3.57	3.43

Technical Skill/Physical Effort (Mean)

Technical skill required	4.85	4.00
Physical effort required	4.86	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.43	3.57
Outcome depends on the skill and judgment of physician	5.00	5.00
Estimated risk of malpractice suit with poor outcome	5.00	5.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.14	4.86
Intra-Service intensity/complexity	5.00	5.00
Post-Service intensity/complexity	4.86	3.57

ADDITIONAL RATIONALE

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

The survey median RVW 17.00 is recommended for 29867 (IWPUT=0.081). This value is 8.23 work RVUs less than the primary reference code 27487 and takes into account: 1) A lower total time for 29867 compared with 27487 (390 vs 513); 2) The similar time segment complexity measures for 29867 compared with 27487; and 3) The significantly higher mental effort and judgment measures for 29867 compared with 27487. As a second reference, we offer 27446 which has a work RVU of 15.82, total time of 271 minutes, and IWPUT of 0.091.

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) 0013T Arthroscopy, knee, surgical, implantation of osteochondral graft(s) for treatment of articular surface defect; allografts

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

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100

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? 4

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? No

If no, please select another crosswalk and provide a brief rationale. 29888 or 29889, as arthroscopic procedures, would be better crosswalks for PLI

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:29868 Tracking Number: V3 Global Period: 090	Recommended Work Relative Value Specialty Society RVU: 24.13 RUC RVU: 23.59
---	---

CPT Descriptor: Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 24-year-old active male is status post meniscectomy with persistent activity-limiting knee pain and/or recurrent effusions. His pain is persistent despite ongoing conservative treatment including activity modification, physical therapy, and NSAIDs. He shows no significant mal-alignment or instability. At operation, he undergoes an arthroscopically aided meniscal transplantation.

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging and laboratory studies, with special attention to reports concerning ligament stability examination and review of MRI, if available; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and or patient's family) to explain operative risks and benefits and to obtain informed consent. The physician marks the operative site. Preoperative work also includes pre-operative scrubbing; positioning the patient, using a mechanical leg holder to support the upper thigh and facilitate movement and exposure of the knee; positioning of a fluoroscopic C-arm used during the intraoperative period, supervising prepping and personally draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite; applying the tourniquet on the upper thigh, if appropriate; and securing the "well leg" on a knee support attached to the operating table thereby holding it out of the way in elevation and abduction.

Description of Intra-Service Work:

The meniscal remnant is removed and the meniscal bed is prepared arthroscopically. Routinely, two tibial bone tunnels are created for a medial meniscal transplant or a tibial trough is created for a lateral meniscal transplant. This allows for maximal stabilization of the anterior and posterior horn attachments. The graft is carefully prepared to fit into the bone tunnels or trough. A mini-arthrotomy is made to introduce the meniscal allograft. Once the meniscus is positioned, it is secured to the tunnels or trough. The arthrotomy is repaired and the meniscus is arthroscopically sutured around its periphery to the meniscocapsular junction with multiple sutures. The meniscus is secured. The incisions are closed and the knee and portals are injected with marcaine with epinephrine.

Description of Post-Service Work:

- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- Patient's vital signs are checked.
- Circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative prescriptions and medications are written and reviewed
- Preparation of discharge records

- Post-discharge office visits for this procedure for 90 days - - Close monitoring of the postoperative effusion and pain dominates the early period and motion and strength then become the focus of post-op care.
- Assessment of circulation, sensation and motor function of the operated extremity
- Assessment of surgical wounds; Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation of laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress..

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Dale Blasier, MD (AAOS) William Beach, MD (AANA)				
Specialty(s):	AAOS; AANA				
CPT Code:	29868				
Sample Size:	70	Resp n:	31	Response: 44.28 %	
Sample Type: Random					
		Low	25 th pctl	Median*	75 th pctl
Survey RVW:		15.00	20.00	24.13	29.50
Pre-Service Evaluation Time:				45.0	
Pre-Service Positioning Time:				15.0	
Pre-Service Scrub, Dress, Wait Time:				15.0	
Intra-Service Time:		100.00	131.00	180.00	180.00
Post-Service		Total Min**	CPT code / # of visits		
Immed. Post-time:		30.00			
Critical Care time/visit(s):		0.0	99291x 0.0	99292x 0.0	
Other Hospital time/visit(s):		49.0	99231x 1.0	99232x 1.0	99233x 0.0
Discharge Day Mgmt:		36.0	99238x 1.00	99239x 0.00	
Office time/visit(s):		99.0	99211x 0.0	12x 2.0	13x 3.0 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>
27487	090	25.23

CPT Descriptor Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
27446	090	15.82

CPT Descriptor Arthroplasty, knee, condyle and plateau; medial OR lateral compartment

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 38.7 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 29868	Key Reference CPT Code: <u>27487</u>
Median Pre-Service Time	75.00	60.00
Median Intra-Service Time	180.00	200.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	49.0	95.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	99.0	92.00
Median Total Time	469.00	513.00

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	4.27	4.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.91	4.64
Urgency of medical decision making	3.36	3.36

Technical Skill/Physical Effort (Mean)

Technical skill required	4.64	4.09
Physical effort required	4.64	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.18	3.36
Outcome depends on the skill and judgment of physician	5.00	4.73
Estimated risk of malpractice suit with poor outcome	4.91	4.55

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.55	4.73
Intra-Service intensity/complexity	4.91	4.55
Post-Service intensity/complexity	4.27	3.91

ADDITIONAL RATIONALE

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

The survey median RVW 24.13 is recommended for 29868 (IWPUT=0.087). This value is slightly less than the primary reference code 27487 and takes into account: 1) A slightly lower total time for 29868 compared with 27487 (489 vs 513); and 2) The slightly higher time segment complexity measures and mental effort and judgment measures for 29868 compared with 27487. As a second reference, we offer 27446 which has a work RVU of 15.82, total time of 271 minutes, and IWPUT of 0.091.

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) 0014T Meniscal transplantation, medial or lateral, knee (any method)

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

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 800
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? 2
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? No

If no, please select another crosswalk and provide a brief rationale. 29888 or 29889, as arthroscopic procedures, would be better crosswalks for PLI.

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:27412 Tracking Number: V4 Global Period: 090

Specialty Society RVU: **25.00** RUC RVU: **23.23**

CPT Descriptor: Autologous chondrocyte implantation, knee

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 27-year-old man presents with a history of traumatic injury to the knee causing him to have mechanical symptoms and significant pain. Radiographs showed no mal-alignment and little or no bony changes. A diagnostic arthroscopy and chondral biopsy confirmed a full thickness chondral defect. The patient continues to have pain despite conservative treatment. The size and/or location of the defect is not amenable to autograft tissue transfer or allograft tissue transplantation. At operation, he undergoes an autologous chondrocyte implantation.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Communicating with the patient (and/or the patient's family) to briefly rediscuss the procedure and the operative risks and benefits; and reviewing the previous x-rays, MRI and ultrasound studies prior to marking the site of surgery on the patient. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite. A tourniquet is applied on the lower extremity. The lower extremity is exsanguinated and the tourniquet inflated to appropriate pressures.

Description of Intra-Service Work: Under general anesthesia, an arthrotomy and excision of the diseased or injured articular cartilage, back to a stable rim, is performed. Care is taken not to disrupt the subchondral bone to avoid bleeding. A periosteal patch is harvested from the femur or tibia to cover the chondral defect. The patch is meticulously sewed into place to provide a watertight seal over the chondral defect. The previously obtained chondrocytes, which were cultured and prepared, are then re-implanted under the patch. The remainder of the patch is sealed with sutures and "fibrin glue". Once the cells are properly introduced the arthrotomy is repaired and the patient is returned to the post anesthetic recovery room and the floor for post-operative care.

Description of Post-Service Work: - Monitoring patient stabilization in the recovery room.

- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- Patient's vital signs are checked.
- Circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative prescriptions and medications are written and reviewed
- Preparation of discharge records
- Post-discharge office visits for this procedure for 90 days - - Close monitoring of the postoperative effusion and pain dominates the early period and motion and strength then become the focus of post-op care.
- Assessment of circulation, sensation and motor function of the operated extremity
- Assessment of surgical wounds; Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures

- Evaluation of laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress..

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Dale Blasier, MD (AAOS) William Beach, MD (AANA)				
Specialty(s):	AAOS; AANA				
CPT Code:	27412				
Sample Size:	70	Resp n:	37	Response: 52.85 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	18.88	23.00	25.00	30.00	42.90
Pre-Service Evaluation Time:			45.0		
Pre-Service Positioning Time:			15.0		
Pre-Service Scrub, Dress, Wait Time:			15.0		
Intra-Service Time:	120.00	130.00	180.00	213.00	270.00
Post-Service	Total Min**	CPT code / # of visits			
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>49.0</u>	99231x 1.0	99232x 1.0	99233x 0.0	
Discharge Day Mgmt:	<u>36.0</u>	99238x 1.00	99239x 0.00		
Office time/visit(s):	<u>99.0</u>	99211x 0.0	12x 2.0	13x 3.0	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>
27487	090	25.23

CPT Descriptor Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
27284	090	23.41

CPT Descriptor Arthrodesis, hip joint (including obtaining graft);

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

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

Number of respondents who choose Key Reference Code: 13 % of respondents: 35.1 %

TIME ESTIMATES (Median)

New/Revised
CPT Code:
27412 Key
Reference
CPT Code:
27487

Median Pre-Service Time	75.00	0.06
Median Intra-Service Time	180.00	200.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	49.0	95.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	99.0	92.00
Median Total Time	469.00	453.06

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

The number of possible diagnosis and/or the number of management options that must be considered	4.92	4.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.92	4.45
Urgency of medical decision making	4.83	3.91

Technical Skill/Physical Effort (Mean)

Technical skill required	4.92	4.18
Physical effort required	4.92	4.09

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.36
Outcome depends on the skill and judgment of physician	4.92	4.64
Estimated risk of malpractice suit with poor outcome	4.83	4.73

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.67	4.82
Intra-Service intensity/complexity	4.92	4.73
Post-Service intensity/complexity	4.25	4.27

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.*

The survey median RVW 25.00 is recommended for 27412 (IWPUT=0.085). This value is slightly less than the primary reference code 27487 and takes into account: 1) The slightly higher total time (although different time/visit pattern) for 27412 compared with 27487 (538 vs 513); 2) The higher time segment complexity measures for 27412 compared with 27487; and 3) The significantly higher mental effort and judgment measures for 27412 compared with 27487. As a second reference, we offer 27284 which has a work RVU of 23.41, total time of 482 minutes, and IWPUT of 0.082.

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) 27599 Unlisted procedure, femur or knee

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

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 800

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? 0
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. Surgical

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

CPT Code:27415 Tracking Number: V5 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **20.00** RUC RVU: **18.49**

CPT Descriptor: Osteochondral allograft, knee, open

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old man presents with a several year history of pain and locking in his right knee. He states that he had previously injured the knee while playing sports and reports frequent knee pain with vigorous activities and weather changes, severe enough to limit his activities and requiring NSAIDs. He has had occasional giving-way episodes, locking with certain activities, and has had previous surgical treatment for a medial femoral condyle osteochondral injury. He has a large effusion with mild pain on palpation of the medial joint line. Range of motion of the knee is full except in terminal flexion. Flexion and rotation cause pain over the medial joint line. There is normal stability and a normal weight bearing line. Imaging studies revealed intact menisci and ligamentous structures and an osteochondral defect of the medial femoral condyle. At operation, he undergoes resurfacing of the medial femoral osteochondral defect of his knee utilizing a fresh-frozen osteochondral allograft.

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: Communicating with the patient (and/or the patient's family) to briefly rediscuss the procedure and the operative risks and benefits; and reviewing the previous x-rays, MRI and ultrasound studies prior to marking the site of surgery on the patient. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite. A tourniquet is applied on the lower extremity. The lower extremity is exsanguinated and the tourniquet inflated to appropriate pressures.

Description of Intra-Service Work: Under general anesthesia, a medial or lateral para-patellar arthrotomy is performed to allow exposure of the entire osteochondral defect. Appropriate debridement of the lesion is confirmed and/or completed. The defect is carefully sized and marked. The defect is then prepared for graft implantation (cylindrical lesions can be prepared with a dowel technique whereas non-cylindrical lesions require manual recipient site preparation). The previously thawed osteochondral allograft is tediously prepared in a cylindrical or geographic shape. Multiple modifications of the allograft tissue are often required to obtain an appropriate fit to the articular surface defect. Once the graft is appropriately fashioned and placed, it is stabilized with resorbable or non-resorbable fixation. The knee is then brought through a range of motion to assure proper fixation and alignment of the osteochondral graft with the native medial femoral condyle.

Description of Post-Service Work: Postoperative work begins after skin closure in the operating room and includes application of sterile dressings, and immobilizing splint, and a Continuous Passive Motion (CPM) apparatus, as necessary. Postoperative work also includes monitoring patient stabilization in the recovery room, with special attention to monitoring of neurovascular status and function of the foot; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including continued monitoring of neurovascular function; adjustments to the splint and CPM apparatus; care and removal of drain; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of

periodic imaging reports, if needed; direct patient physiotherapy and assess physiotherapy progress; and pain medication adjustments. Careful monitoring of the physical therapy regimen is very important

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Dale Blasier, MD (AAOS) William Beach, MD (AANA)				
Specialty(s):	AAOS; AANA				
CPT Code:	27415				
Sample Size:	70	Resp n:	28	Response: 40.00 %	
Sample Type:	Random				
		Low	25 th pctl	Median*	75th pctl
Survey RVW:		14.00	18.00	20.00	27.25
Pre-Service Evaluation Time:				45.0	
Pre-Service Positioning Time:				15.0	
Pre-Service Scrub, Dress, Wait Time:				15.0	
Intra-Service Time:		100.00	120.00	120.00	180.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	30.00				
Critical Care time/visit(s):	0.0	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	49.0	99231x 1.0	99232x 1.0	99233x 0.0	
Discharge Day Mgmt:	36.0	99238x 1.00	99239x 0.00		
Office time/visit(s):	99.0	99211x 0.0	12x 2.0	13x 3.0	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>
27487	090	25.23

CPT Descriptor Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
27284	090	23.41

CPT Descriptor Arthrodesis, hip joint (including obtaining graft);

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

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

Number of respondents who choose Key Reference Code: 11 % of respondents: 39.2 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 27415	Key Reference CPT Code: 27487
Median Pre-Service Time	75.00	60.00
Median Intra-Service Time	120.00	200.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	49.0	95.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	99.0	92.00
Median Total Time	409.00	513.00

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	4.50	4.10
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	3.70	3.30

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.20
Physical effort required	5.00	4.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.40	3.20
Outcome depends on the skill and judgment of physician	4.80	4.60
Estimated risk of malpractice suit with poor outcome	4.60	4.50

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.30	4.50
Intra-Service intensity/complexity	5.00	4.70
Post-Service intensity/complexity	4.60	3.60

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.*

The survey median RVW 20.00 is recommended for 27415 (IWP/UT=0.088). This value is 5.23 work RVUs less than the primary reference code 27487 and takes into account: 1) A lower total time for 27415 compared with 27487 (470 vs 513); and 2) The higher time segment complexity measures and mental effort and judgment measures for 27415 compared with 27487. As a second reference, we offer 27284 which has a work RVU of 23.41, total time of 482 minutes, and IWP/UT of 0.082.

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: No

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

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are 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) 27599 Unlisted procedure, femur or knee

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 300

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? 10

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. Surgical

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	Meeting Date: RUC April 2004 Specialty: AAOS, AANA	CPT:		27412 (V4)		27415 (V5)		29866 (V1)		29867 (V2)		29868 (V3)	
2		DESCRIPTOR:		Autologous chondrocyte implantation, knee		Osteochondral allograft, knee, open		Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft)		Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)		Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	
3	Global			90		90		90		90		90	
4	Location	Code	Desc	NF	FAC	NF	FAC	NF	FAC	NF	FAC	NF	FAC
5	TOTAL TIME	L037D	RN/LPN/MA	N/A	249	N/A	249	N/A	234	N/A	249	N/A	249
6	PRE-service time	L037D	RN/LPN/MA		75		75		75		75		75
7	SERVICE time	L037D	RN/LPN/MA		12		12		6		12		12
8	POST-service time	L037D	RN/LPN/MA		162		162		153		162		162
9	PRE-SERVICE - BEFORE ADMISSION												
10	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA		5		5		5		5		5
11	Coordinate pre-surgery services	L037D	RN/LPN/MA		20		20		20		20		20
12	Schedule space and equipment in facility	L037D	RN/LPN/MA		8		8		8		8		8
13	Provide pre-service education/obtain consent	L037D	RN/LPN/MA		20		20		20		20		20
14	Phone calls & prescriptions	L037D	RN/LPN/MA		7		7		7		7		7
16	SERVICE PERIOD - ADMISSION TO DISCHARGE												
37	99238 discharge time	L037D	RN/LPN/MA		12		12		6		12		12
39	POST-SERVICE - AFTER DISCHARGE												
40	99211 16 minutes												
41	99212 27 minutes				2		2		3		2		2
42	99213 36 minutes				3		3		2		3		3
43	99214 53 minutes												
44	99215 63 minutes												
45	Total Office Visit Time:	L037D	RN/LPN/MA		162		162		153		162		162
46	MEDICAL SUPPLIES												
47	pack, minimum multi-specialty visit	SA048	pack		5		5		5		5		5
48	pack, post-op incision care (suture & staple)	SA053	pack		1		1		1		1		1
49	EQUIPMENT												
50	Power Table	E11003			1		1		1		1		1

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2004

Laryngoscopic Excision of Microscopic Non-Neoplastic Lesions

Due to technological advances and a better understanding of vocal fold submucosa preservation for normal voice production, the CPT Editorial Panel created two new CPT codes. These new CPT codes accurately describe microdissection within the lamina propria for the removal of lesions from the vocal fold surface and subsequent reconstruction with either uninvolved local mucosal flaps or implants of autogenous or alloplastic materials. The RUC believed that the two new codes descriptors should be revised to distinguish these procedures from existing codes intended to report removal of neoplastic lesions. The RUC also believed code descriptor for 31546 should be revised to include the work of harvesting the graft in this procedure. The CPT Editorial Panel accepted the RUC's requests in February 2004 to: 1) revise code 31545 in order to distinguish this procedure from existing codes intended to report removal of neoplastic lesions, and 2) revise the descriptor of code 31546, deleting reference to the use of allograft material for flap reconstruction. The committee also approved the addition of two cross-references to instruct 1) the use of the unlisted procedure code to report allograft flap reconstruction procedures and 2) the inappropriate additional use of code 20926 to report autograft flap reconstruction.

31545

The RUC reviewed the survey results presented by the specialty society for new CPT codes 31545 *Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord: reconstruction with local tissue flap(s)* and 31546 *Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord: reconstruction with graft(s) (includes obtaining autograft)* in relation to their reference code 31541 *Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope* (Work RVU = 4.52). In addition, due to the microsurgical precision of the two new codes, it was understood that the two codes are performed only under general anesthesia, whereas code 31541 can be performed with local or general anesthesia. The RUC believed that inter-operatively, the new codes are more intense, and require more technical skill and additional work than code 31541. In addition to microsurgical lesion removal, 31545 adds reconstruction with a local tissue flap to cover the defect and 31546 adds reconstruction with an autograft or allograft to cover the defect. The RUC agreed with the specialty society's survey results and work relative value recommendation for code 31545. **The RUC recommends a relative work value of 6.30 for code 31545.**

31546

In order to establish a work relative value for 31546, the RUC agreed that the specialty society survey results should be used (which was without the harvesting of the graft), and the additional work of harvesting the graft would be then added. The RUC agreed to determine an appropriate increment of physician work to represent the harvesting of the graft by focusing on the intra service work of code 20926 *Tissue grafts, other (eg, paratenon, fat, dermis)* (Work RVU = 5.52). Using a building block approach the RUC determined that the intra-service work component of 20926 had a relative value of 1.23. The RUC then added this intra-service work component of harvesting tissue grafts to the specialty society recommended relative value of 8.50, for a total relative work value of 9.73. **The RUC recommends a relative work value of 9.73 for code 31546.**

Practice Expense

The RUC reviewed and agreed with the specialty society clinical labor time recommended in the facility setting of 30 minutes pre-service and 6 minutes in the service period. There are no practice expense inputs in the non-facility setting as these services require that they be performed in the facility. The RUC recommended practice expense inputs are attached.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	RUC Work RVU Recommendation
●31545	C1	Laryngoscopy, direct, operative, with operating microscope or telescope, with <u>submucosal</u> removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)	000	6.30
●31546	C2	reconstruction with graft(s) (eg, <u>includes obtaining</u> autograft, allograft) (Do not report 31546 in addition to 20926 for graft harvest) (For reconstruction of vocal cord with allograft, use 31599) (For harvesting of grafts, use the appropriate code, eg, 20926) (Do not report codes 31540, 31541, or 69990 in conjunction with code 31545 or 31546)	000	9.73

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

New CPT Code: 31545 (C1)

Global: 000

RUC Recommended RVW: 6.30

Descriptor: Laryngoscopy, direct, operative, with operating microscope or telescope, with removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)

Survey Vignette (Typical Patient)

A 34-year-old man presents with a six-month history of altered voice quality and a right vocal fold lesion demonstrating increased vascularity. Prior videostroboscopy revealed that the vibratory characteristics of the right vocal fold were significantly altered, while those on the left were within normal limits. During phonation, the larynx did not close completely due to the mass of the lesion. Medical therapy has not eliminated his hoarseness. He undergoes removal of lesions of the vocal cord and reconstruction with local tissue flaps

Percentage of Survey Respondents who found Vignette to be Typical: 91% responded that the vignette described the typical patient. 9% indicated that the typical patient was a professional/performer, relying on voice for income (ie, surgery presented career implications).

Clinical Description Of Service:

Pre-operative work:

- Review the preoperative labs; Write pre-operative orders for peri-operative medications
- Verify with pre-operative nurse that no narcotics or sedatives are given in the pre-operative area in order to reduce the total narcotic load (when high, there is an increase risk of post-operative airway complications).
- Review the procedure and expected outcomes with the patient/family and answer questions
- Obtain informed consent
- Speak with the anesthesiologist regarding the planned procedure, potential difficulty with ventilation and intubation and the need for possible alternative airway management techniques
- Change into scrubs
- Verify the necessary equipment is present in the operating room, including operating microscope
- Scrub and gown
- Monitor/assist with patient positioning
- Monitor general anesthesia induction to assist with any airway problems; small endotracheal tube utilized

Intra-operative Work:

A direct laryngoscope is used to examine the oral cavity, oropharynx, hypopharynx and larynx. Once it is ascertained that no additional lesions were present, the patient's vocal folds are visualized and the laryngoscope suspended. The larynx is examined with rigid optical telescopes so that the entire extent of the lesion could be determined. The operating microscope is used to view the larynx at high magnification. The affected vocal fold and lesion are palpated with microlaryngeal rigid probes and suction devices. A micro-sickle knife and micro-scissors are used to make an incision into the vocal fold lining. A micro-probe is used to microdissect within the lamina propria, so that the lesion is separated from the uninvolved lamina propria. A flap is developed that measures 5 mm in length, 4 mm from superior to inferior, and was 400 microns in thickness. Sharp dissection is required to release the lesion from the surrounding normal tissues. Bimanual dissection is required throughout the dissection. Once the lesion is separated from adjacent tissue, it is removed. The preserved mucosal microflaps are then trimmed and repositioned so that, as much as possible, the defect over the medial surface of the vocal fold is closed primarily.

Postoperative work:

- Monitor patient stabilization in the operating room, including monitoring extubation of patient
- Coordinate postoperative care with recovery room nursing staff
- Write order for patient activities, once awake
- Write postoperative note in patient's chart
- Dictate operative report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Check patient's vital signs in PACU
- Consult with the family/patient regarding the surgery
- Write orders for CPAP unit, oxymetazoline, and supplemental oxygen, as needed
- Assess airway prior to discharge to determine the safety of breathing in an unmonitored setting
- Review instructions for post-discharge wound care and home care with patient and family
- Write orders for post-discharge medications
- Prepare discharge records

SURVEY DATA

Presenter(s):		James Denny, MD			
Specialty(s):		American Academy of Otolaryngology – Head and Neck Surgery			
CPT Code:		31545			
Sample Size:	40	Resp n:	32	Resp %:	80%
Sample Type:		Random			
		Low	25th pctl	Median	75th pctl
Survey RVW:		4.53	6.30	7.00	9.06
Pre-Service Evaluation Time:				40	
Pre-Service Positioning Time:				10	
Pre-Service Scrub, Dress, Wait Time:				10	
Intra-Service Time:		30	60	60	90
Post-Service		Total Min*	CPT code / # of visits		
Immed. Post-time:		15			
Critical Care time/visit(s):					
Other Hospital time/visit(s):					
Discharge Day Mgmt:		18	99238 x 0.5		
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(S):

CPT	Descriptor	new '04 RVW	Glob
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope	4.52	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 31545	Ref CPT 31541
Pre-service	60	45
Intra-service	60	60
Same Day Immediate Post-service	15	20
Critical care		
Other hospital visit		
Discharge day management	18	
Office visit		
TOTAL TIME	153	125

INTENSITY/COMPLEXITY MEASURES (MEAN)

Respondents who chose key reference code	19	19
--	----	----

TIME SEGMENTS

Pre-service	2.89	2.47
Intra-service	4.16	3.05
Post-service	2.58	2.37

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.67	2.95
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	2.79
Urgency of medical decision making	2.68	2.63

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.47	2.74
Physical effort required	3.84	2.58

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.05	3.05
Outcome depends on the skill and judgment of physician	4.42	2.89
Estimated risk of malpractice suit with poor outcome	4.16	3.21

ADDITIONAL RATIONALE

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

Pre-operatively, new codes 31545 and 31546 represent similar work to 31541. While 31541 may be performed under local or general anesthesia, 31545 and 31546 will only be performed under general anesthesia. Intraoperatively, new codes 31545 and 31546 are more intense, requiring more technical skill and additional work, than 31541. CPT 31541 describes a procedure performed prior to the development of current understanding of vocal fold physiology and widespread acceptance of the "cover-body" theory of vocal fold vibration. The existing code's descriptor term "stripping" describes removal by grasping the lesion and pulling or avulsing it from the vocal fold without regard for normal, uninvolved tissue. Further, the descriptor term "tumor" implies removal of neoplastic lesions. In addition to microsurgical lesion removal, 31545 adds reconstruction with a local tissue flap to cover the defect and 31546 adds reconstruction with an autograft or allograft to cover the defect. Although the lesions removed under 31545 and 31546 are not tumors; their small size and locations mandate microsurgical precision within tissue planes whose dimensions are less than 500 microns for successful and reliable treatment. Postoperatively, until discharge, the patients undergoing flap reconstruction will require more immediate

attention and monitoring for airway or bleeding problems.

After reviewing the survey results and the IWPUT analysis of the new codes and the reference code, the AAOHNS consensus panel believes the survey median for 31545 is too high relative to 31546 and 31541. The AAOHNS recommends the survey 25th percentile RVW of 6.30 for 31545 (IWPUT=0.069) and the survey median RVW of 8.50 for 31546 (IWPUT=0.067). Based on the clinical comparison presented above, these RVW recommendations set new codes 31545 and 31546 in correct relation to each other and to the reference code 31541.

<u>Building Block Analysis</u>		31545 Recommended RVW: 6.30	
	Svy Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)
eval & positioning	50	0.0224	1.12
scrub, dress, wait	10	0.0081	0.08
Pre-service total			1.20

<u>Post-service:</u>	Time	Intensity	(=time x intensity)
Immediate post	15	0.0224	0.34
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
Discharge 99238	0.5	1.28	0.64
Post-service total			0.98

	Time	IWPUT	INTRA-RVW
<u>Intra-service:</u>	60	0.069	4.12

31541 Ref RVW 4.50		
MFS RVW:	RUC Std.	RVW
Svy Data	RUC Std.	RVW
Time	Intensity	(=time x intensity)
45	0.0224	1.01
	0.0081	0.00
		1.01

Time	Intensity	(=time x intensity)
20	0.0224	0.45
Visit n	E/M RVW	(=n x RVW)
	1.28	0.00
		0.45

Time	IWPUT	INTRA-RVW
60	0.051	3.04

Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? **NO**
2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. **N/A**

FREQUENCY INFORMATION

How was this service previously reported

31599 Unlisted procedure, larynx

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

Specialty: Otolaryngology 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: Otolaryngology
Frequency: less than 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: Otolaryngology
Frequency: less than 100

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

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

New CPT Code: 31546 (C2) **Global:** 000 **RUC Recommended RVW:** 8.50- 9.73

Descriptor: Laryngoscopy, direct, operative, with operating microscope or telescope, with removal of non-neoplastic lesion(s) of vocal cord; reconstruction with graft(s) (eg, autograft, allograft)
(For harvesting of grafts, use the appropriate code, eg, 20926)

Survey Vignette (Typical Patient)

A 27-year-old woman presents with a three-year history of dysphonia. Two years prior, she was found to have vocal nodules, which subsequently were surgically excised. Her voice never returned to normal and she had significant difficulty fulfilling her vocal requirements at work. Recent videostroboscopy revealed that the middle portion of the left vocal fold was stiff; non-vibratory. Medical therapy has yielded no change in the vocal fold stiffness nor adequate improvement in voice quality. In an effort to reconstruct the vocal fold and improve the vibratory characteristics of the fold to improve her voice, she undergoes scar dissection and reconstruction with an autograft. [When completing this survey, please only include the physician work related to the primary procedure, 31546. Work related to procuring the autograft would be separately reportable.]

Percentage of Survey Respondents who found Vignette to be Typical: 91% responded that the vignette described the typical patient. 9% indicated that the typical patient was a professional/performer, relying on voice for income (ie, surgery presented career implications).

Clinical Description Of Service:

Pre-operative work:

- Review the preoperative labs; Write pre-operative orders for peri-operative medications
- Verify with pre-operative nurse that no narcotics or sedatives are given in the pre-operative area in order to reduce the total narcotic load (when high, there is an increase risk of post-operative airway complications).
- Review the procedure and expected outcomes with the patient/family and answer questions
- Obtain informed consent
- Speak with the anesthesiologist regarding the planned procedure, potential difficulty with ventilation and intubation and the need for possible alternative airway management techniques
- Change into scrubs
- Verify the necessary equipment is present in the operating room, including operating microscope
- Scrub and gown
- Monitor/assist with patient positioning
- Monitor general anesthesia induction to assist with any airway problems; small endotracheal tube utilized

Intra-operative Work:

A direct laryngoscope is used to examine the oral cavity, oropharynx, hypopharynx, and larynx. Once it is ascertained that no additional lesions are present, the patient's vocal folds are visualized and the laryngoscope suspended. The larynx is examined with rigid optical telescopes so that the entire glottic region can be evaluated. The operating microscope is used to view the larynx at high magnification. The affected vocal fold is palpated with microlaryngeal rigid probes and suction devices, revealing that 50% of the vibratory portion of the left vocal fold is stiff and does not distract from the underlying structures. An incision is made in the overlying mucosa and a plane created between it and underlying structures. The surgical microdissection through scar tissue is meticulous. Caution is required to maintain the integrity of the delicate remaining vocal cord cover creating a microflap 700 microns in thickness. An autogenous fat tissue graft that had been separately harvested is placed in the region of the deficient lamina propria. Still under high magnification through the endoscope, the graft and mucosal flaps are fixed in place with microsutures.

Postoperative work:

- Monitor patient stabilization in the operating room, including monitoring extubation of patient
- Coordinate postoperative care with recovery room nursing staff
- Write order for patient activities, once awake
- Write postoperative note in patient's chart
- Dictate operative report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Check patient's vital signs in PACU
- Consult with the family/patient regarding the surgery
- Write orders for CPAP unit, oxymetazoline, and supplemental oxygen, as needed
- Assess airway prior to discharge to determine the safety of breathing in an unmonitored setting
- Review instructions for post-discharge wound care and home care with patient and family
- Write orders for post-discharge medications
- Prepare discharge records

SURVEY DATA

Presenter(s):	James Denny, MD				
Specialty(s):	American Academy of Otolaryngology – Head and Neck Surgery				
CPT Code:	31546				
Sample Size:	40	Resp n:	32	Resp %:	80%
Sample Type:	Random				
	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:	5.50	6.73	8.50	10.00	15.00
Pre-Service Evaluation Time:			40		
Pre-Service Positioning Time:			10		
Pre-Service Scrub, Dress, Wait Time:			10		
Intra-Service Time:	30	60	90	109	150
Post-Service	Total Min*	CPT code / # of visits			
Immed. Post-time:	20				
Critical Care time/visit(s):					
Other Hospital time/visit(s):					
Discharge Day Mgmt:	18	99238 x 0.5			
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(S):

CPT	Descriptor	new '04 RVW	Glob
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope	4.52	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 31545	Ref CPT 31541
Pre-service	60	45
Intra-service	90	60
Same Day Immediate Post-service	20	20
Critical care		
Other hospital visit		
Discharge day management	18	
Office visit		
TOTAL TIME	188	125

INTENSITY/COMPLEXITY MEASURES (MEAN)

Respondents who chose key reference code	20	20
--	----	----

TIME SEGMENTS

Pre-service	2.89	2.47
Intra-service	4.16	3.05
Post-service	2.58	2.37

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.67	2.95
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	2.79
Urgency of medical decision making	2.68	2.63

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.47	2.74
Physical effort required	3.84	2.58

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.05	3.05
Outcome depends on the skill and judgment of physician	4.42	2.89
Estimated risk of malpractice suit with poor outcome	4.16	3.21

ADDITIONAL RATIONALE

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

Pre-operatively, new codes 31545 and 31546 represent similar work to 31541. While 31541 may be performed under local or general anesthesia, 31545 and 31546 will only be performed under general anesthesia. Intraoperatively, new codes 31545 and 31546 are more intense, requiring more technical skill and additional work, than 31541. CPT 31541 describes a procedure performed prior to the development of current understanding of vocal fold physiology and widespread acceptance of the "cover-body" theory of vocal fold vibration. The existing code's descriptor term "stripping" describes removal by grasping the lesion and pulling or avulsing it from the vocal fold without regard for normal, uninvolved tissue. Further, the descriptor term "tumor" implies removal of neoplastic lesions. In addition to microsurgical lesion removal, 31545 adds reconstruction with a local tissue flap to cover the defect and 31546 adds reconstruction with an autograft or allograft to cover the defect. Although the lesions removed under 31545 and 31546 are not tumors; their small size and locations mandate microsurgical precision within tissue planes whose dimensions are less than 500 microns for successful and reliable treatment. Postoperatively, until discharge, the patients undergoing flap reconstruction will require more immediate

attention and monitoring for airway or bleeding problems.

After reviewing the survey results and the IWPUR analysis of the new codes and the reference code, the AAOHNS consensus panel believes the survey median for 31545 is too high relative to 31546 and 31541. The AAOHNS recommends the survey 25th percentile RVW of 6.30 for 31545 (IWPUR= 0.069) and the survey median RVW of 8.50 for 31546 (IWPUR=0.067). Based on the clinical comparison presented above, these RVW recommendations set new codes 31545 and 31546 in correct relation to each other and to the reference code 31541.

<u>Building Block Analysis</u>		31546 RVW	
		Recommende d RVW:	8.50
	Svy Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)
eval & positioning	58	0.0224	1.30
scrub, dress, wait	10	0.0081	0.08
Pre-service total			1.38

31541 Ref RVW	
MFS RVW:	4.50
Svy Data	RUC Std.
Time	Intensity
45	0.0224
	0.0081
	1.01

<u>Post-service:</u>	Time	Intensity	(=time x intensity)
Immediate post	20	0.0224	0.45
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
Discharge 99238	0.5	1.28	0.64
Post-service total			0.64

Time	Intensity	(=time x intensity)
20	0.0224	0.45
Visit n	E/M RVW	(=n x RVW)
	1.28	0.00
		1.28

	Time	IWPUR	INTRA-RVW
<u>Intra-service:</u>	90	0.067	6.03

Time	IWPUR	INTRA-RVW
60	0.51	3.04

Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? **Yes**
2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Obtaining a graft would be reported in addition to this primary procedure:

20926 Tissue grafts, other (eg, paratenon, fat, dermis) (2004RVW=5.50 global=090)

FREQUENCY INFORMATION

How was this service previously reported

31599 Unlisted procedure, larynx - plus 20926 to obtain graft

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

Specialty: Otolaryngology ~~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: Otolaryngology
Frequency: less than 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: Otolaryngology
Frequency: less than 100

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

		CPT	31545	31546
Meeting Date: RUC January 2004	DESCRIPTOR		Laryngoscopy, direct, operative, w-operating microscope or telescope, with removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)	Laryngoscopy, direct, operative, w-operating microscope or telescope, with removal of non-neoplastic lesion(s) of vocal cord; reconstruction with graft(s) (eg, autograft, allograft)
			Facility	Facility
	GLOBAL		0	0
TOTAL TIME	L037D	RN/LPN/MTA	36	36
PRE-service time	L037D	RN/LPN/MTA	30	30
SERVICE time	L037D	RN/LPN/MTA	6	6
POST-service time	L037D	RN/LPN/MTA	0	0
PRE-SERVICE - BEFORE ADMISSION	Code	Desc		
Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5
Coordinate pre-surgery services	L037D	RN/LPN/MTA	10	10
Schedule space and equipment in facility	L037D	RN/LPN/MTA	5	5
Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	7	7
Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3
SERVICE PERIOD - ADMIT TO DISCHARGE	Code	Desc		
99238 discharge visit			0.5	0.5
Dischg day mgmt outpt=6" 99238=12" 99239=15"	L037D	RN/LPN/MTA	6	6
POST-SERVICE Period - AFTER DISCHARGE			N/A	N/A
MEDICAL SUPPLIES			N/A	N/A
Equipment			N/A	N/A

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February and April 2004

Bronchoscopy Stent Revisions, Endobronchial Ultrasound

The CPT Editorial Panel in November 2003 revised two bronchoscopy procedures and created four new codes, in order to create more specific bronchial and tracheal stent placement techniques. Some procedures involve dilation and placement of one or more stents, while others may involve a revision of an existing stent and therapeutic intervention.

The RUC reviewed the survey data separately for each of the new and revised codes. The RUC believed that the reference codes used in the surveys were appropriate for the services. The physician work for the new codes was believed by the RUC to be more intense and time consuming than the reference codes, and the specialty society's recommended work values seemed appropriate. In addition, RUC understood that these new and revised procedures typically required general anesthesia in a facility setting, and therefore should not be on the conscious sedation list.

31630 and 31631

The specialty society's survey results for the two existing revised codes, 31630 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with tracheal or bronchial dilation or closed reduction of fracture* (Work RVU = 3.81) and 31631 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)* (Work RVU = 4.36) supported their current values and recommended no change in the work values. The RUC reviewed the physician time for each of the codes and recommended that the surveyed times be used, replacing the existing Harvard time, with one modification. The RUC believed that the intra-service time for 31630 should be 45 minutes instead of the surveyed 60 minutes, as the newly created family should reflect consistent time amongst its similar codes. **The RUC recommends that the specialty's physician surveyed time replace the existing Harvard time, and the intra-service time of 31630 be 45 minutes. The RUC also recommends no change in the existing physician work relative values for codes 31630 and 31631.**

31636

The RUC reviewed the physician work of new code 31636 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial* in relation to its reference codes 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 = 3.36) and 31628 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance;*

with transbronchial lung biopsy(s), single lobe (Work RVU = 3.80). The RUC believed that the work of the new code was more difficult and required more time and physician work than either of the reference codes and supported the specialty society's median surveyed work value. **The RUC recommends a 4.30 work relative value for code 31636.**

31637

The RUC reviewed the physician work of the new code 31637, *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented (List separately in addition to code for primary procedure)* in relation to its reference code 31636 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of bronchial stent (includes tracheal/bronchial dilation as required)*, initial (RUC recommended Work RVU=4.30). The RUC believed that because the reference code has pre and post service time associated with it, 15 and 25 minutes, respectively, and the reference code has a longer intra-service time than the surveyed code 45 minutes and 30 minutes, respectively, that the surveyed code should have less work than the work associated with the reference code. The RUC believed that this work value should be similar to the difference between the basic bronchoscopy code, 31622 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)* (RVU=2.78) and 31636. **Therefore, the RUC recommends a work relative value of 1.58 for 31637.**

31638

The RUC reviewed the work and physician time of new code 31638 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with revision of a tracheal or bronchial stent inserted at a previous session (includes tracheal/bronchial dilation as required)* in relation to its reference codes 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 = 3.36) and 31628 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe* (Work RVU = 3.80). The RUC believed the specialty's survey results were appropriate for the entire service, and understood that the additional intra-service time for this code was appropriate considering the family of codes and the reference codes. The RUC agreed with the specialty's recommended work value for 31638. **The RUC recommends a work relative value of 4.88 for new code 31638.**

31620

The RUC reviewed the procedure in great detail and provided justification for the intensity of the code. The RUC reviewed code 92979 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)* (ZZZ global, RUC Surveyed, Work RVU = 1.44) and the specialty society's reference code 31628 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe* (000 global, RUC Surveyed, Work RVU = 3.80). The RUC did not believe that the work of 31628 was comparable to 31620, but believed it was closer to the work of code 92979. The RUC then reviewed the differences in intra service work of two other codes to capture the ultrasound work component

and make its recommendation. The RUC reviewed the difference between codes 43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (Work RVU = 1.59) and 43231 *Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination* (RUC Surveyed, Work RVU = 3.19). The RUC extracted the pre-service and post-service work from both codes 43200 and 43231 resulting in 0.91 and 2.31 respectively. The RUC then recommended subtracting the intra-service work of 43200 from 43231 to capture only the ultrasound portion of work, resulting in a work RVU of 1.40. **The RUC recommends a Work RVU of 31620 of 1.40. In addition, the RUC recommends that this could be added to the Conscious Sedation List.**

Practice Expense:

31630, 31631, 31636 and 31638

The RUC understood that these procedures would only be safely performed in the facility setting and therefore did not recommend practice expense inputs in the non-facility setting. The RUC reviewed the specialty society recommended practice expense inputs for the facility setting carefully, and altered the clinical labor staff type and lowered the time, to be consistent to similar practice expense inputs of 000 day global bronchoscopy procedures that have been through the RUC process. The revised practice expense inputs are attached.

31637 and 31620

The RUC understood that 31637 would only be performed in addition to its base code 31636 and therefore did not recommend practice expense inputs. As for 31620, RUC agreed that the cleaning of the ultrasound probe clinical labor time would be reduced to 5 minutes, and supplies and equipment were altered to account for the any duplication in the base code 31622 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)*. The revised practice expense inputs for 31620 are attached.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
✚•31620	J5	Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure(s) (Use 31620 in conjunction with 31622-31638)	ZZZ	1.40

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)
▲31630		with tracheal/ or bronchial dilation or closed reduction of fracture	000	3.81
▲31631	J1	<p>with tracheal dilation and placement of tracheal stent <u>placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)</u></p> <p>(For placement of bronchial stent, see 31636, 31637)</p> <p>(For revision of tracheal/bronchial stent, use 31638)</p>	000	4.36
●31636	J2	with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), ³ initial bronchus	000	4.30
✚●31637	J3	<p>each additional major bronchus stented (List separately in addition to code for primary procedure)</p> <p>(Use 31637 in conjunction with 31636)</p>	ZZZ	1.58
●31638	J4	with revision of a tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)	000	4.88

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

CPT Code:31620 Tracking Number: J5 Global Period: ZZZ **Recommended Work Relative Value**
Specialty Society RVU: **1.60** RUC RVU: **1.40**

CPT Descriptor: Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure(s))

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient has a 1.0 cm nodule identified on chest CT scan. The nodule appears to abut the left upper lobe bronchus. At bronchoscopy, a decision is made to perform an endobronchial ultrasound to determine if the nodule invades the bronchial wall.

Percentage of Survey Respondents who found Vignette to be Typical: 33%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 84%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The physician inserts the flexible bronchoscope with a biopsy channel of at least 2.8 mm and inspects the left upper lobe bronchus. No abnormality is identified. Then a miniaturized ultrasound catheter probe bearing a mechanical transducer at its tip that rotates 360 degrees is inserted. To ensure complete contact with the tracheobronchial wall, the catheter has a balloon at the tip that, after being filled with water, provides complete circular contact. Once inside the airways, the balloon is inflated until complete circular contact with the left upper lobe bronchus is achieved, and the airway wall, adjacent lung parenchyma, wall and the surrounding mediastinum become visible. To add the longitudinal dimension to the cross-sectional image, the probe is moved along the axis of the airways, attempting to localize and examine the ultrasound characteristics of the lesion. An ultrasound picture is taken for the patient's record, even if the lesion is not identified.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Alan Plummer, MD, FCCP and Scott Manaker, MD, PhD, FCCP				
Specialty(s):	ATS & ACCP				
CPT Code:	31620				
Sample Size:	23	Resp n:	18	Response: 78.26 %	
Sample Type:	Panel				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.30	3.00	3.80	4.30	8.60
Pre-Service Evaluation Time:			0.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	10.00	15.00	20.00	29.00	45.00
Post-Service	Total Min**	CPT code / # of visits			

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>
31628	000	3.80

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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
31625	000	3.36

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

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 4.0 %

TIME ESTIMATES (Median)

New/Revised
CPT Code:
31620 Key
Reference
CPT Code:
31628

Median Pre-Service Time	0.00	15.00
Median Intra-Service Time	20.00	45.00
Median Immediate Post-service Time	0.00	25.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	20.00	85.00

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	4.00	4.00
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.00
--------------------------	------	------

Physical effort required	4.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	4.00	4.00
Estimated risk of malpractice suit with poor outcome	3.00	3.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	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.*

ATS and ACCP recommends a work value of 1.60. This is between the 25th percentile and the median WRVUs recommended by the respondents. In reviewing other endoscopic codes, we noted that CPT codes 43200 (Esophagus endoscopy) has a work RVU of 1.59, and CPT code 43231 (Esophagus endoscopy with ultrasound) has a work RVU of 3.19, a difference of 1.60 between the two codes. We believe that endobronchial ultrasound is more difficult to perform than esophageal ultrasound and, therefore, should have at least a WRVU of 1.60.

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. 316XX is a ZZZ (add-on) code used to report the use of endobronchial ultrasound in addition to the basic bronchoscopic procedure, 31622. CPT code 31622 is a 000 day global period code with a WRVU of 2.78. The endoscopic payment rules apply to the base bronchoscopy code(s) reported.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31899, Unlisted procedure trachea or bronchi

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

Specialty Pul Medicine How often? Sometimes

Specialty Thoracic Surgeons How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Pulmonary Med	Frequency 828	Percentage 69.00 %
-------------------------	---------------	--------------------

Specialty Thoracic Surgeons	Frequency 120	Percentage 10.00 %
-----------------------------	---------------	--------------------

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 300

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

Specialty Pulmonary Med	Frequency 207	Percentage 69.00 %
-------------------------	---------------	--------------------

Specialty Thoracic Surgery	Frequency 30	Percentage 10.00 %
----------------------------	--------------	--------------------

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. 76932

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:31630 Tracking Number: J Global Period:000 **Recommended RVW: 3.80**

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with tracheal/ bronchial or closed reduction of fracture.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50 year old woman is seen for shortness of breath 6 months after prolonged hospitalization for sepsis, during which she required a tracheostomy. The tracheostomy tube was removed 5 months previously. Plain radiographs and CT scans confirm the presence of a focal stenosis in the mid-trachea. It was elected to proceed with a bronchoscopy and tracheal dilation and, if necessary placement of a stent. After successful dilation, no residual stenosis exists, and no stent is necessary.

Percentage of Survey Respondents who found Vignette to be Typical: 92.00%

Description of Pre-Service Work: Plain radiographic films and CT scans are again reviewed. Procedure discussed with patient and/or family.

Description of Intra-Service Work: A rigid bronchoscope is advanced to the stenotic area. A dilation catheter is placed through the bronchoscope into the opening of the focal stenosis and under fluoroscopy is threaded distally to just beyond the focal stenosis.

Description of Post-Service Work: Findings are discussed with the patient and family and instructions given about post-operative and follow-up care. Treatment options are discussed. A report is written as well as needed prescriptions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2004				
Presenter(s):	Scott Manaker, MD, PhD, FCCP & Alan Plummer, MD, FCCP				
Specialty(s):	American College of Chest Physicians & American Thoracic Society				
CPT Code:	31630				
Sample Size:	1031	Resp n:	26	Resp %:	2.5
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	2.25	3.76	3.96	4.50	8.00
Pre-Service Evaluation Time:			20.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		

Intra-Service Time:		25.00	45.00	60	80.00	180.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	30.00					
Critical Care time/visit(s):	0.00	99291x 0 99292x 0				
Other Hospital time/visit(s):	0.00	99231x 0 99232x 0 99233x 0				
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00				
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00				

To calculate above and below time recommendations, tab here

**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>
31628	000	3.79

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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
31629	000	3.35

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)

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

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

Number of respondents who choose Key Reference Code: 7

TIME ESTIMATES (Median)

	New/Revised CPT Code: 31630	Key Reference CPT Code: 31628
Median Pre-Service Time	50.00	43.00
Median Intra-Service Time	45.00	42.00
Median Immediate Post-service Time	30.00	18.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	125.00	103.00

Calculate total
reference time
tab here

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.00
--	------	------

Urgency of medical decision making	5.00	3.00
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	3.00
--------------------------	------	------

Physical effort required	5.00	2.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	3.00
---	------	------

Outcome depends on the skill and judgement of physician	5.00	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	5.00	3.00
------------------------------------	------	------

Post-Service intensity/complexity	4.00	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.*

An electronic 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 member of the practice management committees of the two societies who agreed to the recommendations. The representatives from the committees were 10 in number. Additionally, there wer 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? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

N/A

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

Specialty Pulmonology	How often? Sometimes
Specialty Otolaryngology	How often? Sometimes
Specialty Thoracic Surgery	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 911
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Pulmonology	Frequency 219	Percentage	24.03%
Specialty Otolaryngology	Frequency 276	Percentage	30.29%
Specialty Thoracic Surgery	Frequency 180	Percentage	19.75%

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

Specialty Pulmonology	Frequency 147	Percentage	24.05%
Specialty Otolaryngology	Frequency 185	Percentage	30.27%
Specialty Thoracic Surgery	Frequency 121	Percentage	19.80%

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

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

CPT Code:31631 Tracking Number: J1 Global Period:000 **Recommended RVW: 4.35**

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient is evaluated for dyspnea and stridor is found to have squamous cell carcinoma extensively involving the distal trachea. At bronchoscopy, the markedly narrow lumen is dilated, and a tracheal stent is placed.

Percentage of Survey Respondents who found Vignette to be Typical: 30.00%

Description of Pre-Service Work: Procedure discussed with patient and/or family. Plain radiographic films and CT scans are again reviewed to pre-measure and ascertain the size of the stent(s) to be deployed. The stent length should exceed the length of the lesion to some degree to ensure patency. If the stent is too small, it may migrate; conversely, if it is too large it may not open upon deployment or may cause stress on the airway wall.

Description of Intra-Service Work: A rigid bronchoscope is advanced to the stenotic area. A dilation catheter is placed through the bronchoscope into the small opening in the tumor mass and threaded through the tumor mass under fluoroscopy. The dilating catheter is removed, and a guide wire is inserted through the bronchoscope into the now patent trachea. The bronchoscope is removed, leaving the guide wire in place, and the stent catheter is manipulated over the guide wire into the previously stenotic area. The bronchoscope is again inserted and the area is visualized both through the bronchoscope and by fluoroscopy.

Description of Post-Service Work: Findings are discussed with the patient and family and instructions given about post-operative and follow-up care. Treatment options are discussed. A report is written as well as needed prescriptions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		01/2004			
Presenter(s):	Scott Manaker, MD, PhD, FCCP & Alan Plummer, MD, FCCP				
Specialty(s):	American College of Chest Physicians & American Thoracic Society				
CPT Code:	31631				
Sample Size:	1031	Resp n:	31	Resp %:	3.0
Sample Type:	Random				
		Low	25 th pctl	Median*	75 th pctl
Survey RVW:		2.50	4.01	4.50	5.50
Pre-Service Evaluation Time:				20.00	

Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	30.00	43.00	45.00	63.00	210.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	30.00				
Critical Care time/visit(s):	0.00	99291x 0 99292x 0			
Other Hospital time/visit(s):	0.00	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			

To calculate above and below time recommendations, tab here

**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>
31628	000	3.79

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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
31629	000	3.35

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)

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

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

Number of respondents who choose Key Reference Code: 29

TIME ESTIMATES (Median)

	New/Revised CPT Code: 31631	Key Reference CPT Code: 31628
Median Pre-Service Time	45.00	43.00
Median Intra-Service Time	45.00	42.00
Median Immediate Post-service Time	30.00	18.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	120.00	103.00

Calculate total
reference time
tab here**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	3.00
Urgency of medical decision making	5.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.00
Physical effort required	4.00	3.00
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	5.00	3.00
Outcome depends on the skill and judgement of physician	5.00	4.00
Estimated risk of malpractice suit with poor outcome	4.00	3.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	3.00
Intra-Service intensity/complexity	5.00	3.00
Post-Service intensity/complexity	4.00	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.*

An electronic 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 member of the practice management committees of the two

societies who agreed to the recommendations. The representatives from the committees were 10 in number. 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? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonology How often? Sometimes

Specialty Otolaryngology How often? Sometimes

Specialty Thoracic Surgery How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1594

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Pulmonology	Frequency 561	Percentage	35.19%
Specialty Otolaryngology	Frequency 192	Percentage	12.04%
Specialty Thoracic Surgery	Frequency 307	Percentage	19.25%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
1,094 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Pulmonology	Frequency 385	Percentage	35.19%
Specialty Otolaryngology	Frequency 132	Percentage	12.06%
Specialty Thoracic Surgery	Frequency 211	Percentage	19.28%

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

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

CPT Code:31636 Tracking Number: J2 Global Period:000 **Recommended RVW: 4.30**

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required; initial bronchus

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with Stage IV (metastatic) adenocarcinoma of the left lower lobe develops shortness of breath, and left lower lobe atelectasis from progressive endobronchial tumor growth, seen on serial CT scans. At bronchoscopy, following dilation a stent is placed in the left lower lobe bronchus.

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

Description of Pre-Service Work: Procedure discussed with patient and/or family. Plain radiographic films and CT scans are again reviewed to pre-measure and ascertain the size of the stent(s) to be deployed. The stent length should exceed the length of the lesion to some degree to ensure patency. If the stent is too small, it may migrate; conversely, if it is too large it may not open upon deployment or may cause stress on the airway wall.

Description of Intra-Service Work: A rigid bronchoscope is advanced to the stenotic area. A dilation catheter is placed through the bronchoscope into the small opening in the tumor mass and is threaded distally to just beyond the tumor mass under fluoroscopy. The dilating catheter is removed, and a guide wire is inserted through the bronchoscope into the now patent trachea. The bronchoscope is removed, leaving the guide wire in place, and the stent catheter is manipulated over the guide wire into the previously stenotic area. The bronchoscope is again inserted and the area is visualized both through the bronchoscope and by fluoroscopy. Two metal markers are taped to the external chest wall under fluoroscopy. The stent is then deployed, using both of the markers for fluoroscopic guides and under direct vision by the physician using the bronchoscope.

Description of Post-Service Work: Findings are discussed with the patient and family and instructions given about post-operative and follow-up care. Treatment options are discussed. A report is written as well as needed prescriptions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		01/2004					
Presenter(s):	Scott Manaker, MD, PhD, FCCP & Alan Plummer, MD, FCCP						
Specialty(s):	American College of Chest Physicians & American Thoracic Society						
CPT Code:	31636						
Sample Size:	1031	Resp n:	27	Resp %: 2.6%			
Sample Type:	Random						
			Low	25th pctl	Median*	75th pctl	High

Survey RVW:	2.25	4.00	4.30	5.00	10.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	25.00	30.00	45.00	60.00	90.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	25.00				
Critical Care time/visit(s):	0.00	99291x 0 99292x 0			
Other Hospital time/visit(s):	0.00	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			

To calculate above and below time recommendations, tab here

**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>
31629	000	3.35

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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
31628	000	3.79

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

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

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

Number of respondents who choose Key Reference Code: 10

TIME ESTIMATES (Median)

	New/Revised CPT Code: 31636	Key Reference CPT Code: 31629
Median Pre-Service Time	45.00	43.00
Median Intra-Service Time	45.00	42.00
Median Immediate Post-service Time	25.00	18.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	115.00	103.00

Calculate total
reference time
tab here**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.00
--	------	------

Urgency of medical decision making	4.00	3.00
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.00
--------------------------	------	------

Physical effort required	4.00	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.00
---	------	------

Outcome depends on the skill and judgement of physician	5.00	4.00
---	------	------

Estimated risk of malpractice suit with poor outcome	4.00	3.00
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	5.00	4.00
------------------------------------	------	------

Post-Service intensity/complexity	4.00	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.*

An electronic 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 member of the practice management committees of the two

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

☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

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

☐ Historical precedents.

☐ Other reason (please explain)

Specialty Pulmonology	Frequency 900	Percentage	60.00 %
Specialty Thoracic Surgery	Frequency 600	Percentage	40.00 %
Specialty	Frequency 0	Percentage	0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
1125 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Pulmonology	Frequency 675	Percentage 60.00%
Specialty Thoracic Surgery	Frequency 450	Percentage 40.00%
Specialty	Frequency 0	Percentage 0.00%

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

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

CPT Code:31637 Tracking Number: J3 Global Period: ZZZ **Recommended Work Relative Value**
Specialty Society RVU: **1.58** RUC RVU: **1.58**

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of bronchial stent (includes tracheal/bronchial dilation as required; each additional major bronchus stented (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with Stage IV (metastatic) adenocarcinoma of the left lower lobe develops shortness of breath and left lower lobe atelectasis from progressive endobronchial tumor growth, seen on serial chest CT scans. It was elected to proceed with bronchoscopy with dilation and stenting of the left lower lobe bronchus. At bronchoscopy, it becomes evident that the right main bronchus is circumferentially involved and nearly obstructed by tumor; therefore, a decision was made to dilate and stent also the right main bronchus.

Percentage of Survey Respondents who found Vignette to be Typical: 37%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 39%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The CT scan is re-reviewed to pre-measure and ascertain the size of the stent to be deployed. Proper stent sizing is critical. The stent length should exceed the length of the lesion to some degree to ensure patency. If the stent is too small in diameter, it may migrate; conversely, if it is too large it may not open upon deployment or may cause stress on the airway wall. Following removal of the bronchoscope after deploying the first stent, the bronchoscope is inserted into the right main bronchus and is advanced to the obstruction in the right bronchus, where bulky tumor is visualized both through the bronchoscope and by fluoroscopy extending down to where a small opening is seen through a tumor mass into the right main bronchus. A dilation catheter is placed through the bronchoscope into the small opening in the tumor mass, and threaded through the tumor mass into the right lower lobe bronchus under fluoroscopic guidance. Then, under fluoroscopic guidance, the obstructed endobronchial area is dilated. The dilating catheter is removed and repositioned more proximally in the right mainstem where a repeat dilation is performed under fluoroscopy. Next, a guide wire is inserted through the bronchoscope into the now patent right lower lobe. Then, the bronchoscope is removed, leaving the guide wire in place, and the stent catheter is manipulated over the guide wire into the right lower lobe bronchus. Two metal markers (e.g., paper clips) are taped to the external chest wall under fluoroscopy. The stent is then deployed, using both of the markers for fluoroscopic guides and under direct vision by the physician using the bronchoscope. The two metal markers are repositioned and taped to the external chest wall under fluoroscopy to mark the carina and left mainstem bronchus. Care must be taken to ensure overlap between the distal end of the proximal stent and the proximal end of the distal stent.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2004
Presenter(s):	Alan Plummer, MD, FCCP and Scott Manaker, MD, PhD, FCCP
Specialty(s):	ATS & ACCP
CPT Code:	31637

CPT Code: 51057

Sample Size: 105	Resp n: 38	Response: 36.19 %				
Sample Type: Panel						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		1.40	3.99	4.30	4.35	6.80
Pre-Service Evaluation Time:				0.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		15.00	20.00	30.00	45.00	120.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	0.00					
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>
316X1	000	4.30

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of bronchial stent (includes tracheal/bronchial dilation as required)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
31631	000	4.35

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with tracheal dilation and placement of tracheal stent

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

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

Number of respondents who choose Key Reference Code: 37 % of respondents: 24.0 %

TIME ESTIMATES (Median)

New/Revised
CPT Code:
31637 Key
Reference
CPT Code:
316X1

Median Pre-Service Time	0.00	15.00
Median Intra-Service Time	30.00	45.00
Median Immediate Post-service Time	0.00	25.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	30.00	85.00

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	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	4.00	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	5.00
--------------------------	------	------

Physical effort required	4.00	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	4.00
Outcome depends on the skill and judgment of physician	5.00	4.00
Estimated risk of malpractice suit with poor outcome	4.00	4.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	5.00	4.00
Post-Service intensity/complexity	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.*

For insertion of the second bronchial stent, we chose a work RVU between the 25th percentile and the median; i.e., 1.58.

We chose this number because it is very similar to the difference between the basic WRVUs for the basic bronchoscopy code, 31622 (2.78), and the WRVUs for 316X1, Insertion of endobronchial stent (4.30).

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: 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

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31899, Unlisted procedure trachea or bronchi; 31631, Insertion of tracheal stent

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Thoracic Surgery How often? Sometimes

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Thoracic Surgery	Frequency 145	Percentage 25.00 %
----------------------------	---------------	--------------------

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

Specialty Thoracic Surgery	Frequency 36	Percentage 24.82 %
----------------------------	--------------	--------------------

Do many physicians perform this service across the United States?

If no, please select another crosswalk and provide a brief rationale. 31622

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

CPT Code:31638

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

CPT Code:31638 Tracking Number: J42 Global Period:000 **Recommended RVW: 4.88**

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with revision of a tracheal or bronchial stent inserted at a previous session (includes tracheal/bronchial dilation as required)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45year-old woman is seen for dyspnea, cough, and fever two months after placement of a bronchial stent for narrowing of the bronchial anastomosis after single right lung transplant. Diagnostic studies indicate that the stent has migrated distally in the airway to partially obstruct the middle and lower lobe bronchi. Therefore, a decision is made to perform a bronchoscopy and reposition the stent to obtain optimum results..

Percentage of Survey Respondents who found Vignette to be Typical: 90.00%

Description of Pre-Service Work: Procedure discussed with patient and/or family. Plain radiographic films and CT scans are again reviewed to locate the migrated stent and pre-measure and ascertain the size of the stent(s) to be deployed. The stent length should exceed the length of the lesion to some degree to ensure patency. If the stent is too small, it may migrate; conversely, if it is too large it may not open upon deployment or may cause stress on the airway wall.

Description of Intra-Service Work: A rigid bronchoscope is advanced to the focal stenotic area. Under fluoroscopic guidance and direct visualization through the bronchoscope, the migrated stent is located. Using forceps, the physician removes any necrotic tissue and, finally, the stent. The bronchoscope is removed and reinserted. A dilation catheter is placed through the bronchoscope into the small opening of the focal stenosis and under fluoroscopy is threaded distally to just beyond the focal stenosis. The dilating catheter is removed, and a guide wire is inserted through the bronchoscope into the now patent bronchi. The bronchoscope is removed, leaving the guide wire in place, and the stent catheter is manipulated over the guide wire into the previously stenotic area. The bronchoscope is again inserted and the area is visualized both through the bronchoscope and by fluoroscopy. Two metal markers are taped to the external chest wall under fluoroscopy. The stent is then deployed, using both of the markers for fluoroscopic guides and under direct vision by the physician using the bronchoscope.

Description of Post-Service Work: Findings are discussed with the patient and family and instructions given about post-operative and follow-up care. Treatment options are discussed. A report is written as well as needed prescriptions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2004
Presenter(s):	Scott Manaker, MD, PhD, FCCP & Alan Plummer, MD, FCCP
Specialty(s):	American College of Chest Physicians & American Thoracic Society
CPT Code:	31638

Sample Size: 1031		Resp n: 21		Resp %: 2.0%		
Sample Type: Random						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		2.75	4.00	4.88	5.63	12.00
Pre-Service Evaluation Time:				20.00		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				15.00		
Intra-Service Time:		25.00	45.00	60.00	80.00	180.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		30.00				
Critical Care time/visit(s):		0.00	99291x 0 99292x 0			
Other Hospital time/visit(s):		0.00	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:		0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):		0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			

To calculate above and below time recommendations, tab here

**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>
31629	000	3.35

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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
31628	000	3.79

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

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

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

Number of respondents who choose Key Reference Code: 10

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 31638</u>	<u>Key Reference CPT Code: 31629</u>
Median Pre-Service Time	50.00	43.00
Median Intra-Service Time	60.00	42.00
Median Immediate Post-service Time	30.00	18.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00

Median Total Time	140.00	103.00
-------------------	--------	--------

Calculate total
reference time
tab here

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.00
--	------	------

Urgency of medical decision making	5.00	3.00
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	3.00
--------------------------	------	------

Physical effort required	5.00	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	3.00
---	------	------

Outcome depends on the skill and judgement of physician	5.00	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	5.00	3.00
------------------------------------	------	------

Post-Service intensity/complexity	4.00	3.00
-----------------------------------	------	------

ADDITIONAL RATIONALE

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

An electronic 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

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

☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

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

☐ Historical precedents.

☐ Other reason (please explain)

- | 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?
375 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Pulmonology	Frequency 225	Percentage	60.00%
Specialty Thoracic Surgery	Frequency 150	Percentage	40.00%
Specialty	Frequency 0	Percentage	0.00%

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

AMA/Specialty Society Update Process
PEAC Summary of Recommendation
ZZZ Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure(s))

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

Geographic Practice Setting %: Rural Suburban Urban

Type of Practice %: Solo Practice
50% Single Specialty Group
Multispecialty Group
50% Medical School Faculty Practice Plan

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

ACCP and ATS utilized a consensus panel to develop the recommendations regarding the practice expense inputs. There were 24 members of the panel consisting of 20 Pulmonologists, 1 Respiratory Care Practitioner, 2 Practice Administrators, and 1 Registered Nurse. Ten of the pulmonologists were from single specialty groups practicing in a suburban setting, and the other ten pulmonologists were medical school faculty practicing in an urban setting. One practice administrator was from a suburban setting, and the other practice administrator and RN were from urban settings.

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities:

Prepare Ultrasound probe and necessary supplies. Administer and monitor additional conscious sedation. Assist physician in performing procedure. Clean probe (2/3 of scope cleaning time).

Total Staff Time Non Facility: 52 min

Visits in Global Period: N/A

CMS's Staff Type Code*	Clinical Labor	Service Period	Cost Estimate and Source (if applicable)
L042B	RT	27	
L051A	RN	20	

	A	B	C	D	E	F
1			31630		31631	
2		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Bronchoscopy with traceal/bronchial dilation or closed reduction of fracture		Bronchoscopy with placement of tracheal stent(s)	
3	LOCATION		Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD					
5	TOTAL CLINICAL LABOR TIME	RT	0.0	18.0	0.0	21.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	RT	0.0	18.0	0.0	18.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	RT	0.0	0.0	0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	RT	0.0	0.0	0.0	3.0
9	PRE-SERVICE					
10	Start: Following visit when decision for surgery or procedure made					
11	Complete pre-service diagnostic & referral forms	LO42B		5		5
12	Coordinate pre-surgery services	LO42B		3		3
13	Schedule space and equipment in facility					
14	Provide pre-service education/obtain consent	LO42B		7		7
15	Follow-up phone calls & prescriptions	LO42B		3		3
16	Other Clinical Activity (please specify)					
17	End: When patient enters office/facility for surgery/procedure					
18	SERVICE PERIOD					
19	Start: When patient enters office/facility for surgery/procedure					
20	Pre-service services					
21	Review charts					
22	Greet patient and provide gowning					
23	Obtain vital signs					
24	Provide pre-service education/obtain consent					
25	Prepare room, equipment, supplies	LO42B				
26	Prepare and position patient/ monitor patient/ set up IV					
27	Sedate/apply anesthesia					
28	Intra-service					
29	Assist Physician in performing procedure	LO42B				
30	Conscious Sedation	LO51A				
31	Post-Service					
32	Monitor pt. following service/check tubes, monitors, drains					
33	Clean room/equipment by physician staff					
34	Clean Ultrasound Probe 2/3 of scope cleaning time	LO42B				
35	Clean Surgical Instrument Package					
36	Complete Report and Rx					
37	Review/read X-ray, lab, and pathology reports					
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
39	Discharge day management 99238 –12 minutes 99239 –15 minutes					
40	Other Clinical Activity (please specify)					
41	End: Patient leaves office					
42	POST-SERVICE Period					
43	Start: Patient leaves office/facility					
44	Conduct phone calls/call in prescriptions	LO42B				3
45	Office Visits					
46	List Number and Level of Office Visits					
47	99211 16 minutes					
48	99212 27 minutes					
49	99213 36 minutes					
50	99214 53 minutes					
51	99215 63 minutes					
52	Other					
53	Total Office Visit Time				0	0
54	Other Activity (please specify)					
55	End: with last office visit before end of global period					
56	MEDICAL SUPPLIES					

	A	B	C	D	E	F
1			31630		31631	
2		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Bronchoscopy with tracheal/bronchial dilation or closed reduction of fracture		Bronchoscopy with placement of tracheal stent(s)	
3	LOCATION		Non Facility	Facility	Non Facility	Facility
57	Balloon Sheath -- MAJ-643R* \$770 for pack of 5 = \$154 each			No Code		
58	O2 -- 2L/min X 20 min work time			SD084		
59						
60						
61	Equipment					
62	Ultrasound Processor EU-M303* -- \$29,200					
63	Balloon Sheath Probe UM-BS20-26R-3* -- \$5,680					
64	Motor Drive Unit MAJ-682* -- \$6,300					
65	lightsource					
66	infusion pump			E91001		
67	ECG Monitor			E55002		
68	Pulse Oximeter			E55003		
69	suction source with regulator			E30001		
70	Vido system, indoscopy (processor, digital capture, monitor, pinter, cart)					
71	power table			E11003		
72	Bronchoscope			E3123		
73						
74						
75						
76	* Olympus; Melville, NY					

	A	B	G	H	I	J
1			31636		31638	
2		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Bronchoscopy with placement of bronchial stent; initial		Bronchoscopy with revision of a tracheal or bronchial stent	
3	LOCATION		Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD					
5	TOTAL CLINICAL LABOR TIME	RT	0.0	21.0	0.0	21.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	RT	0.0	18.0	0.0	18.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	RT	0.0	0.0	0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	RT	0.0	3.0	0.0	3.0
9	PRE-SERVICE					
10	Start: Following visit when decision for surgery or procedure made					
11	Complete pre-service diagnostic & referral forms	LO42B		5		5
12	Coordinate pre-surgery services	LO42B		3		3
13	Schedule space and equipment in facility					
14	Provide pre-service education/obtain consent	LO42B		7		7
15	Follow-up phone calls & prescriptions	LO42B		3		3
16	Other Clinical Activity (please specify)					
17	End: When patient enters office/facility for surgery/procedure					
18	SERVICE PERIOD					
19	Start: When patient enters office/facility for surgery/procedure					
20	Pre-service services					
21	Review charts					
22	Greet patient and provide gowning					
23	Obtain vital signs					
24	Provide pre-service education/obtain consent					
25	Prepare room, equipment, supplies	LO42B				
26	Prepare and position patient/ monitor patient/ set up IV					
27	Sedate/apply anesthesia					
28	Intra-service					
29	Assist Physician in performing procedure	LO42B				
30	Conscious Sedation	LO51A				
31	Post-Service					
32	Monitor pt. following service/check tubes, monitors, drains					
33	Clean room/equipment by physician staff					
34	Clean Ultrasound Probe 2/3 of scope cleaning time	LO42B				
35	Clean Surgical Instrument Package					
36	Complete Report and Rx					
37	Review/read X-ray, lab, and pathology reports					
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
39	Discharge day management 99238 –12 minutes 99239 –15 minutes					
40	Other Clinical Activity (please specify)					
41	End: Patient leaves office					
42	POST-SERVICE Period					
43	Start: Patient leaves office/facility					
44	Conduct phone calls/call in prescriptions	LO42B		3		3
45	Office Visits					
46	List Number and Level of Office Visits					
47	99211 16 minutes					
48	99212 27 minutes					
49	99213 36 minutes					
50	99214 53 minutes					
51	99215 63 minutes					
52	Other					
53	Total Office Visit Time		0	0	0	0
54	Other Activity (please specify)					
55	End: with last office visit before end of global period					
56	MEDICAL SUPPLIES					

	A	B	G	H	I	J
1			31636		31638	
2		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Bronchoscopy with placement of bronchial stent; initial		Bronchoscopy with revision of a tracheal or bronchial stent	
3	LOCATION		Non Facility	Facility	Non Facility	Facility
57	Balloon Sheath – MAJ-643R* \$770 for pack of 5 = \$154 each					
58	O2 – 2L/min X 20 min work time					
59						
60						
61	Equipment					
62	Ultrasound Processor EU-M303* – \$29,200					
63	Balloon Sheath Probe UM-BS20-26R-3* – \$5,680					
64	Motor Drive Unit MAJ-682* – \$6,300					
65	lightsource					
66	infusion pump					
67	ECG Monitor					
68	Pulse Oximeter					
69	suction source with regulator					
70	Vido system, indoscopy (processor, digital capture, monitor, pinter, cart)					
71	power table					
72	Bronchoscope					
73						
74						
75						
76	* Olympus; Melville, NY					

	A	B	K	L
1			31620	
2		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Endobronchial ultrasound (EBUS) during bronchoscopic diag. or therapeutic interventions.	
3	LOCATION		Non Facility	Facility
4	GLOBAL PERIOD			
5	TOTAL CLINICAL LABOR TIME	RT	47.0	N/A
6	TOTAL PRE-SERV CLINICAL LABOR TIME	RT	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	RT	47.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	RT	0.0	0.0
9	PRE-SERVICE			
10	Start: Following visit when decision for surgery or procedure made			
11	Complete pre-service diagnostic & referral forms	LO42B		
12	Coordinate pre-surgery services	LO42B		
13	Schedule space and equipment in facility			
14	Provide pre-service education/obtain consent	LO42B		
15	Follow-up phone calls & prescriptions	LO42B		
16	Other Clinical Activity (please specify)			
17	End: When patient enters office/facility for surgery/procedure			
18	SERVICE PERIOD			
19	Start: When patient enters office/facility for surgery/procedure			
20	Pre-service services			
21	Review charts			
22	Greet patient and provide gowning			
23	Obtain vital signs			
24	Provide pre-service education/obtain consent			
25	Prepare room, equipment, supplies	LO42B	2	
26	Prepare and position patient/ monitor patient/ set up IV			
27	Sedate/apply anesthesia			
28	Intra-service			
29	Assist Physician in performing procedure	LO42B	20	
30	Conscious Sedation	LO51A	20	
31	Post-Service			
32	Monitor pt. following service/check tubes, monitors, drains			
33	Clean room/equipment by physician staff			
34	Clean Ultrasound Probe 2/3 of scope cleaning time	LO42B	5	
35	Clean Surgical Instrument Package			
36	Complete Report and Rx			
37	Review/read X-ray, lab, and pathology reports			
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			
39	Discharge day management 99238 --12 minutes 99239 --15 minutes			
40	Other Clinical Activity (please specify)			
41	End: Patient leaves office			
42	POST-SERVICE Period			
43	Start: Patient leaves office/facility			
44	Conduct phone calls/call in prescriptions	LO42B		
45	Office Visits			
46	List Number and Level of Office Visits			
47	99211 16 minutes			
48	99212 27 minutes			
49	99213 36 minutes			
50	99214 53 minutes			
51	99215 63 minutes			
52	Other			
53	Total Office Visit Time		0	0
54	Other Activity (please specify)			
55	End: with last office visit before end of global period			
56	MEDICAL SUPPLIES			

	A	B	K	L
1			31620	
2		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Endobronchial ultrasound (EBUS) during bronchoscopic diag. or therapeutic interventions.	
3	LOCATION		Non Facility	Facility
57	Balloon Sheath -- MAJ-643R* \$770 for pack of 5 = \$154 each		1	
58	O2 -- 2L/min X 20 min work time		40L	
59				
60				
61	Equipment			
62	Ultrasound Processor EU-M303* -- \$29,200		1	
63	Balloon Sheath Probe UM-BS20-26R-3* -- \$5,680		1	
64	Motor Drive Unit MAJ-682* -- \$6,300		1	
65	lightsource		1	
66	infusion pump			
67	ECG Monitor		1	
68	Pulse Oximeter		1	
69	suction source with regulator		1	
70	Vido system, indoscopy (processor, digital capture, monitor, pinter, cart)		1	
71	power table		1	
72	Bronchoscope		1	
73				
74				
75				
76	* Olympus; Melville, NY			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Chronic Indwelling Pleural Catheter

The CPT Editorial Panel created one new code to represent a new technology and technique for management of pleural effusions. The technique of insertion, and management of a chronic indwelling pleural catheter with cuff into the pleural space, and perioperative management had not been represented in existing CPT codes.

The RUC began its review of 32019 *Insertion of indwelling tunneled pleural catheter with cuff* by assessing 000 day global codes, including 32020 *Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)* (RUC Surveyed, MPC listed, 000 day global Work RVU = 3.97), 61107 *Twist drill hole for subdural or ventricular puncture; for implanting ventricular catheter or pressure recording device* (Work RVU = 4.99) and 45380 *Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple* (RUC Surveyed, MPC List, Work RVU = 4.43) in relation to this new code. The RUC believed that the new code does not require the same amount of work associated with code 61107 and 45380, and the RUC felt that the work associated with 32020 was the best reference. In relation to code 32020, the RUC felt that because of the additional tunneling and counter incision of the placement of the cuff associated with the new code warranted a 5% higher work RVU. In addition, the RUC and the presenters understood that the discharge day time reported on the summary of recommendation form was in error and should be deleted. **The RUC recommends a relative work value of 4.17 for code 32019, and there should be no physician time for discharge day management.**

The RUC also recommends that code 32019 be placed on the conscious sedation list.

Practice Expense for 32019

The RUC reviewed the revised recommended practice expense inputs in detail and agreed to reduce the clinical labor time in the pre-service time period, and in the intra-service time periods, in both clinical settings. **The revised practice expense inputs are attached and recommended by the RUC.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 32019	W1	<p>Insertion of indwelling tunneled pleural catheter with cuff</p> <p><u>(Do not report 32019 in conjunction with 32000, 32002, 32005, 32020, 36000, 36410, 62318, 62319, 64450, 64470, 64475)</u></p> <p><u>(If imaging guidance is performed, use 75989)</u></p>	000	4.17

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

Recommended Work Relative Value

CPT Code:32019 Tracking Number: W1 Global Period: 000 Specialty Society RVU: **5.19** RUC RVU: **4.17**

CPT Descriptor: Insertion of Indwelling tunneled pleural catheter with cuff (Do not report 32019 in conjunction with 32000, 32002, 32005, 32020, 36000, 36410, 62318, 62319, 64450, 64470, 64475) (If imaging guidance is performed, use 75989)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 68 year-old woman with breast cancer who has undergone a mastectomy with post-operative chemotherapy presents six months later with chronic malignant pleural effusion.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 38%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Subsequent evaluation reveals a large right pleural effusion. Diagnostic and therapeutic thoracentesis (to dryness) is performed. Her dyspnea is relieved and cytology examination demonstrates metastatic adenocarcinoma within the fluid consistent with breast primary. The patient has relief of her dyspnea. Three weeks later the patient again develops dyspnea. Physical examination demonstrates decreased breath sounds within the right chest, and dullness to percussion on the right. A chest roentgenogram is obtained which demonstrates a significant right pleural effusion. Subsequent bilateral decubitus films demonstrate a right unilateral free-flowing effusion. A decision is made to place a chronic indwelling catheter with cuff as definitive treatment for the malignant pleural effusion procedure. Preoperatively, the surgeon reviews the laboratory and imaging studies and evaluates the cardiopulmonary risks with additional studies as needed, and communicates with and obtains informed consent from the patient and/or family.

Description of Intra-Service Work: The patient is taken to operating room or clean procedure room and placed in a semi-fowler position with the arm extended. After placement of appropriate intravenous catheters, nasal oxygen, and monitoring equipment, the right chest is prepped and draped in the usual sterile fashion. Patient is given moderate sedation intravenously. Local anesthesia is used. Using the Seldinger technique, the free-flowing pleural fluid is located and a wire is inserted into the pleural space along the right axillary line. Local anesthetic is used to allow for painless 1 cm incision over the wire. A second (counter) incision is made lower and medial to the first incision, under local anesthesia and placed approximately 5-10 cm away. The subcutaneous space between the two incisions is anesthetized with the local anesthetic solution.

A tunneling device is then utilized to pass the chronic indwelling catheter with cuff through the lower incision through the subcutaneous tissue, and then into and exiting from the upper incision. Care is taken to place the cuff in a subcutaneous position just lateral (within 1 cm) of the lower incision (just under the skin incision). An obturator/dilator with a peel-away sheath is then used to tunnel through the intercostal space, through the parietal pleura, and into the pleural space while guided by the previously placed wire. The obturator / dilator is removed, and the catheter is fed through the peel-away sheath, through the pleural defect, and into the pleural cavity. The peel-away sheath is removed as the catheter is positioned without twists or bends, to allow easy egress of the pleural fluid. The upper incision is then closed in two layers. A suction bottle is attached to the external portion of the catheter to drain the effusion. The catheter is secured into position at the lower, medial incision.

Sterile dressings are applied.

Description of Post-Service Work: Upon recovery from the procedure, the patient and family are instructed on the appropriate method of drainage. A chest roentgenogram (AP alone, or PA and lateral) is obtained to confirm position of the catheter, and the result of the drainage. The patient is then discharged to home health or hospice.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Bill Putnam, MD				
Specialty(s):	STS/AATS				
CPT Code:	32019				
Sample Size:	75	Resp n:	32	Response:	%
Sample Type: Convenience					
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.50	5.53	6.00	7.50	10.00
Pre-Service Evaluation Time:			15.0		
Pre-Service Positioning Time:			10.0		
Pre-Service Scrub, Dress, Wait Time:			15.0		
Intra-Service Time:	15.00	20.00	30.00	45.00	90.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	<u>20.00</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>
49421	090	5.53

CPT Descriptor Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
32020	000	3.97

CPT Descriptor Tuve thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedue)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 68.7 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 32019	Key Reference CPT Code: 49421
Median Pre-Service Time	40.00	45.00
Median Intra-Service Time	30.00	41.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	29.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	18.00
Median Total Time	90.00	148.00

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

The number of possible diagnosis and/or the number of management options that must be considered	2.00	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.00
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.00
Physical effort required	2.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	3.00
Outcome depends on the skill and judgment of physician	3.00	2.00
Estimated risk of malpractice suit with poor outcome	3.00	3.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	3.00	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 STS selected a work RVU of 5.19 slightly under the 25th percentile of 5.53. We recognize that the majority of our surveyees selected code 49421 as a reference code which has a 90 day global period. While we feel that a work RVU of 5.53 would be accurate for code 320XX, we recognize the disparity between the 0 and 90 day globals, however, the pre-intra, and immediate post work values are similar as are the intensity factors and the mental effort, judgement, technical skill, physical effort, and psychological stress factors. In order to account for these variances, we determined that the work rvu we selected represents a reasonable compromise.

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) 32020-22

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

Specialty cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Commonly

Specialty pulmonology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 4500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty cardiothoracic surgery Frequency 2700 Percentage 60.00 %

Specialty general surgery Frequency 1350 Percentage 30.00 %

Specialty Pulmonology Frequency 450 Percentage 10.00 %

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

2,700 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Cardiothoracic surgery Frequency 1620 Percentage 60.00 %

Specialty General Surgery Frequency 810 Percentage 30.00 %

Specialty Pulmonology Frequency 270 Percentage 10.00 %

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. 32020

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

	A	B	C	D
1				
2			32019	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Insertion of indwelling tunneled pleural catheter with cuff	
4	LOCATION		Non Facility	Facility
5	GLOBAL PERIOD			
6	TOTAL CLINICAL LABOR TIME		106.0	23.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		5.0	20.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		98.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		3.0	3.0
10	PRE-SERVICE			
11	Start: Following visit when decision for surgery or procedure made			
12	Complete pre-service diagnostic & referral forms	L042B	5	5
13	Coordinate pre-surgery services	L042B		
14	Schedule space and equipment in facility			5
15	Provide pre-service education/obtain consent			7
16	Follow-up phone calls & prescriptions			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	L042B	2	
23	Greet patient and provide gowning	L042B	3	
24	Obtain vital signs	L042B	5	
25	Provide pre-service education/obtain consent	L042B	7	
26	Prepare room, equipment, supplies	L042B	2	
27	Setup scope (non facility setting only)			
28	Prepare and position patient/ monitor patient/ set up IV	L051A	2	
29	Sedate/apply anesthesia	L051A	2	
30	Intra-service			
31	Monitor patient – conscious sedation	L051A	30	
32	Assist physician in performing procedure	L042B	20	
33	Post-Service			
34	Monitor pt. following service/check tubes, monitors, drains	L051A	15	
35	Clean room/equipment by physician staff	L042B	3	
36	Clean Scope			
37	Clean Surgical Instrument Package			
38	Complete diagnostic forms, lab & X-ray requisitions	L042B	2	
39	Review/read X-ray, lab, and pathology reports	L042B		
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L042B	5	
41	Discharge day management 99238 –12 minutes 99239 –15 minutes			
42	Other Clinical Activity (please specify)			
43	End: Patient leaves office			
44	POST-SERVICE Period			
45	Start: Patient leaves office/facility			
46	Conduct phone calls/call in prescriptions	L042B	3	3
47	Office visits:			
48	List Number and Level of Office Visits			
49	99211 16 minutes	16		
50	99212 27 minutes	27		
51	99213 36 minutes	36		
52	99214 53 minutes	53		
53	99215 63 minutes	63		
54	Other			
55				
56	Total Office Visit Time		0	0
57	Other Activity (please specify)			
58	End: with last office visit before end of global period			

	A	B	C	D
2			32019	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Insertion of indwelling tunneled pleural catheter with cuff	
4	LOCATION		Non Facility	Facility
59	MEDICAL SUPPLIES			
60	PEAC multispecialty supply package	SA048	1	
61	Post-op incision care kit	SA054	1	
62	Conscious Sedation Pack	SA044	1	
63	Chux	SB044	2	
64	Mask with face shield	SB034	2	
65	Sterile gloves	SB024	1	
66	Sterile Drape for Mayo Stand	SB012	1	
67	Suction Cannister	SD009	1	
68	Suction Vacuum	SD010	1	
69	Catheter Insertion Kit 50-7000* -- \$329.00	No Code	1	
70	Vacuum Bottle 50-7205 -- \$31.00	No Code	2	
71	Micropore Tape	SG079	32 in	
72	EQUIPMENT			
73	Power Exam Table	E11011	X	
74	Mayo Stand	NC585	X	
75	Exam Lamp	E3006	X	
76				
77				
78	*Denver Biomedical, Inc.			
79	14998 West 6th Street			
80	Bldg E 700			
81	Golden, CO 80401			
82	1-800-824-8454			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Lung Transplantation

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes 32850 *Donor pneumonectomy(ies) (including cold preservation), from cadaver donor-with preparation and maintenance of allograft (cadaver)*; 32855 and 32856 *Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the pulmonary venous/atrial cuff, pulmonary artery, and bronchus-; unilateral and bilateral, respectively* are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at this time the **RUC does not submit any recommendations for codes 32850, 32855 and 32856.**

Lung allotransplantation involves three distinct components of physician work:

1) Cadaver donor pneumonectomy(-ies) which include(s) harvesting the allograft and cold preservation of the allograft (perfusing with cold preservation solution and cold maintenance) (see 32850).

2) Backbench work

Preparation of a cadaver donor single lung allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the pulmonary venous/atrial cuff, pulmonary artery, and bronchus, unilaterally (see 32855).

Preparation of a cadaver donor double lung allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the pulmonary venous/atrial cuff, pulmonary artery, and bronchus, bilaterally (see 32856).

3) Recipient lung allotransplantation which includes transplantation of a single or double lung allograft and care of the recipient (see 32851).

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 32850	X1	Donor pneumonectomy(ies) (including cold preservation), from cadaver donor-with preparation and maintenance of allograft (cadaver)	XXX	Currently not on the MFS, No RUC Recommendation at this time.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
32851		<i>Lung transplant, single; without cardiopulmonary bypass</i>	090	38.57 (No Change)
32852		<i>with cardiopulmonary bypass</i>	090	41.74 (No Change)
32853		<i>Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass</i>	090	47.74 (No Change)
32854		<i>with cardiopulmonary bypass</i>	090	50.90 (No Change)
● 32855	X2	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral	XXX	Currently not on the MFS, No RUC Recommendation at this time.
● 32856	X3	bilateral (For repair or resection procedures on the donor lung, see 32491, 32500, 35216, or 35276)	XXX	Currently not on the MFS, No RUC Recommendation at this time.



American Society of Transplant Surgeons
1020 North Fairfax Street, #200, Alexandria, VA 22314
Telephone: (703) 684-5990
Fax: (703) 684-6303

April 1, 2004

William L. Rich III, MD, FACS
Chair, AMA/Relative Value Update Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Re: Organ Transplantation Codes

Dear Dr. Rich:

At its February 2004 meeting, the AMA's CPT Editorial Panel approved the American Society of Transplant Surgeons' (ASTS) proposal for organ transplantation coding changes in CPT.

Specifically, the Panel approved:

- New explanatory text for each of the six transplantation sections in CPT (Lung, Heart/Lung, Liver, Pancreas, Intestine, and Kidney);
- Editorial revisions to a number of current code descriptors;
- Eleven new codes describing standard backbench work for organ grafts;
- Eight new codes describing reconstructive backbench work for organ grafts; and
- One new code describing complete removal of a transplanted intestinal allograft.

ASTS has completed the AMA/RUC survey for physician relative work for the eight new codes describing reconstructive backbench work. The AMA/RUC Summary of Recommendation Forms are attached. Practice expense recommendations are also attached. The discussion that follows presents the ASTS' rationale for surveying only these eight new codes.

1. Donor Excision Codes

(RUC Tracking numbers: X1, X2, X3, AC1, AC2, AE1, AE3, AE4, AE5, AE6, AE7, AF1, AG1, AG2, AG8)

The CPT Panel approved editorial revisions to both cadaver and living donor excision codes. For 12 codes, the phrase *including cold preservation* replaced the phrase *with preparation and maintenance of allograft*. For one code, the editorial revision removes the language *excluding preparation and maintenance of allograft*.

Cadaver donor excision services are not paid under the Medicare physician fee schedule (MFS). Instead, these services are considered organ acquisition costs to the hospital and are reimbursed under Part A of Medicare through a payment to the hospital. Medicare regulation at 42 CFR, Section 412.100 provides that certain costs related to inpatient hospital services including, specifically, *organ acquisition costs incurred by hospitals with approved organ transplantation centers* . . . are made on a reasonable

cost basis. *Organ acquisition costs* are defined at 42 CFR, Section 412.100 to include, among other things, the surgeon's fee for excising cadaver organs. Although this regulation refers to kidney excision, CMS has stated elsewhere that this regulation applies to all organs, not just kidney. The Medicare Provider Reimbursement Manual, Part III §3625.3 specifically instructs hospitals to include *surgeon's (sic) fees for excising cadaveric organs* in reporting organ acquisition costs on the hospital cost report.

Additionally, we note that in 1994, ASTS attempted to perform RUC surveys for the extremely variable work of cadaver donor excision services. The values that the RUC recommended to CMS were not based on the survey results, but on facilitation, in an attempt to standardize a non-standard service. The following text, taken from the *Federal Register* (December 8, 1994, p. 63453), presents the CMS decision regarding the RUC recommendations:

We reviewed the RUC recommendation for these cadaver donor codes as a group with representatives of the RUC, our CMDs, and representatives of the specialty societies involved with transplant surgery. We have concluded that the assignment of RVUs to these codes could lead to inequitable payment to some physicians because of the marked variations in time associated with organ acquisitions. Therefore, payment for these services will not be made under the physician fee schedule. Rather, the services furnished by a surgeon who retrieves a cadaveric donor organ that is intended for a Medicare-covered transplant will continue to be paid outside the hospital prospective payment system at 100 percent of the reasonable cost under Part A on a retrospective basis, as set forth at 42 CFR 412.100. These costs are included in the organ acquisition charge of the Certified Transplant Center or the Independent Organ Procurement Organization. (emphasis added)

ASTS did not conduct a RUC survey for the cadaver donor excision codes, which were assigned AMA tracking numbers, for two reasons. First, the revisions to nomenclature were editorial in nature. Second, the RUC survey is designed for work-RVU recommendations for new and revised codes for payment under the MFS. Since excision of cadaveric organs may not be reimbursed under the MFS, by law, and since these services still involve *marked variations in time*, it is not appropriate for these codes to be reviewed through the RUC survey process.

Living donor excision services are reimbursed under the MFS. However, ASTS did not survey these codes because the changes were editorial and did not alter the underlying work. For transplant surgeons, the phrase *preparation and maintenance of allograft*, as it relates to the donor procedures, refers to *perfusion with cold preservation solution and cold maintenance*. For the transplant surgeon, in no instance, would *preparation and maintenance* have included backbench standard graft preparation or additional reconstructive work. The revised descriptors are meant to more clearly describe the work related to the donor procedure and not to change the work. We articulated this to the CPT Panel and the RUC just last year, when the new living liver donor codes were created and reviewed. At that time, CPT (and the RUC) indicated that we should pursue revising the language for all donor codes to make this consistent and clear to everyone. The CPT proposals, reviewed and accepted in February 2004, presented these editorial revisions.

2. Standard Backbench Codes

(RUC Tracking numbers: X2, X3, Y2, Y4, AC3, AE2, AF2, AG3, AG4)

The CPT Panel approved eleven new codes describing standard backbench work. ASTS did not survey these codes at this time because CMS and ASTS are in discussions regarding whether standard backbench

work should be considered an organ acquisition cost which is reimbursed under Part A, or whether these services should be treated as a Part B service paid under the MFS. Current Medicare regulations and guidance do not specifically address this issue.

ASTS has written to CMS stating its views that backbench work should be treated as a hospital organ acquisition cost because of the nature of the work. Briefly, the standard backbench codes describe work that is always necessary to prepare a graft for implantation. However, this work is extremely variable in its execution, as shown by the following examples: 1) The standard backbench graft preparation can be performed at either the donor or recipient site of service; 2) The recipient may die and the prepared graft will need to be sent to a different site for a different recipient; or 3) The grafts may be “split” and then transplanted in one or more recipients at one or more locations. Because of the marked variability in this work, similar to cadaver organ acquisition, it makes most sense to consider this work as a hospital organ acquisition cost. The ASTS has asked CMS to issue definitive guidance on this subject. If CMS determines that backbench work is part of hospital organ acquisition costs reimbursed under Part A, it would not be appropriate for these codes to be reviewed through the RUC survey process. However, if CMS determines that these new codes are new Part B services to be paid under the MFS, then ASTS will conduct AMA/RUC surveys.

3. Backbench Reconstruction Codes

(RUC Tracking numbers: AC4, AC5, AE8, AE9, AF3, AG5, AG6, AG7)

The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts. These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

ASTS has conducted RUC surveys for these codes. As we stated in our CPT proposal, there were no existing codes to describe reconstructive backbench work. We do not know the extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, ASTS believes these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team. It is appropriate that these new backbench reconstruction codes be reviewed by the RUC for MFS RVW recommendations to CMS.

4. Removal of Intestinal Allograft

(RUC Tracking number: AC6)

The CPT Panel approved one new code to describe removal of a transplanted intestinal allograft. ASTS attempted to survey this code, but only received a few responses. This service is infrequently performed (approximately 10 times annually), and is performed by a limited number of transplant surgeons in the country. Our discussions with these surgeons revealed the fact that total postoperative patient care is extensive. These patients will be hospitalized for 21 or more days, followed by two to three office visits weekly. Although there are codes in the MFS that have extensive hospital care (e.g. 39503 with LOS=30 days) or that have extensive outpatient care (e.g. 66172 with 12 office visits), there are no codes in the MFS that have the combination of significant hospital and office work through a 90-day global period.

Dr. William Rich

April 1, 2004

Page 4

Valuing a code with this extensive total work using a survey of magnitude estimation is not possible because there are no good references for "total work."

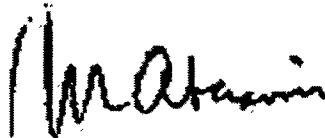
Additionally, the surgeons who perform this service correctly point out that the intestinal transplantation codes (44135 and 44136) are restricted services under Part B and do not have assigned work-RVUs. Restricted status means that special coverage instructions apply. If a restrictive service is covered and no RVUs are shown, the service is carrier-priced. ASTS recommends that new code 441X4 for removal of intestinal allograft be listed as carrier priced. We also suggest that the global period assignment be 000 instead of 090, since there is so much variability in the post-service work for these patients.

5. Direct Practice Expense

For the eight backbench donor organ reconstruction codes (441X2, 441X3, 471X4, 471X5, 485X2, 503X3, 503X4, and 503X5), ASTS recommends zero direct practice expense inputs. Any necessary clinical staff labor is already included with the primary procedure. There would be no office supplies or office equipment utilized for these facility-only codes.

ASTS appreciates the opportunity to submit this information to the RUC, along with our physician work recommendations for the eight new reconstructive backbench codes. If you have any questions prior to the RUC meeting, please contact me at 312-695-0254 or Ms. Gail Durant, ASTS Executive Director, at 703-684-5990

Sincerely,



Michael M. Abecassis, MD, FACS
RUC Advisor, ASTS

cc: Abraham Shaked, MD, PhD, FACS
President, ASTS

Attachments

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Heart-Lung, Heart Transplantation

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes 33930 *Donor cardiectomy-pneumonectomy (including cold preservation) ~~with preparation and maintenance of allograft~~*; 33933 *Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the aorta, superior vena cava, inferior vena cava, and trachea for implantation*; 33940 *Donor cardiectomy (including cold preservation) ~~with preparation and maintenance of allograft~~*; and 33944 *Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation* are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at this time **the RUC does not submit any recommendations for codes 33930, 33933, 33940, and 33944.**

Heart with or without lung allotransplantation involves three distinct components of physician work:

1) Donor cardiectomy with or without pneumonectomy. Cadaver donor cardiectomy with or without pneumonectomy includes harvesting the allograft and cold preservation of the allograft (perfusing with cold preservation solution and cold maintenance) (see 33930, 33940).

2) Backbench work.

Preparation of a cadaver donor heart and lung allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the aorta, superior vena cava, inferior vena cava, and trachea for implantation (see 33933).

Preparation of a cadaver donor heart allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation (see 33944).

3) Allotransplantation. Recipient heart with or without lung allotransplantation includes transplantation of allograft and care of the recipient (see 33935, 33945).

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲33930	Y1	Donor cardiectomy-pneumonectomy (including cold preservation) with preparation and maintenance of allograft	XXX	Currently not on the MFS, No RUC Recommendation at this time.
●33933	Y2	Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the aorta, superior vena cava, inferior vena cava, and trachea for implantation	090	Currently not on the MFS, No RUC Recommendation at this time.
33935		<i>Heart-lung transplant with recipient cardiectomy-pneumonectomy</i>	090	60.87 (No Change)
▲33940	Y3	Donor cardiectomy (including cold preservation) with preparation and maintenance of allograft	090	Currently not on the MFS, No RUC Recommendation at this time.
●33944	Y4	Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues to prepare the aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation <u>(For repair or resection procedures on the donor heart, see 33300, 33310, 33320, 33400, 33463, 33464, 33510, 33641, 35216, 35276 or 35685)</u>	XXX	Currently not on the MFS, No RUC Recommendation at this time.
33945		<i>Heart transplant, with or without recipient cardiectomy</i>	090	42.04 (No Change)



American Society of Transplant Surgeons
1020 North Fairfax Street, #200, Alexandria, VA 22314
Telephone: (703) 684-5990
Fax: (703) 684-6303

April 1, 2004

William L. Rich III, MD, FACS
Chair, AMA/Relative Value Update Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Re: Organ Transplantation Codes

Dear Dr. Rich:

At its February 2004 meeting, the AMA's CPT Editorial Panel approved the American Society of Transplant Surgeons' (ASTS) proposal for organ transplantation coding changes in CPT.

Specifically, the Panel approved:

- New explanatory text for each of the six transplantation sections in CPT (Lung, Heart/Lung, Liver, Pancreas, Intestine, and Kidney);
- Editorial revisions to a number of current code descriptors;
- Eleven new codes describing standard backbench work for organ grafts;
- Eight new codes describing reconstructive backbench work for organ grafts; and
- One new code describing complete removal of a transplanted intestinal allograft.

ASTS has completed the AMA/RUC survey for physician relative work for the eight new codes describing reconstructive backbench work. The AMA/RUC Summary of Recommendation Forms are attached. Practice expense recommendations are also attached. The discussion that follows presents the ASTS' rationale for surveying only these eight new codes.

1. Donor Excision Codes

(RUC Tracking numbers: X1, X2, X3, AC1, AC2, AE1, AE3, AE4, AE5, AE6, AE7, AF1, AG1, AG2, AG8)

The CPT Panel approved editorial revisions to both cadaver and living donor excision codes. For 12 codes, the phrase *including cold preservation* replaced the phrase *with preparation and maintenance of allograft*. For one code, the editorial revision removes the language *excluding preparation and maintenance of allograft*.

Cadaver donor excision services are not paid under the Medicare physician fee schedule (MFS). Instead, these services are considered organ acquisition costs to the hospital and are reimbursed under Part A of Medicare through a payment to the hospital. Medicare regulation at 42 CFR, Section 412.100 provides that certain costs related to inpatient hospital services including, specifically, *organ acquisition costs incurred by hospitals with approved organ transplantation centers . . .* are made on a reasonable

cost basis. *Organ acquisition costs* are defined at 42 CFR, Section 412.100 to include, among other things, the surgeon's fee for excising cadaver organs. Although this regulation refers to kidney excision, CMS has stated elsewhere that this regulation applies to all organs, not just kidney. The Medicare Provider Reimbursement Manual, Part III §3625.3 specifically instructs hospitals to include *surgeon's (sic) fees for excising cadaveric organs* in reporting organ acquisition costs on the hospital cost report.

Additionally, we note that in 1994, ASTS attempted to perform RUC surveys for the extremely variable work of cadaver donor excision services. The values that the RUC recommended to CMS were not based on the survey results, but on facilitation, in an attempt to standardize a non-standard service. The following text, taken from the *Federal Register* (December 8, 1994, p. 63453), presents the CMS decision regarding the RUC recommendations:

We reviewed the RUC recommendation for these cadaver donor codes as a group with representatives of the RUC, our CMDs, and representatives of the specialty societies involved with transplant surgery. We have concluded that the assignment of RVUs to these codes could lead to inequitable payment to some physicians because of the marked variations in time associated with organ acquisitions. Therefore, payment for these services will not be made under the physician fee schedule. Rather, the services furnished by a surgeon who retrieves a cadaveric donor organ that is intended for a Medicare-covered transplant will continue to be paid outside the hospital prospective payment system at 100 percent of the reasonable cost under Part A on a retrospective basis, as set forth at 42 CFR 412.100. These costs are included in the organ acquisition charge of the Certified Transplant Center or the Independent Organ Procurement Organization. (emphasis added)

ASTS did not conduct a RUC survey for the cadaver donor excision codes, which were assigned AMA tracking numbers, for two reasons. First, the revisions to nomenclature were editorial in nature. Second, the RUC survey is designed for work-RVU recommendations for new and revised codes for payment under the MFS. Since excision of cadaveric organs may not be reimbursed under the MFS, by law, and since these services still involve *marked variations in time*, it is not appropriate for these codes to be reviewed through the RUC survey process.

Living donor excision services are reimbursed under the MFS. However, ASTS did not survey these codes because the changes were editorial and did not alter the underlying work. For transplant surgeons, the phrase *preparation and maintenance of allograft*, as it relates to the donor procedures, refers to *perfusion with cold preservation solution and cold maintenance*. For the transplant surgeon, in no instance, would *preparation and maintenance* have included backbench standard graft preparation or additional reconstructive work. The revised descriptors are meant to more clearly describe the work related to the donor procedure and not to change the work. We articulated this to the CPT Panel and the RUC just last year, when the new living liver donor codes were created and reviewed. At that time, CPT (and the RUC) indicated that we should pursue revising the language for all donor codes to make this consistent and clear to everyone. The CPT proposals, reviewed and accepted in February 2004, presented these editorial revisions.

2. Standard Backbench Codes

(RUC Tracking numbers: X2, X3, Y2, Y4, AC3, AE2, AF2, AG3, AG4)

The CPT Panel approved eleven new codes describing standard backbench work. ASTS did not survey these codes at this time because CMS and ASTS are in discussions regarding whether standard backbench

work should be considered an organ acquisition cost which is reimbursed under Part A, or whether these services should be treated as a Part B service paid under the MFS. Current Medicare regulations and guidance do not specifically address this issue.

ASTS has written to CMS stating its views that backbench work should be treated as a hospital organ acquisition cost because of the nature of the work. Briefly, the standard backbench codes describe work that is always necessary to prepare a graft for implantation. However, this work is extremely variable in its execution, as shown by the following examples: 1) The standard backbench graft preparation can be performed at either the donor or recipient site of service; 2) The recipient may die and the prepared graft will need to be sent to a different site for a different recipient; or 3) The grafts may be “split” and then transplanted in one or more recipients at one or more locations. Because of the marked variability in this work, similar to cadaver organ acquisition, it makes most sense to consider this work as a hospital organ acquisition cost. The ASTS has asked CMS to issue definitive guidance on this subject. If CMS determines that backbench work is part of hospital organ acquisition costs reimbursed under Part A, it would not be appropriate for these codes to be reviewed through the RUC survey process. However, if CMS determines that these new codes are new Part B services to be paid under the MFS, then ASTS will conduct AMA/RUC surveys.

3. Backbench Reconstruction Codes

(RUC Tracking numbers: AC4, AC5, AE8, AE9, AF3, AG5, AG6, AG7)

The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts. These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

ASTS has conducted RUC surveys for these codes. As we stated in our CPT proposal, there were no existing codes to describe reconstructive backbench work. We do not know the extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, ASTS believes these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team. It is appropriate that these new backbench reconstruction codes be reviewed by the RUC for MFS RVW recommendations to CMS.

4. Removal of Intestinal Allograft

(RUC Tracking number: AC6)

The CPT Panel approved one new code to describe removal of a transplanted intestinal allograft. ASTS attempted to survey this code, but only received a few responses. This service is infrequently performed (approximately 10 times annually), and is performed by a limited number of transplant surgeons in the country. Our discussions with these surgeons revealed the fact that total postoperative patient care is extensive. These patients will be hospitalized for 21 or more days, followed by two to three office visits weekly. Although there are codes in the MFS that have extensive hospital care (e.g. 39503 with LOS=30 days) or that have extensive outpatient care (e.g. 66172 with 12 office visits), there are no codes in the MFS that have the combination of significant hospital and office work through a 90-day global period.

Dr. William Rich

April 1, 2004

Page 4

Valuing a code with this extensive total work using a survey of magnitude estimation is not possible because there are no good references for "total work."

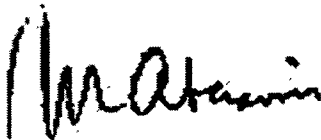
Additionally, the surgeons who perform this service correctly point out that the intestinal transplantation codes (44135 and 44136) are restricted services under Part B and do not have assigned work-RVUs. Restricted status means that special coverage instructions apply. If a restrictive service is covered and no RVUs are shown, the service is carrier-priced. ASTS recommends that new code 441X4 for removal of intestinal allograft be listed as carrier priced. We also suggest that the global period assignment be 000 instead of 090, since there is so much variability in the post-service work for these patients.

5. Direct Practice Expense

For the eight backbench donor organ reconstruction codes (441X2, 441X3, 471X4, 471X5, 485X2, 503X3, 503X4, and 503X5), ASTS recommends zero direct practice expense inputs. Any necessary clinical staff labor is already included with the primary procedure. There would be no office supplies or office equipment utilized for these facility-only codes.

ASTS appreciates the opportunity to submit this information to the RUC, along with our physician work recommendations for the eight new reconstructive backbench codes. If you have any questions prior to the RUC meeting, please contact me at 312-695-0254 or Ms. Gail Durant, ASTS Executive Director, at 703-684-5990

Sincerely,



Michael M. Abecassis, MD, FACS
RUC Advisor, ASTS

cc: Abraham Shaked, MD, PhD, FACS
President, ASTS

Attachments

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Endovascular Graft for Abdominal Aortic Aneurysm

The CPT Editorial Panel transferred a category III code (0001T) to category I status due to the FDA approval of a modular endovascular prosthesis which is the device used in new code 348X1 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs)*. The RUC reviewed the survey data for this code, especially the comparison with the reference service 34802 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)* (work RVU = 22.97). The survey median value of 24.00 RVUs was based on survey results from 63 vascular surgeons. The presenters explained that code 348X1 is very similar to the reference service and while there are some subtleties in terms of which endograft fits best in which patient, the overall spectrum of patients is the same. Deployment of the modular three-piece endograft used in 348X1 is very similar to the reference service two-piece endograft, except that 348X1 has one additional component that must be precisely deployed inside the patient. Maneuvering and deployment of this additional piece requires about 15 minutes of extra intra-service time. The intra-service intensity and complexity 348X1 is slightly higher than the reference service. The survey respondents reported a pre-service time of 25 minutes less for the new procedure as compared to the reference service but the presenters attributed this difference to random survey variation rather than clinical reality. Length of hospital stay, number and level of in-hospital visits, discharge day management, and the number and level of office visits is identical to the reference service. Therefore, the main difference between the two codes is an additional 15-minutes of intra-service time in the new service. The RUC agreed that this additional time and slightly higher intensity justifies a one RVU difference with the reference service and recommends the survey median of 24.00 RVUs.

The RUC recommends a work RVU of 24.00 for code 348X1.

Practice Expense

The standard inputs for 90 day global period codes only performed in the facility were applied.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
34800		<i>Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis</i>	090	20.72 (No Change)
34802		<i>using modular bifurcated prosthesis (one docking limb)</i>	090	22.97 (No Change)
●34803	Z1	using modular bifurcated prosthesis (two docking limbs) <u>(For endovascular repair of abdominal aortic aneurysm or dissection involving visceral vessels using a fenestrated modular bifurcated prosthesis (two docking limbs), use Category III codes 0078T-0079T)</u>	090	24.00
34804		<i>using unibody bifurcated prosthesis</i>	090	22.97 (No Change)
34805		<i>using aorto-uniiliac or aorto-unifemoral prosthesis</i>	090	21.85 (No Change)
✚34808		<i>Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)</i> <i>(Use 34808 in conjunction with codes 34800, 34813, 34825, 34826)</i> (For radiological supervision and interpretation, use 75952 in conjunction with 34800, 34802, <u>34803</u> , 34804, 34805, 34808) (For open arterial exposure, report codes 34812, 34820, 34833, 34834 as appropriate, in addition to codes 34800, 34802, <u>34803</u> , 34804, 34805, 34808)	ZZZ	4.12 (No Change)
0001T		Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; modular bifurcated prosthesis (two docking limbs)	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(For radiological supervision and interpretation, use 75952 in conjunction with 0001T) <u>(0001T has been deleted. To report, use 348X1)</u> <i>(0002T has been deleted. To report, use 34805)</i>		

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

CPT Code:34803 Tracking Number: Z1 Global Period: 090	Recommended Work Relative Value Specialty Society RVU: 24.00 RUC RVU: 24.00
---	---

CPT Descriptor: Endovascular repair of infrarenal abdominal aortic aneurysm or dissection;using modular bifurcated prosthesis (two docking limbs)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

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.

Important Note: As you estimate the time, intensity, and work RVUs for 3480X 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.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 11%

Is conscious sedation inherent in your reference code? No

Description of 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 risks. In addition, an extensive and detailed review of the preoperative imaging studies (CT, CT angiogram, CT with 3-D reconstructions, MRI, and/or contrast angiogram) 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. 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, patient positioning, waiting for the anesthetic to become effective, prepping and draping the patient.

Description of Intra-Service Work:

Reporting the deployment of 348X1 will follow the detailed coding guidelines in the CPT introductory notes for Endovascular Repair of Abdominal Aortic Aneurysm. The intraservice work includes:

- Perform road-mapping arteriogram with specific attention to renal artery origins
- Final examination of endovascular components for correct models, sizing, etc
- Exchange soft J-wires for superstiff wires
- Reconfirm appropriate device chosen, unpackage the main-body component and prepare the device for insertion
- Anticoagulate patient with IV heparin
- Load main-body component onto the ipsilateral superstiff wire and advance to the femoral artery
- Introduce tip of main device into arteriotomy
- Open proximal vascular clamp and advance front of device into artery
- Use rubber constrictors to limit blood loss
- Under fluoroscopic guidance direct main-body device through external iliac
- Advance device into common iliac and subsequently into aorta

- Push device thru AAA carefully so tip lies above renal artery origins and the proximal edge lies near the renal arteries
- Repeat arteriography as needed to absolutely confirm renal origin location
- Begin deployment
- Make final precise adjustments to align top of device just below renal origins
- Deploy main body device with constant attention to exact positioning
- Make final position adjustments, keep proximal edge just below renals checking distally to determine that position above the aortic bifurcation is correct
- Deploy main body device to the point of opening the contralateral docking port
- Cannulate the contralateral docking port using a selective catheter/guidewire combination, and advance the catheter into the main body of the graft to the level of the proximal anastomosis
- Inject contrast and image graft to confirm placement of the catheter within the graft
- Perform final angiogram to confirm position of the proximal anastomosis, and make any final adjustment to position of the proximal anastomosis at the level of the renals
- Deploy fixation portion of the main body component
- Advance contralateral superstiff wire into the suprarenal aorta
- Through a contralateral sheath, do angiography to roadmap position of the contralateral common iliac bifurcation
- Confirm appropriate length and diameter of the contralateral limb, unpackage limb, prepare device for introduction
- Load contralateral limb onto contralateral superstiff wire and advance to femoral artery
- Introduce contralateral limb device through arteriotomy, and advance under fluoro through iliac artery into docking position
- Confirm appropriate overlap of contralateral limb with main body device, and confirm appropriate position of distal anastomosis above internal iliac origin
- Deploy contralateral docking limb
- Finish deployment of main body component by deploying the ipsilateral docking port
- Recapture proximal portion of introduction device above proximal anastomosis, and remove introducer device for the main-body component
- Perform angiography through sheath to confirm position of ipsilateral common iliac bifurcation
- Confirm appropriate length & diameter of ipsilateral limb, open and prepare the device for insertion into patient
- Load ipsilateral limb device onto superstiff wire, advance to femoral artery, and introduce through arteriotomy
- Observe fluoroscopically as ipsilateral limb is advanced through iliac arteries into docking position
- Confirm appropriate overlap of limb with main body device, and confirm appropriate position of distal anastomosis above internal iliac origin
- Deploy ipsilateral limb
- Remove introducer devices for bilateral iliac limbs, using fluoroscopic guidance to prevent disruption of graft position
- Deploy suprarenal fixation portion of the main body component
- Advance contralateral superstiff wire into the suprarenal aorta
- Angioplasty all 5 anastomoses to seat graft, and angioplasty graft components as needed for complete expansion (note: angioplasty within target zone is included in 348X1, not separately reportable)
- Reposition flush catheter to the level of the proximal anastomosis, and perform completion arteriogram
- Re-balloon any areas of Type I endoleak as needed
- Deploy stents, if needed, within body of prosthesis to seal endoleaks or treat kinks
(note: stent placement in body of graft is included in 348X1, not separately reportable)
- Perform final completion arteriogram
- Perform completion pressure measurements
- Remove catheters/wires/sheaths using fluoroscopic guidance

Description of Post-Service Work: Post-service work begins when the patient is transferred to a post procedure recovery unit. This includes writing orders, 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, write orders and notes, etc. 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 previous similar primary endovascular repair codes have been assigned 90-day global periods. Thus, all related office visits for 90-days are included in the post-service work of 348X1.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):		Gary Seabrook, MD; Bibb Allen, MD; Bob Vogelzang, MD				
Specialty(s):		SVS; ACR; SIR				
CPT Code:		34803				
Sample Size: 200		Resp n: 63		Response: 31.50 %		
Sample Type: Random						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		22.00	23.50	24.00	25.00	38.00
Pre-Service Evaluation Time:				75.0		
Pre-Service Positioning Time:				15.0		
Pre-Service Scrub, Dress, Wait Time:				20.0		
Intra-Service Time:		60.00	120.00	165.00	180.00	270.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		30.00				
Critical Care time/visit(s):		0.0	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):		49.0	99231x 1.0	99232x 1.0	99233x 0.0	
Discharge Day Mgmt:		36.0	99238x 1.00	99239x 0.00		
Office time/visit(s):		38.0	99211x 0.0	12x 1.0	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>
34802	090	22.97

CPT Descriptor Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)

<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: 61 % of respondents: 96.8 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 34803	Key Reference CPT Code: 34802
Median Pre-Service Time	110.00	135.00
Median Intra-Service Time	165.00	150.00
Median Immediate Post-service Time	30.00	40.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	49.0	49.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	38.0	38.00
Median Total Time	428.00	448.00

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	4.20	4.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	4.22
Urgency of medical decision making	3.64	3.54

Technical Skill/Physical Effort (Mean)

Technical skill required	4.66	4.32
Physical effort required	4.10	3.93

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.23	4.24
Outcome depends on the skill and judgment of physician	4.52	4.52
Estimated risk of malpractice suit with poor outcome	4.00	4.05

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.21	3.95
Intra-Service intensity/complexity	4.69	4.37
Post-Service intensity/complexity	3.25	3.26

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 new service 348X1 is very similar to the reference service chosen by almost all respondents. There are some subtleties in terms of which endograft fits best in which patient, but the overall spectrum of patients is the same. Deployment of the 348X1, modular three-piece endograft, is also very similar to the reference service two-piece endograft, with the obvious exception that the new service has one additional component that must be precisely deployed inside the patient. Maneuvering and deployment of this additional piece requires about 15 minutes of extra intra-service time, and respondents noted intra-service intensity and complexity measures of the three-piece device higher than the reference service.

There are minor differences in pre-service time according to the survey data, with the new service requiring 25 minutes less. We believe this represents an idiosyncrasy of the survey process because if anything, more pre-service time is required for aneurysm measurements when using the 3-piece device compared to the 2-piece device, while all other aspects of pre-service patient care are the exactly equivalent. Immediate post-service time is 10-minutes less than the reference service. Again, since the patient spectrum is identical, we believe this represents random survey variation rather than clinical reality. Length of hospital stay, number and level of in-hospital visits, discharge day management, and the number and level of office visits is identical to the reference service, both by survey and in clinical reality.

Overall, we believe the 15-minutes of intraservice time inherent in the new service, coupled with the higher intra-service intensity and complexity measures of the new service, justifies the one extra RVU survey respondents felt was appropriate compared to reference.

IWPUT Comparison with Reference service chosen by 98% of respondents

348X1 Svy RVW: 24.00
 Svy Data RUC Std. RVW
 Pre-service: Time Intensity(=time x intensity)
 Pre-service eval & positioning 75 0.0224 1.68
 Pre-service scrub, dress, wait 35 0.0081 0.28
 Pre-service total: 1.96

34802 REF RVW: 22.97
 Svy Data RUC Std. RVW
 Pre-service: Time Intensity(=time x intensity)
 Pre-service eval & positioning 120 0.0224 2.69
 Pre-service scrub, dress, wait 15 0.0081 0.12
 Pre-service total: 2.81

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 1.51 0.00
 99232 1 1.06 1.06
 99231 1 0.64 0.64
 99238 1 1.28 1.28
 99239 1.75 0.00
 99215 1.73 0.00
 99214 1.08 0.00
 99213 1 0.65 0.65
 99212 1 0.43 0.43
 99211 0.17 0.00
 Post-service total 4.73

Post-service: Time Intensity(=time x intensity)
 Immediate post 40 0.0224 0.90
 Subsequent visits: Visit n E/M RVW(=n x RVW)
 99233 1.51 0.00
 99232 1 1.06 1.06
 99231 1 0.64 0.64
 99238 1 1.28 1.28
 99239 1.75 0.00
 99215 1.73 0.00
 99214 1.08 0.00
 99213 1 0.65 0.65
 99212 1 0.43 0.43
 99211 0.17 0.00
 Post-service total 4.96

Intra-service: Time IWPUT INTRA-RVW
 165 0.105 17.30

Intra-service: Time IWPUT INTRA-RVW
 150 0.101 15.20

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.
3. Based on the CPT endovascular coding conventions noted above, the vignette patient described in Question 16 will be reported with the following codes (assuming no other separately reportable procedures are required):
- 4.
5. 3480X: Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; modular bifurcated prosthesis (two docking limbs)

6. 34812-50: Open femoral artery exposure for delivery of aortic endovascular prosthesis, bilateral
7. 36200-50: Introduce catheter in aorta, bilateral (one catheter into aorta from each femoral artery)
8. 75952: Radiological S&I for endovascular AAA repair.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0001T

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

Specialty Vasc Surg How often? Commonly

Specialty Radiology/IR How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Vasc Surg Frequency 4500 Percentage 64.28 %

Specialty Radiology/IR Frequency 2500 Percentage 35.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
5,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Vasc Surg Frequency 3333 Percentage 66.66 %

Specialty Radiology/IR Frequency 1666 Percentage 33.32 %

Specialty Frequency Percentage %

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Long Descriptor: 34803 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis, (two docking limbs)

Sample Size: N/A Response Rate (%): N/A Global Period: 090

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

Standard RUC/PEAC times for 90-day global period pre-service in-facility activities and post-procedure office visits were applied. A crosswalk to code 34802 (Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)), which was approved by the RUC in April, 2000, was used to develop these recommendations. Physician representatives from ACR, SIR, and SVS reviewed and approved the recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Review test/exam results
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

Post-Service Clinical Labor Activities:

- Greet patient, escort to room
- Provide gowning
- Interval history & vital signs & chart
- Assemble previous test reports/results
- Assist physician during exam

Post-Service Clinical Labor Activities (continued):

- 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

Total Staff Time Out of Office: 135 minutes

Visits in Global Period: 1 X 99212; 1 X 99213

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 and Source (if applicable)
L037D	RN/LPN/MTA	60	12			2	63	

*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 2004. 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)
SA053	Post-op incision care package (staple)	1		
SA048	PEAC Multi-specialty Supply Pkg	2		

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

CMS's Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)
E11001	Exam table	

* From CMS'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: FACILITY

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 <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>5</u>	<u>RN/LPN/MTA</u> Other _____
Coordinate pre-surgery services/review test/exam results <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>20</u>	<u>RN/LPN/MTA</u> Other _____
Schedule space and equipment in facility <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>8</u>	<u>RN/LPN/MTA</u> Other _____
Office visit before surgery/procedure	_____	RN, LPN, MA, Other _____
Review test and exam results	_____	_____
Provide pre-service education/obtain consent <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>20</u>	<u>RN/LPN/MTA</u> Other _____
Follow-up phone calls & prescriptions <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>7</u>	<u>RN/LPN/MTA</u> Other _____
Other Activity (please specify)	_____	RN, LPN, MA, Other _____

End: When patient enters hospital for surgery/procedure

Service Period

Start. Patient admitted to hospital for surgery/procedure

Pre-service services

Review charts	_____	RN, LPN, MA, Other _____
Greet patient and provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	_____	RN, LPN, MA, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____

Intra-service

Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____
--	-------	--------------------------

Post-service

Monitor pt. following service/check tubes, monitors, drains	____ RN, LPN, MA, Other ____
Clean room/equipment by physician staff	____ RN, LPN, MA, Other ____
Assist with ICU or hospital visits	____ RN, LPN, MA, Other ____
Total Number of ICU visits	____
Total Number of hospital visits	____
Complete diagnostic forms, lab & X-ray requisitions	____ RN, LPN, MA, Other ____
Review/read X-ray, lab, and pathology reports	____ RN, LPN, MA, Other ____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	____ RN, LPN, MA, Other ____
Coordination of care by staff in office	____ RN, LPN, MA, Other ____
Other Activity (please specify)	____
_____	____ RN, LPN, MA, Other ____

End: Patient discharge from hospital

Post-Service Period

Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	____ RN, LPN, MA, 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	
	<u>RN/LPN/MTA</u> Other ____

OFFICE VISIT LEVEL

99212; standard 27 minutes per visit

99213; standard 36 minutes per visit

List total number of office visits

A 36

27

B 2

63

Total office visit time (A * B)

Conduct phone calls between office visits	____ RN, LPN, MA, Other ____
Other Activity (please specify)	____
_____	____ RN, LPN, MA, Other ____

End: With last office visit before end of global period

	A	B	C	D	E
1				34803	
2	Crosswalked from 34802 (Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb) -- Approved by RUC April 2000	CMS 2004 STAFF TYPE, MED SUPPLY, OR EQUIP CODE		Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs)	
3	LOCATION			NF	FAC
4	GLOBAL PERIOD			N/A	90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA		135
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		63
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7
17	End: When patient enters office/facility for				
18	SERVICE PERIOD				
19	Start: When patient enters office/facility for				
39	Discharge day management 99238 --12 minutes				12
41	End: Patient leaves office				
42	POST-SERVICE PERIOD				
43	Start: Patient leaves office/facility				
44	Conduct phone calls/call in prescriptions				
45	Office visits:				
46	List Number and Level of Office Visits				
47	99211 16 minutes		16		
48	99212 27 minutes X 1		27		27
49	99213 36 minutes x 1		36		36
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
53					
54	Total Office Visit Time	L037D	RN/LPN/MTA		63
55	Other Activity (please specify)				
56	End: with last office visit before end of global period				
57	MEDICAL SUPPLIES				
58	pack, minimum multi-specialty visit	SA048	pack		2
59	pack, post-op incision care (suture & staple)	SA053	pack		1
60	EQUIPMENT				
61	exam table	E11001			1

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2004

Endovenous Ablation Therapy

Current CPT codes describe the contemporary treatment of extremity venous reflux and varicose veins as surgical vein ligation and stripping, phlebectomy, and pharmacologic sclerotherapy. Newer techniques using either laser or radiofrequency devices under imaging guidance and monitoring are now being used. The CPT Editorial Panel created four new codes to describe these newer medical techniques.

The RUC reviewed the survey results for the new Endovenous Ablation Therapy family of codes and did not agree with the specialty society's survey results indicating a high work intensity of the intra-service time period. The procedures involve identifying and mapping the specific incompetent veins through ultrasound imaging, and carefully applying radiofrequency energy. The RUC believed the work intensity for the family more accurately reflected the work intensity of code 34501 *Valvuloplasty, femoral vein* (Work RVU = 15.98, August 2000, 2nd Five Year Review), and code 58560 *Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)* (Work RVU = 6.99; 000 day global). The RUC believed that because of the ultrasound guidance involved, the injections of anesthetic agents, and the risk of nerve injury, the intensity of work was comparable to these two codes.

The RUC then developed a building block approach based on the intra-service work per unit of time for this family of codes. The RUC believed intra-service work intensity of code 34501 was similar to 36475, 36476, and 36479 of approximately 0.075. The work intensity of 0.075 was then used within a building block approach for these codes using the specialty society's surveyed physician time. For Code 36478 a slightly higher intensity was used to account for the use of the laser, and the building block approach was applied. In addition, the RUC however recommended that for 36476 and 36479 the pre-service and post-service physician time components should be eliminated from the building block calculations, because specialty society's original CPT coding proposal did not account for the time. **The RUC recommends only the intra-service physician time reported on the specialty's survey results for ZZZ global codes 36476 and 36479**

The resulting building block approach indicated that the relative values of the family of codes were lower than the 25th percentile of the specialty society's surveyed values. The RUC was comfortable with the following building block approaches:

<u>Building Block Analysis</u>	36475		RUC Rec = 6.72
	Survey Data	RUC Std.	RVW
	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	50	0.0224	1.12
Pre-service scrub, dress, wait	15	0.0081	0.12
<u>Intra-service:</u>	60	0.075	4.50
Immediate Post	15	0.0224	0.34
Post-Service Discharge Day	.5	1.28	0.64

<u>Building Block Analysis</u>	36476		RUC Rec = 3.38
	Survey Data	RUC Std.	RVW
	Time	Intensity	(=time x intensity)
<u>Intra-service:</u>	45	0.075	3.38

<u>Building Block Analysis</u>	36478		RUC Rec = 6.72
	Survey Data	RUC Std.	RVW
	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	50	0.0224	1.12
Pre-service scrub, dress, wait	15	0.0081	0.12
<u>Intra-service:</u>	55	0.082	4.50
Immediate Post	15	0.0224	0.34
Post-Service Discharge Day	.5	1.28	0.64

<u>Building Block Analysis</u>	36479		RUC Rec = 3.38
	Survey Data	RUC Std.	RVW
	Time	Intensity	(=time x intensity)
<u>Intra-service:</u>	45	0.075	3.38

Practice Expense

The RUC reviewed the practice expense inputs for this new family of codes, and made reductions to the clinical labor staff type and time to reflect the typical service. Medical supplies and equipment were adjusted as well. The practice expense inputs recommended by the RUC in the facility and non-facility settings are attached.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●36475	K1	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	000	6.72
✚●36476	K2	second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) (Use 36476 in conjunction with 36475) (Do not report 36475, 36476 in conjunction with 36000–36005; 36478, 36479, 36410, 36425, 37204, 75894, 76000–76003, 76937, 76942, 93970–93971)	ZZZ	3.38
●36478	K3	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	000	6.72
✚●36479	K4	second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) (Use 36479 in conjunction with 36478) (Do not report 36478, 36479 in conjunction with 36000–36005;	ZZZ	3.38

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>36475, 36476, 36410, 36425, 37204, 75894, 76000–76003, 76937, 76942, 93970–93971)</u>		

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

CPT Code: 36475

Tracking No: K1 **Global:** 000

RUC Recommended RVW: ~~8.40~~ 6.72

Descriptor: Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated

(Do not report 36475, 36476 in conjunction with 36000–36005; 36478, 36479, 36410, 36425, 37204, 75894, 76000–76003, 76937, 76942, 93970–93971)

Vignette Used in Survey:

The patient is a 50 year old G2P2 female with painful, unilateral leg swelling that increases during the course of the day while at her job that requires that she is standing for a significant portion of the day. She has been diagnosed with great saphenous vein insufficiency with resultant superficial varicosities by way of history, physical examination, and non-invasive ultrasound testing all of which were performed during a previous outpatient office visit. At that time various treatment options were discussed and the patient has decided to undergo percutaneous endovenous radiofrequency ablation therapy of the insufficient saphenous vein. If it is necessary for endovenous ablation therapy to be coupled with stab phlebectomy and/or sclerotherapy these services are separately reportable using existing codes.

(Imaging guidance for endovenous ablation therapy is included in code 36475, however code 93970-93971 would be separately reportable if performed as an independent diagnostic study on the same date of service)

Percentage of Survey Respondents who found Vignette to be Typical: 91% of the respondents indicated vignette to be typical.

Clinical Description Of Service: (this information was not provided to survey respondents)

Pre-service Work:

The operating physician reviews the previously obtained diagnostic non-invasive imaging studies, history and physical exam, and lab tests. The procedure is reviewed with the patient, including a final discussion of alternatives and risks. Informed consent is obtained. The physician checks to ensure presence of sterile drapes, sterile ultrasound probe cover, gel, flush solutions, pressure bag and sterile IV set, local tumescent anesthetic, scalpel, access needle, dilator, vascular sheath, guide wires, sterile Radiofrequency ablation catheter, and other necessary supplies and equipment. Change into surgical scrubs and position patient such that target veins are accessible. Prep and drape patient.

Intra-service Work:

- Set up operating field
- Attach pressurized heparin saline drip to the sterile Radiofrequency ablation catheter.
- Test actuation, temperature, and impedance to ensure that all components are connected and operating properly.
- Use ultrasound guidance to find target greater saphenous vein (GSV) access site
- Use ultrasound guidance to map and mark entire length of target vein, noting vein depth and diameter
- Use ultrasound guidance to map vein tributaries
- Instill local anesthesia at access site.
- Incise skin over GSV access site.
- Perform venotomy
- Using Seldinger technique to introduce guide wire
- Advance dilator over guidewire
- Exchange dilator for sheath of appropriate size.
- Secure sheath in place by suture, remove guidewire and flush sheath.
- Place RF probe through the sheath and advance to the saphenofemoral junction using ultrasound guidance

- Locate tip of probe just below the superficial epigastric tributary vein
- Verify RF probe position by ultrasound
- Using ultrasound guidance, infiltrate tumescent anesthesia into the perivenous space to create a “halo” of fluid around the GSV from the entry site to the saphenofemoral junction
- With patient in Trendelenberg, verify target parameters are within acceptable range
- Reconfirm RF position with ultrasound imaging
- Apply RF energy
- Carefully withdraw probe, maintaining target vein wall temperature by varying pullback rate and/or applying compression over the limb
- Monitor impedance, power and vein wall temperature throughout procedure.
- Record total RF application time
- Repeat ultrasound of the saphenous to confirm successful ablation

Post-service Work:

- Elevate extremity and apply sterile dressings.
- Apply compression wrap or stocking starting at foot and ending at most proximal thigh
- Transfer patient to stretcher
- Ensure patient hemodynamic stability and comfort in Recovery area
- Write orders
- Dictate operative note
- Review results with patient’s family
- Communicate with referring physician
- Review results with patient after sedation wears off
- Evaluate after recovery interval for discharge suitability
- Provide discharge activity advice to patient/family
- Arrange for follow-up care as required

SURVEY DATA

Presenters:	Robert Vogelzang, M.D., Zachary Rattner, MD, Gary Seabrook, M.D., and Bibb Allen, M.D.				
Specialties:	Society for Interventional Radiology, Society for Vascular Surgery, American College of Radiology				
CPT Code:	36475				
Sample Size:	300	Resp n:	68	Resp %:	23%
Sample Type:	Random				
		Low	25th pctl	Median	75th pctl
Survey RVW:		5.00	7.32	8.20	12.00
Pre-Service Evaluation Time:				40	
Pre-Service Positioning Time:				10	
Pre-Service Scrub, Dress, Wait Time:				15	
Intra-Service Time:		25	45	60	90
Post-Service	Total Min*	CPT code / # of visits			
Immed. Post-time:	15				
Critical Care time/visit(s):					
Other Hospital time/visit(s):					
Discharge Day Mgmt:	18	99238 x 0.5			
Office time/visit(s):		None – 000-day global			

*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	'04 RVW (January 7, 2004 Federal Register)	Glob
35476	Transluminal balloon angioplasty, percutaneous; venous	6.03	000
35471	Transluminal balloon angioplasty, percutaneous; renal or visceral artery	10.05	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 36475	Ref CPT 35476	Svy CPT 36475	Ref CPT 35471
Pre-service	65	NO DATA	65	NO DATA
Intra-service	60		60	
Same Day Immediate Post-service	15		15	
Critical care				
Other hospital visit				
Discharge day management	18		18	
Office visit				
TOTAL TIME	158	145 (PR)	158	230 (PR)

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below	15	15	10	10
--	----	----	----	----

TIME SEGMENTS

Pre-service	2.67	2.57	3.60	2.67
Intra-service	3.07	2.79	3.80	3.78
Post-service	2.27	2.14	2.70	2.56

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.73	3.70	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	3.13	3.60	3.00
Urgency of medical decision making	1.80	2.33	2.20	2.78

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.60	3.27	4.00	3.78
Physical effort required	2.73	2.87	3.60	2.78

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.60	3.07	2.80	3.67
Outcome depends on the skill and judgment of physician	3.40	3.53	4.10	3.67
Estimated risk of malpractice suit with poor outcome	3.13	2.67	3.90	3.44

ADDITIONAL RATIONALE**Work Value Recommendation:****IWPUT Calculation:**

<u>36475</u>		RVW	
glob = 000		Rec RVW	6.72
	Svy Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	50	0.0224	1.12
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			1.24
<u>Post-service:</u>	Time	Intensity	(=time x intensity)
Immediate post	15	0.0224	0.34
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
Discharge 99238	0.5	1.28	0.64
Post-service total			0.98
	Time	IWPUT	INTRA-RVW
<u>Intra-service:</u>	60	0.075	4.5

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:

While this service *may* be reported with other services, we believe it is *not typically* reported with others. The procedures that may be reported simultaneously include the following. Multiple procedure payment reduction rules would apply:

- 36470 Injection of sclerosing solution; single vein, RVW 1.08
- 36471 Injection of sclerosing solution; multiple veins, same leg, RVW 1.56
- 37765 Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions, RVW 7.31
- 37766 Stab phlebectomy of varicose veins, one extremity; >20 stab incisions, RVW 9.25

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

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are 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?

37799 – Unlisted procedure, vascular surgery

76999 – Unlisted ultrasound procedure (e.g., diagnostic, interventional)

We are aware of one Medicare carrier instructing providers to report the imaging component of this procedure using code, 76986 – Ultrasound guidance, intraoperative

We have been informed that some commercial carriers instructed providers to use the following codes:

37204 – Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck

75894 – Transcatheter therapy, embolization, any method, radiological supervision and interpretation or

76940 – Ultrasound guidance for, and monitoring of, tissue ablation

Several Blue Shield carriers have instructed providers to use the following code:

S-2130 – Radiofrequency ablation of refluxing saphenous vein

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
Specialty: radiology	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:	20,000
Specialty: radiology	Frequency:	20,000

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	Frequency:	2,000
Specialty: radiology	Frequency:	2,000

Do many physicians perform this service across the United States? There are approximately 2,000 vascular surgeons and 4,000 interventional radiologists in the U.S, and we believe half of them perform this service. We suspect that approximately 3,000 physicians perform the service.

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

CPT Code: 36476

Tracking No: K2Global: ZZZ

RUC Recommended RVW: 5.17 3.38

Descriptor: Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

(Use 36476 in conjunction with 36475)

(Do not report 36475, 36476 in conjunction with 36000–36005; 36478, 36479, 36410, 36425, 37204, 75894, 76000–76003, 76937, 76942, 93970–93971)

Vignette Used in Survey:

(Imaging guidance for endovenous ablation therapy is included in code 36476, however code 93970-93971 would be separately reportable if performed as an independent diagnostic study on the same date of service)

The patient is a 50 year old G2P2 female with painful, unilateral leg swelling that increases during the course of the day while at her job that requires that she is standing for a significant portion of the day. She has been diagnosed with great and small saphenous vein insufficiency with resultant superficial varicosities by way of history, physical examination, and non-invasive ultrasound testing all of which were performed during a previous outpatient office visit. At that time various treatment options were discussed and the patient has decided to undergo percutaneous endovenous radiofrequency ablation therapy of the insufficient great and small saphenous veins. If it is necessary for endovenous ablation therapy to be coupled with stab phlebectomy and/or sclerotherapy these services are separately reportable using existing codes.

Percentage of Survey Respondents who found Vignette to be Typical: 98% of the respondents indicated vignette to be typical.

Clinical Description Of Service:

Additional Preoperative Work:

Additional pre-service work includes examining the extra veins to be ablated, review of additional pre-procedural imaging services, and extra time positioning the patient such that both the primary vein and the additional vein are accessible for treatment. This is important because the typical second vein is the lesser saphenous, which is located directly posterior on the calf. Operators must be able to reach this vein in addition to the primary target, the greater saphenous, which is located medially.

Additional Intra-operative Work:

- Retest actuation, temperature, and impedance to ensure that all components are connected and operating properly.
- Use ultrasound guidance to find target secondary vein access site
- Use ultrasound guidance to map and mark entire length of target vein, noting vein depth and diameter
- Use ultrasound guidance to map vein tributaries
- Instill local anesthesia at new access site.
- Incise skin over new access site.
- Perform venotomy
- Using Seldinger technique to introduce guide wire
- Advance dilator over guidewire
- Exchange dilator for sheath of appropriate size.
- Secure sheath in place by suture, remove guidewire and flush sheath.
- Place RF probe through the sheath and advance to target endpoint using ultrasound guidance

- Verify RF probe position by ultrasound
- Using ultrasound guidance, infiltrate tumescent anesthesia into the perivenous space to create a “halo” of fluid around the target vein from the entry site to the endpoint
- With patient in Trendelenberg, verify target parameters are within acceptable range
- Reconfirm RF position with ultrasound imaging
- Apply RF energy
- Carefully withdraw probe, maintaining target vein wall temperature by varying pullback rate and/or applying compression over the limb
- Monitor impedance, power and vein wall temperature throughout procedure.
- Record total RF application time
- Repeat ultrasound of the saphenous to confirm successful ablation

Additional Postoperative Work:

- Apply additional dressings

SURVEY DATA

Presenter(s):	Robert Vogelzang, M.D., Zachary Rattner, MD, Gary Seabrook, M.D., and Bibb Allen, M.D.				
Specialty(s):	Society for Interventional Radiology, Society for Vascular Surgery, American College of Radiology				
CPT Code:	36476				
Sample Size:	300	Resp n:	44	Resp %:	15%
Sample Type:	Random				
	Low	25th pctl	Median	75th pctl	High
Survey RVW:	1.00	6.01	7.75	11.25	30.00
Additional Pre-Service Time:			13		
Intra-Service Time:	15	30	45	65	120
Additional Post-Service Time:			10		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'04 RVW (January 7, 2004 Federal Register)	Glob
35476	Transluminal balloon angioplasty, percutaneous; venous	6.03	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 36476	Ref CPT 35476
Pre-service	13	NO DATA
Intra-service	45	
Same Day Immediate Post-service	10	
Critical care		
Other hospital visit		
Discharge day management		
Office visit		
TOTAL TIME	45	145 (PR)

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below	10	10
--	----	----

TIME SEGMENTS

Pre-service	2.80	2.60
Intra-service	3.40	3.00
Post-service	2.20	2.40

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.20	2.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	3.00
Urgency of medical decision making	2.10	2.60

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.40	3.30
Physical effort required	3.10	3.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.60	3.00
Outcome depends on the skill and judgment of physician	3.20	3.00
Estimated risk of malpractice suit with poor outcome	3.20	2.50

ADDITIONAL RATIONALE

<u>36476</u>			RVW
glob = ZZZ		Rec RVW	3.38
	Svy Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	0	0.0224	0
Pre-service scrub, dress, wait	0	0.0081	0
Pre-service total			
<u>Post-service:</u>	Time	Intensity	(=time x intensity)
Immediate post	0	0.0224	0
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
Discharge 99238	0	1.28	0

Post-service total	0		
	Time	IWPUT	INTRA-RVW
Intra-service:	45	0.075	3.38

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.)

- ☐ **XX** The surveyed code is an add-on code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are 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	Pre time	Intra-time	Post-time
36475	0	65	60	33
36476	ZZZ		45	
Total		65	105	33

FREQUENCY INFORMATION

How was this service previously reported? 37799

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
Specialty: radiology	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: 1,000
Specialty: radiology	Frequency: 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

Frequency: 500

Specialty: radiology

Frequency: 500

Do many physicians perform this service across the United States? Estimate 2,000 physicians perform this service

PCL XL error

Warning: UndefinedFontNotRemoved - MS PCLXLFont 015

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

CPT Code: 36478 **Tracking No:** K3Global: 000 **RUC Recommended RVW:** 8.40 6.72

Descriptor: Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated

(Do not report 36478, 36479 in conjunction with 36000–36005; 36475, 36476, 36410, 36425, 37204, 75894, 76000–76003, 76937, 76942, 93970–93971)

Vignette Used in Survey:

The patient is a 50 year old G2P2 female with painful, unilateral leg swelling that increases during the course of the day while at her job that requires that she is standing for a significant portion of the day. She has been diagnosed with great saphenous vein insufficiency with resultant superficial varicosities by way of history, physical examination, and non-invasive ultrasound testing all of which were performed during a previous outpatient office visit. At that time various treatment options were discussed and the patient has decided to undergo percutaneous endovenous laser ablation therapy of the insufficient saphenous vein. If it is necessary for endovenous ablation therapy to be coupled with stab phlebectomy and/or sclerotherapy these services are separately reportable using existing codes.

(Imaging guidance for endovenous ablation therapy is included in code 36478, however code 93970-93971 would be separately reportable if performed as an independent diagnostic study on the same date of service)

Percentage of Survey Respondents who found Vignette to be Typical: 91% of the respondents indicated vignette to be typical.

Clinical Description Of Service: (this information was not provided to survey respondents)

Pre-service Work:

The operating physician reviews the previously obtained diagnostic non-invasive imaging studies, history and physical exam, and lab tests. The procedure is reviewed with the patient, including a final discussion of alternatives and risks. Informed consent is obtained. The physician checks to ensure presence of sterile drapes, sterile ultrasound probe cover, gel, flush solutions, pressure bag and sterile IV set, local tumescent anesthetic, scalpel, access needle, dilator, vascular sheath, guide wires, laser fiber, safety goggles for all present during the procedure and any other necessary supplies and equipment. Change into surgical scrubs and position patient such that target veins are accessible. Prep, drape and place safety goggles on patient.

Intra-service Work:

- Set up operating field
- Attach pressurized heparin saline drip to the sterile laser ablation catheter.
- Test actuation, temperature, and impedance to ensure that all components are connected and operating properly.
- Use ultrasound guidance to find target greater saphenous vein (GSV) access site
- Use ultrasound guidance to map and mark entire length of target vein, noting vein depth and diameter
- Use ultrasound guidance to map vein tributaries
- Instill local anesthesia at access site.
- Incise skin over GSV access site.
- Perform venotomy
- Using Seldinger technique to introduce guide wire
- Advance dilator over guidewire
- Exchange dilator for sheath of appropriate size.
- Secure sheath in place by suture, remove guidewire and flush sheath.
- Place laser fiber through the sheath and advance to the saphenofemoral junction using ultrasound guidance

- Locate tip of fiber just below the superficial epigastric tributary vein
- Verify fiber position by ultrasound
- Using ultrasound guidance, infiltrate tumescent anesthesia into the perivenous space to create a “halo” of fluid around the GSV from the entry site to the saphenofemoral junction
- With patient in Trendelenberg, verify target parameters are within acceptable range
- Reconfirm laser fiber position with ultrasound imaging
- Apply laser energy
- Carefully withdraw laser fiber, maintaining target vein wall temperature by varying pullback rate and/or applying compression over the limb
- Monitor impedance, power and vein wall temperature throughout procedure.
- Record total laser application time
- Repeat ultrasound of the saphenous to confirm successful ablation
-

Post-service Work:

- Elevate extremity and apply sterile dressings.
- Apply compression wrap or stocking starting at foot and ending at most proximal thigh
- Transfer patient to stretcher
- Ensure patient hemodynamic stability and comfort in Recovery area
- Write orders
- Dictate operative note
- Review results with patient’s family
- Communicate with referring physician
- Review results with patient after sedation wears off
- Evaluate after recovery interval for discharge suitability
- Provide discharge activity advice to patient/family
- Arrange for follow-up care as required

SURVEY DATA

Presenters:	Robert Vogelzang, M.D., Zachary Rattner, MD, Gary Seabrook, M.D., and Bibb Allen, M.D.				
Specialties:	Society for Interventional Radiology, Society for Vascular Surgery, American College of Radiology				
CPT Code:	36478				
Sample Size:	300	Resp n:	34	Resp %:	11.33%
Sample Type:	Random				
		Low	25th pctl	Median	75th pctl
Survey RVW:		5.00	7.50	8.60	10.73
Pre-Service Evaluation Time:				40	
Pre-Service Positioning Time:				10	
Pre-Service Scrub, Dress, Wait Time:				15	
Intra-Service Time:		20	39	55	60
Post-Service	Total Min*	CPT code / # of visits			
Immed. Post-time:	15				
Critical Care time/visit(s):					
Other Hospital time/visit(s):					
Discharge Day Mgmt:	18	99238 x 0.5			
Office time/visit(s):		None – 000-day global			

*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	'04 RVW (January 7, 2004 Federal Register)	Glob
35476	Transluminal balloon angioplasty, percutaneous; venous	6.03	000
35471	Transluminal balloon angioplasty, percutaneous; renal or visceral artery	10.05	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 36478	Ref CPT 35476	Svy CPT 36478	Ref CPT 35471
Pre-service	65	NO DATA	65	NO DATA
Intra-service	55		55	
Same Day Immediate Post-service	15		15	
Critical care				
Other hospital visit				
Discharge day management	18		18	
Office visit				
TOTAL TIME	153	145 (PR)	153	230 (PR)

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below		8		7
--	--	---	--	---

TIME SEGMENTS

Pre-service	4.00	2.20	2.60	3.00
Intra-service	4.00	2.80	3.40	3.60
Post-service	2.80	2.20	2.40	3.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.60	2.40	3.20	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	2.80	3.20	3.20
Urgency of medical decision making	2.00	2.20	1.60	3.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.00	3.00	3.60	4.00
Physical effort required	3.40	2.60	2.80	2.80

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.60	3.00	3.00	3.80
Outcome depends on the skill and judgment of physician	4.40	2.80	3.40	3.80
Estimated risk of malpractice suit with poor outcome	4.00	2.20	2.80	3.60

ADDITIONAL RATIONALE

Work Value Recommendation:**IWPUT Calculation:**

<u>36478</u>		RVW	
glob = 000		Rec RVW	6.72
	Svy Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	50	0.0224	1.12
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			1.24
<u>Post-service:</u>	Time	Intensity	(=time x intensity)
Immediate post	15	0.0224	0.34
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
Discharge 99238	0.5	1.28	0.64
Post-service total			0.98
	Time	IWPUT	INTRA-RVW
<u>Intra-service:</u>	60	0.075	4.5

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:

While this service *may* be reported with other services, we believe it is *not typically* reported with others. The procedures that may be reported simultaneously include the following. Multiple procedure payment reduction rules would apply:

- 36470 Injection of sclerosing solution; single vein, RVW 1.08
- 36471 Injection of sclerosing solution; multiple veins, same leg, RVW 1.56
- 37765 Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions, RVW 7.31
- 37766 Stab phlebectomy of varicose veins, one extremity; >20 stab incisions, RVW 9.25

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

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are 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?**

37799 – Unlisted procedure, vascular surgery

76999 – Unlisted ultrasound procedure (e.g., diagnostic, interventional)

We are aware of one Medicare carrier instructing providers to report the imaging component of this procedure using code, 76986 – Ultrasound guidance, intraoperative

Per providers, some commercial carriers instructed providers to use the following codes:

37204 – Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck

75894 – Transcatheter therapy, embolization, any method, radiological supervision and interpretation or

76940 – Ultrasound guidance for, and monitoring of, tissue ablation

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

Specialty: radiology

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: 20,000

Specialty: radiology

Frequency: 20,000

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

Frequency: 2,000

Specialty: radiology

Frequency: 2,000

Do many physicians perform this service across the United States? There are approximately 2,000 vascular surgeons and 4,000 interventional radiologists in the U.S, and we believe half of them perform this service. We suspect that approximately 3,000 physicians perform the service.

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

CPT Code: 36479

Tracking No: K42Global: ZZZ

RUC Recommended RVW: 5.17 3.38

Descriptor: Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

(Use 36479 in conjunction with 36478)

(Do not report 36478, 36479 in conjunction with 36000–36005; 36478, 36479, 36410, 36425, 37204, 75894, 76000–76003, 76937, 76942, 93970–93971)

Vignette Used in Survey:

(Imaging guidance for endovenous ablation therapy is included in code 36479, however code 93970-93971 would be separately reportable if performed as an independent diagnostic study on the same date of service)

The patient is a 50 year old G2P2 female with painful, unilateral leg swelling that increases during the course of the day while at her job that requires that she is standing for a significant portion of the day. She has been diagnosed with great and small saphenous vein insufficiency with resultant superficial varicosities by way of history, physical examination, and non-invasive ultrasound testing all of which were performed during a previous outpatient office visit. At that time various treatment options were discussed and the patient has decided to undergo percutaneous endovenous laser ablation therapy of the insufficient great and small saphenous veins. If it is necessary for endovenous ablation therapy to be coupled with stab phlebectomy and/or sclerotherapy these services are separately reportable using existing codes.

Percentage of Survey Respondents who found Vignette to be Typical: 98% of the respondents indicated vignette to be typical.

Clinical Description Of Service:

Additional Preoperative Work:

Additional pre-service work includes examining the extra veins to be ablated, review of additional pre-procedural imaging services, and extra time positioning the patient such that both the primary vein and the additional vein are accessible for treatment. This is important because the typical second vein is the lesser saphenous, which is located directly posterior on the calf. Operators must be able to reach this vein in addition to the primary target, the greater saphenous, which is located medially.

Additional Intra-operative Work:

- Use ultrasound guidance to find target secondary vein access site
- Use ultrasound guidance to map and mark entire length of target vein, noting vein depth and diameter
- Use ultrasound guidance to map vein tributaries
- Instill local anesthesia at new access site.
- Incise skin over new access site.
- Perform venotomy
- Using Seldinger technique to introduce guide wire
- Advance dilator over guidewire
- Exchange dilator for sheath of appropriate size.
- Secure sheath in place by suture, remove guidewire and flush sheath.
- Place laser fiber through the sheath and advance to target endpoint using ultrasound guidance
- Verify laser fiber position by ultrasound
- Using ultrasound guidance, infiltrate tumescent anesthesia into the perivenous space to create a “halo” of fluid around the target vein from the entry site to the endpoint

- With patient in Trendelenberg, verify target parameters are within acceptable range
- Reconfirm laser fiber position with ultrasound imaging
- Apply laser energy
- Carefully withdraw laser fiber, maintaining target vein wall temperature by varying pullback rate and/or applying compression over the limb
- Monitor impedance, power and vein wall temperature throughout procedure.
- Record total laser application time
- Repeat ultrasound of the saphenous to confirm successful ablation

Additional Postoperative Work:

- Apply additional dressings

SURVEY DATA

Presenter(s):	Robert Vogelzang, M.D., Gary Seabrook, M.D., and Bibb Allen, M.D.				
Specialty(s):	Society for Interventional Radiology, Society for Vascular Surgery, American College of Radiology				
CPT Code:	36479				
Sample Size:	300	Resp n:	33	Resp %:	11%
Sample Type:	Random				
	Low	25th pctl	Median	75th pctl	High
Survey RVW:	1.00	6.50	8.20	12.00	25.00
Additional Pre-Service Time:			15		
Intra-Service Time:	15	30	45	60	120
Additional Post-Service Time:			10		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'04 RVW (January 7, 2004 Federal Register)	Glob
35476	Transluminal balloon angioplasty, percutaneous; venous	6.03	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 36479	Ref CPT 35476
Pre-service		NO DATA
Intra-service	45	
Same Day Immediate Post-service		
Critical care		
Other hospital visit		
Discharge day management		
Office visit		
TOTAL TIME	45	145 (PR)

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below	10	10
--	----	----

TIME SEGMENTS

Pre-service	2.80	2.40
Intra-service	3.40	2.60
Post-service	2.40	2.20

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.20	2.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	2.80
Urgency of medical decision making	1.20	1.80
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.80	3.20
Physical effort required	3.00	2.80
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	2.80	3.00
Outcome depends on the skill and judgment of physician	3.40	2.80
Estimated risk of malpractice suit with poor outcome	2.60	2.20

ADDITIONAL RATIONALE

36479		RVW	
glob = ZZZ		Rec RVW	3.38
Svy Data	RUC Std.	RVW	
Time	Intensity	(=time x intensity)	
Pre-service:			
Pre-service eval & positioning	0	0.0224	0
Pre-service scrub, dress, wait	0	0.0081	0
Pre-service total			
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	0	0.0224	0
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
Discharge 99238	0	1.28	0
Post-service total			0
Intra-service:	Time	IWPUT	INTRA-RVW
	45	0.075	3.38

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.)

- ☒ **XX** The surveyed code is an add-on code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are 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	Pre time	Intra-time	Post-time
36478	0	65	55	28
36479	ZZZ		45	
Total		65	95	28

FREQUENCY INFORMATION

How was this service previously reported? 37799

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
Specialty: radiology	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: 1,000
Specialty: radiology	Frequency: 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	Frequency: 500
Specialty: radiology	Frequency: 500

Do many physicians perform this service across the United States? Estimate 2,000 physicians perform this service

	A	B	C	D	E	F	G
1		staff, supply, equip		36475		36476	
2		CODE	DESC	Endovenous ablation therapy of incompetent		Endovenous ablation therapy of incompetent	
3	LOCATION			Non Fac	Facility	Non Fac	Facility
4	GLOBAL PERIOD			000	000	ZZZ	n/a
5	TOTAL TIME - RN/LPN/MTA	L037D	RN/LPN/	36	18	0	0
6	TOTAL TIME - RN/LPN	L042A	RN/LP	64	0	45	0
7	TOTAL TIME - Vascular Technologist/Ultrasound	L054A	Vascular	52	0	32	0
8	PRE-service time - RN/LPN/MTA	L037D	RN/LPN/	12	15	0	0
9	SERVICE time -- RN/LP/MTA	L037D	RN/LPN/	21	0	0	0
10	SERVICE time - RN/LP	L042A	RN/LP	64	0	45	0
11	SERVICE time - Vascular Technologist/Ultrasound	L054A	Vascular	52	0	32	0
12	POST-service time	L037D	RN/LPN/	3	3	0	0
13	PRE-SERVICE - BEFORE ADMISSION						
14	Start: Following decision for surgery visit						
15	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	2	2		
16	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5		
17	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5		
18	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	4			
19	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3		
20	Other Clinical Activity:	L037D	RN/LPN/MTA				
21	End: When pt enters site for service						
22	SERVICE PERIOD - ADMISSION TO DISCHARGE						
23	Start: When pt enters site for procedure						
24	Pre-service services						
25	Review charts	L037D	RN/LPN/MTA	2			
26	Greet patient and provide gowning	L037D	RN/LPN/MTA	3			
27	Obtain vital signs	L037D	RN/LPN/MTA	5			
28	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
29	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2			
30	Setup scope (non facility setting only)Technologist setting up ultrasound equip	L054A	Vascular Technolo	2			
31	Prepare and position pt/ monitor pt/ set up IV	L042A	RN/LPN	2			
32	Sedate/apply anesthesia	L042A	RN/LPN	2			
33	Intra-service						
34	Assist physician in performing procedure	L042A	RN/LPN	60		45	
35	Assist MD / Acquire images	L054A	Vascular Technologist/	45		30	
36	Post-Service						
37	Monitor pt. - check tubes, monitors, drains	L037D	RN/LPN/MTA	3			
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3			
39	Clean Scope						
40	Clean Surgical Instrument Package	L054A	Vascular				
41	Complete diag forms, lab & X-ray requisitions						
42	Review/read X-ray, lab, and pathology reports						
43	Check dressings & wound/home care instructions	L037D	RN/LPN/MTA	3			
44	Coordinate office visits/Prescriptions						
44	Dischg day mgmt outpt=6" 99238=12" 99239=15"	L037D	RN/LPN/MTA				
45	Other Clinical Activity: Process images, complete data sheet, present images and data to the interpreting physician	L054A	Vascular Technologist/Ultras	5		2	
46	End: Patient leaves office/facility						
47	POST-SERVICE Period - AFTER DISCHARGE						
48	Start: Patient leaves office/facility						
49	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3		
50	Office Visits						
51	List Number and Level of Office Visits						
52	99211 16 minutes		16				
53	99212 27 minutes		27				
54	99213 36 minutes		36				
55	99214 53 minutes		53				
56	99215 63 minutes		63				
57	Other:						
58	Total Office Visit Time	L037D	RN/LPN/MTA				
59	Other Activity (please specify)						
60	End: last office visit - end of global period						

	A	B	C	D	E	F	G
1		staff, supply, equip		36475		36476	
2		CODE	DESC	Endovenous ablation therapy of incompetent		Endovenous ablation therapy of incompetent	
3	LOCATION			Non Fac	Facility	Non Fac	Facility
61	MEDICAL SUPPLIES						
62	Procedure-related supply items:						
63	pack, minimum multi-specialty visit	SA048	pack	1			
64	ultrasound transmission gel	SJ062	ml	60		60	
65	transducer sheath, sterile, 96in x 6in	new	item	1			
66	skin marking pen, sterile (Skin Sknbe)	SK075	item	1			
67	surgical mask, with face shield	SB034	item	3			
68	gown, staff, impervious	SB027	item	3			
69	cap, surgical	SB001	item	3			
70	shoe covers, surgical	SB039	pair	3			
71	gloves, sterile	SB024	pair	2			
72	drape, sterile, femoral	SB009	item	1		1	
73	drape, sterile barrier 16in x 29in	SB007	item	1			
74	drape-towel, sterile 18inx26in	SB019	item	4		4	
75	basin, emesis	SJ010	item	1			
76	povidone surgical scrub (Betadine)	SJ042	ml	100		100	
77	tray, catheter insertion	SA063	tray	1			
78	swab-pad, alcohol	SJ053	item	2			
79	lidocaine 2% w-epi inj (Xylocaine w-epi)	SH049	ml	60			
80	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	1			
81	syringe 20ml	SC053	item	1			
82	syringe 30 ml	SC054	item	1			
83	syringe 3ml	SC055	item	1			
84	needle, butterfly 20-25g	SC030	item	1			
85	needle, spinal 18-26g	SC028	item	1		1	
86	hydrogen peroxide	SJ028	ml	100		100	
87	syringe, pressure 200ml	SC060	item	1		1	
88	scalpel with blade, surgical (#10-20)	SF033	item	1			
89	vascular sheath	SD136	item	1		1	
90	dilator, vessel, angiographic	SD043	item	1			
91	guidewire, hydrophilic (GlideWire)	SD089	item	1		0	
92	catheter, RF ablation	NEW	item	1		0	
93	kit, RF introducer	SA026	kit	1			
	kit, endovascular laser (includes: 600µm fiber; 5Fx45cm Introducer Set; 0.035" guidewire; micro-access set: 21g needle; 0.018 guidewire; sheath/dilator)	NEW	kit				
94	suture, nylon, 4-0 to 6-0, p, ps	SF037	item	1		1	
96	sodium bicarbonate 8.4% inj w-needle (1ml uou)	New	item	2		2	
97	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1	
98	stop cock, 3-way	SC049	item	1			
99	tubing, pressure	SD131	item	1			
100	basin, irrigation	SJ009	item	1			
101	bag, pressure infusor	NEW	item	1			
102	bandage, strip 0.75in x 3in	SG021	item	1		1	
103	steri-strips	SG074	item	1		1	
104	tape, porous-hypoallergenic 2in (Scanpore)	SG077	inch	12		12	
105	sanitizing cloth-wipe (patient)	SM021	item	1		1	
106	biohazard bag	SM004	item	0			
107	stockings, knee length, 20-30mm compression	NEW	pair	1			
108	x-ray envelope	SK091	item	0			
109	video tape, VHS	SK086	item	1			
110	IV supplies (Pending confirmation with CMS staff)			1			
111	paper, photo printing (8.5 x 11)	SK058	item	10		10	
112	Equipment						
113	stretcher chair (Pre/Post, only) <i>Standard stretcher chair -- 1 hour recovery</i>	NEW		X		0	
114	ultrasound room, general	NEW		X		X	
115	SVHS video recorder	E52012		X		X	
116	Sony Color Video Printer	E52010		X		X	
117	radiofrequency generator (vascular)	NEW		X		X	
118	laser, endovascular ablation (ELVS)	NEW					

	A	B	C	H	I	J	K
1		staff, supply, equip		36478		36479	
2		CODE	DESC	Endovenous ablation therapy of incompetent		Endovenous ablation therapy of incompetent	
3	LOCATION			Non Fac	Facility	Non Fac	Facility
4	GLOBAL PERIOD			000	000	ZZZ	n/a
5	TOTAL TIME - RN/LPN/MTA	L037D	RN/LPN/	36	18	0	0
6	TOTAL TIME - RN/LPN	L042A	RN/LP	59	0	45	0
7	TOTAL TIME - Vascular Technologist/Ultrasound	L054A	Vascular	44	0	32	0
8	PRE-service time - RN/LPN/MTA	L037D	RN/LPN/	12	15	0	0
9	SERVICE time -- RN/LP/MTA	L037D	RN/LPN/	21	0	0	0
10	SERVICE time - RN/LP	L042A	RN/LP	59	0	45	0
11	SERVICE time - Vascular Technologist/Ultrasound	L054A	Vascular	44	0	32	0
12	POST-service time	L037D	RN/LPN/	3	3	0	0
13	PRE-SERVICE - BEFORE ADMISSION						
14	Start: Following decision for surgery visit						
15	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	2	2		
16	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5		
17	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5		
18	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	4			
19	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3		
20	Other Clinical Activity:	L037D	RN/LPN/MTA				
21	End: When pt enters site for service						
22	SERVICE PERIOD - ADMISSION TO DISCHARGE						
23	Start: When pt enters site for procedure						
24	Pre-service services						
25	Review charts	L037D	RN/LPN/MTA	2			
26	Greet patient and provide gowning	L037D	RN/LPN/MTA	3			
27	Obtain vital signs	L037D	RN/LPN/MTA	5			
28	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
29	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2			
30	Setup scope (non facility setting only)Technologist setting up ultrasound equip	L054A	Vascular Technologist	2			
31	Prepare and position pt/ monitor pt/ set up IV	L042A	RN/LPN	2			
32	Sedate/apply anesthesia	L042A	RN/LPN	2			
33	Intra-service						
34	Assist physician in performing procedure	L042A	RN/LPN	55		45	
35	Assist MD / Acquire images	L054A	Vascular Technologist	37		30	
36	Post-Service						
37	Monitor pt. - check tubes, monitors, drains	L037D	RN/LPN/MTA	3			
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3			
39	Clean Scope						
40	Clean Surgical Instrument Package	L054A	Vascular				
41	Complete diag forms, lab & X-ray requisitions						
42	Review/read X-ray, lab, and pathology reports						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA	3			
44	Coordinate office visits /prescriptions						
45	Dischg day mgmt outpt=6" 99238=12" 99239=15"	L037D	RN/LPN/MTA				
46	Other Clinical Activity: Process images, complete data sheet, present images and data to the interpreting physician	L054A	Vascular Technologist/Ultrasound	5		2	
47	End: Patient leaves office/facility						
48	POST-SERVICE Period - AFTER DISCHARGE						
49	Start: Patient leaves office/facility						
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3		
51	Office Visits						
52	List Number and Level of Office Visits						
53	99211 16 minutes		16				
54	99212 27 minutes		27				
55	99213 36 minutes		36				
56	99214 53 minutes		53				
57	99215 63 minutes		63				
58	Other:						
59	Total Office Visit Time	L037D	RN/LPN/MTA				
60	Other Activity (please specify)						
61	End: last office visit - end of global period						

	A	B	C	H	I	J	K
1		staff, supply, equip		36478		36479	
2		CODE	DESC	Endovenous ablation therapy of incompetent		Endovenous ablation therapy of incompetent	
3	LOCATION			Non Fac	Facility	Non Fac	Facility
61	MEDICAL SUPPLIES						
62	Procedure-related supply items:						
63	pack, minimum multi-specialty visit	SA048	pack	1			
64	ultrasound transmission gel	SJ062	ml	60		60	
65	transducer sheath, sterile, 96in x 6in	new	item	1			
66	skin marking pen, sterile (Skin Scribe)	SK075	item	1			
67	surgical mask, with face shield	SB034	item	3			
68	gown, staff, impervious	SB027	item	3			
69	cap, surgical	SB001	item	3			
70	shoe covers, surgical	SB039	pair	3			
71	gloves, sterile	SB024	pair	2			
72	drape, sterile, femoral	SB009	item	1		1	
73	drape, sterile barrier 16in x 29in	SB007	item				
74	drape-towel, sterile 18inx26in	SB019	item	4		4	
75	basin, emesis	SJ010	item	1			
76	povidone surgical scrub (Betadine)	SJ042	ml	100		100	
77	tray, catheter insertion	SA063	tray	1			
78	swab-pad, alcohol	SJ053	item	2			
79	lidocaine 2% w-epi inj (Xylocaine w-epi)	SH049	ml	60			
80	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	1			
81	syringe 20ml	SC053	item	1			
82	syringe 30 ml	SC054	item	1			
83	syringe 3ml	SC055	item	1			
84	needle, butterfly 20-25g	SC030	item	1			
85	needle, spinal 18-26g	SC028	item	1		1	
86	hydrogen peroxide	SJ028	ml	100		100	
87	syringe, pressure 200ml	SC060	item	1		1	
88	scalpel with blade, surgical (#10-20)	SF033	item	1			
89	vascular sheath	SD136	item	1		1	
90	dilator, vessel, angiographic	SD043	item	1			
91	guidewire, hydrophilic (GlideWire)	SD089	item	1		0	
92	catheter, RF ablation	NEW	item				
93	kit, RF introducer	SA026	kit				
94	kit, endovascular laser (includes: 600µm fiber; 5Fx45cm Introducer Set; 0.035" guidewire; micro-access set: 21g needle; 0.018 guidewire; sheath/dilator)	NEW	kit	1		0	
95	suture, nylon, 4-0 to 6-0, p, ps	SF037	item	1		1	
96	sodium bicarbonate 8.4% inj w-needle (1ml uou)	New	item	2		2	
97	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1	
98	stop cock, 3-way	SC049	item	1			
99	tubing, pressure	SD131	item	1			
100	basin, irrigation	SJ009	item	1			
101	bag, pressure infusor	NEW	item				
102	bandage, strip 0.75in x 3in	SG021	item	1		1	
103	steri-strips	SG074	item	1		1	
104	tape, porous-hypoallergenic 2in (Scanpore)	SG077	inch	12		12	
105	sanitizing cloth-wipe (patient)	SM021	item	1		1	
106	biohazard bag	SM004	item	0			
107	stockings, knee length, 20-30mm compression	NEW	pair	1			
108	x-ray envelope	SK091	item	0			
109	video tape, VHS	SK086	item	1			
110	IV supplies (Pending confirmation with CMS staff)			1			
111	paper, photo printing (8.5 x 11)	SK058	item	10		10	
112	Equipment						
113	stretcher chair (Pre/Post, only) Standard stretcher chair – 1 hour recovery	NEW		X		0	
114	ultrasound room, general	NEW		X		X	
115	SVHS video recorder	E52012		X		X	
116	Sony Color Video Printer	E52010		X		X	
117	radiofrequency generator (vascular)	NEW					
118	laser, endovascular ablation (ELVS)	NEW		X		X	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Upper Arm Cephalic Vein Transposition

The CPT Editorial Panel created a code 36818 *Arteriovenous anastomosis, open; by upper arm cephalic vein transposition* to report a new method of arteriovenous anastomosis for hemodialysis patients. This new procedure is a cephalic vein transposition that requires two upper arm incisions, one medial over the brachial artery, the other lateral to expose the vein.

The RUC reviewed survey data from 30 vascular surgeons and the presenters explained that the reference code selected by the survey respondents, 36819 *Arteriovenous anastomosis, open; by upper arm basilic vein transposition* (work RVU= 13.98) may have contributed to an overestimation of the work involved in this procedure because the reference code has 30 minutes more of intra-service work and the survey respondents rated it with a higher intensity than the new code, but the median survey value was the same as the reference service. The presenters stated that this value overstated the value of the new code given the differences in time and intensity and the median survey value was not used in developing the RUC recommendation. Instead the code was valued by comparing it to other codes in the family as well as by examining the intra-service intensity of the intra-service work. The presenters used a building block analysis that is explained as follows:

The major driver of this code is the intra-service work. Respondents rated intensity and complexity of intra-service work as essentially equal to that of reference code CPT 36819 *Arteriovenous anastomosis, open; by upper arm basilic vein transposition* (work RVU= 13.98) Intra-service time of the new code is 90-minutes compared to 120-minutes for the reference service. According to building block analysis, intra-service work of the reference code is 10.08 RVUs. Based on a linear relationship, the intra-service work of the new code should be $90/120 \times 10.08 = 7.56$ RVUs.

Pre-service work of the new code is 70-minutes compared to 25 minutes for the reference code. In both services 15-minutes may be assumed for scrub, prep, wait, since all of that work is essentially same for similar services. This leaves 55-minutes of the new code for pre-op evaluation, compared to 10-minutes for the reference code. The presenters stated that the difference is primarily due to new JCAHO requirements for performing history and physical update. According to building block analysis, the pre-service work of the reference code 36819 is 0.56 RVUs. In order to determine the pre-service work of the new code, 55 incremental minutes $\times 0.0224$ RVUs per minute (=1.23 RVUs) should be added to the pre-service work of reference code, or pre-service work = 1.79.

Next, the post-service work of the new code can be built from reference code 36819 by subtracting the work of the hospital visits since the office visits are exactly the same. Total post-service work of the reference service is 3.34 RVUs. To obtain total post service work the work associated with one in-patient visit and 1/2 a discharge day should be subtracted. However, the new code has 15 additional minutes of immediate post-service work that should be added back at an intensity of .0224. The post-service calculation is as follows:
 3.34 (total post service for 36819) minus 1×99231 minus 0.5×99238 plus $15 \times 0.0224 = 2.40$ RVUs

3.34
-.64 99231 visit
-.64 half of 99238
+.34 15 minutes x .0224
2.40 post service work

The RVW for new service, built from clinically close reference service, is the sum of intra-service (7.56), plus pre-service (1.79), plus post-service (2.40) = 11.75.

The RUC agreed with the above analysis but disagreed with the pre-service time used to calculate the recommended RVU. The RUC specifically recommends changing the pre-service evaluation time from 45 minutes to 35 minutes. Therefore the total RVU should reflect the reduction of 10 minutes of pre-service time or (10 minutes X .022=.22 RVUs). This results in a final work RVU of (11.75-.22) 11.52. The RUC then compared this value of 11.52 with intra time of 90 minutes to other codes in the family and felt it was in proper rank order with codes 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU=8.92, intra time of 75 minutes), and code 36819 *Arteriovenous anastomosis, open; by upper arm basilic vein transposition* (work RVU = 13.98, intra time of 120 minutes) **The RUC recommends a work relative value of 11.52 for code 36818.**

Practice Expense

The standard inputs for 90 day global period codes only performed in the facility were applied.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 36818	AA1	Arteriovenous anastomosis, open; by upper arm cephalic vein transposition <u>(Do not report 36818 in conjunction with 36819, 36820, 36821, 36830 during a unilateral upper extremity procedure. For bilateral upper extremity open arteriovenous anastomoses performed at the same operative session, append modifier 50 or 59 as appropriate)</u>	090	11.52
▲ 36819		Arteriovenous anastomosis, open; by upper arm basilic vein transposition <u>(Do not report 36819 in conjunction with 36818, 36820-36821, 36830 during a unilateral upper extremity procedure. For bilateral upper extremity open arteriovenous anastomoses performed at the same operative session, append modifier 50 or 59 as appropriate)</u>	090	13.98 (No Change)
36820		<i>by forearm vein transposition</i>	090	13.98 (No Change)
36821		<i>direct, any site (eg, Cimino type) (separate procedure)</i> <u>(Do not report 36819 in conjunction with 36818, 36820-36821, 36830 during a single upper extremity procedure. For bilateral upper extremity open arteriovenous anastomoses performed at the same operative session, append modifier 50 or 59 as appropriate)</u>	090	8.92 (No Change)

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

Recommended Work Relative Value

CPT Code:36818 Tracking Number: AA1 Global Period: 090 Specialty Society RVU: **11.72** RUC RVU: **11.52**

CPT Descriptor: Arteriovenous anastomosis, open; by upper arm cephalic vein transposition

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38-year-old obese diabetic female requires hemodialysis for chronic renal failure. On physical exam she has no visible superficial veins on either side at the wrist, forearm, antecubital fossa or upper arm. Duplex ultrasound identifies a normal diameter cephalic vein 1 cm under the skin on the lateral aspect of her upper arm. In order to create an autogenous hemodialysis access, the vein must be rerouted through a superficial tunnel to reach the brachial artery on the medial aspect of her arm, just above the elbow. A cephalic vein transposition is recommended.

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:

- Review all office notes, H&P, noninvasive vascular lab studies
- Update H&P (required by JCAHO)
- Review operative plan and informed consent with patient & family
- Discuss patient morbidities and surgical approach with Anesthesiologist
- Change into OR scrubs
- Supervise patient positioning, skin prep, and draping
- Wait for anesthetic to become effective

Description of Intra-Service Work:

- Skin incision over the approximate location of the cephalic vein from elbow towards shoulder for distance long enough to accomplish transposition.
- Dissect subcutaneous tissue until the vein is located.
- Ligate and divide all vein branches
- Dissect vein entirely from the surrounding tissue with attention to avoid venous injury
- Make separate small incision over brachial artery just proximal to the antecubital crease
- Dissect brachial veins and adjacent soft tissue from artery
- Encircle small branches of artery with silk ties
- Create superficial subcutaneous tunnel long enough for adequate hemodialysis access and appropriate to allow vein to reach across arm to brachial artery
- Administer intravenous heparin for anticoagulation
- Ligate and divide cephalic vein near antecubital area
- Insert cannula into transected end of vein and gently distend vein
- Search for any venous leaks, suture ligate with 7-0 polypropylene if found
- Stripe vein longitudinally with tissue marking pen to avoid twist on passage through tunnel
- Clamp end of cephalic and pull through the tunnel
- Occlude brachial artery with vascular clamps
- Incise brachial artery to create 7 mm longitudinal arteriotomy
- Trim end of cephalic vein to match arteriotomy
- Perform cobra-head-shaped anastomosis end-of-vein to side-of-artery with 6-0 suture
- Vent proximal and distal artery to flush air and debris out of anastomosis
- Tie anastomotic suture

- Check for thrill in vein
- Inspect vein in tunnel to ensure no leaks or kinks
- Irrigate wounds
- Achieve hemostasis
- Close subcutaneous tissue of both incisions
- Close skin of both incisions
- Check wrist pulse and hand ensure adequate perfusion

Description of Post-Service Work:

- Apply sterile dressings
- Ensure patient stable to transfer out of OR
- Help transfer patient to Recovery Area
- Write post-op orders
- Dictate operative report
- Communicate with patient's family, referring and consulting physicians
- Assist anesthesiologist to ensure smooth emergence from anesthesia
- Discuss results of procedure with patient once he or she is fully awake
- Determine patient is stable for transfer to floor or discharge
- Daily visits if patient admitted to provide postoperative care, write orders and notes, etc.
- Discharge day management includes communicating with all support services, 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 office-based care for 90-day global period

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	Gary Seabrook					
Specialty(s):	SVS					
CPT Code:	36818					
Sample Size:	100	Resp n:	31	Response:	%	
Sample Type:	Random					
		Low	25 th pctl	Median*	75 th pctl	High
Survey RVW:		9.00	13.00	13.98	14.00	18.00
Pre-Service Evaluation Time:				35.0		
Pre-Service Positioning Time:				10.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		50.00	90.00	90.00	120.00	130.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		30.00				
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:		18.0	99238x 0.50	99239x 0.00		
Office time/visit(s):		38.0	99211x 0.0	12x 1.0	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:

Key CPT Code
36819

Global
090

Work RVU
13.98

CPT Descriptor Arteriovenous Anastomosis, open; by upper arm basilic vein transposition

Other Reference CPT Code

Global

Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 74.1 %

TIME ESTIMATES (Median)

New/Revised
CPT Code:
36818 Key
Reference
CPT Code:
36819

Median Pre-Service Time	60.00	25.00
Median Intra-Service Time	90.00	120.00
Median Immediate Post-service Time	30.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	19.00
Median Office Visit Time	38.0	38.00
Median Total Time	236.00	217.00

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	3.14	3.05
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.91	2.86
Urgency of medical decision making	2.32	2.23

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.59
Physical effort required	2.32	2.23

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.86	2.95
Outcome depends on the skill and judgment of physician	3.64	3.73
Estimated risk of malpractice suit with poor outcome	2.73	2.73

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.82	2.82
Intra-Service intensity/complexity	3.23	3.18
Post-Service intensity/complexity	2.36	2.32

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.*

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: No

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

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility 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.

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? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty vascular 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? 10000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty VS	Frequency 5000	Percentage	%
Specialty GS	Frequency 5000	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty VS	Frequency 5000	Percentage	%
Specialty GS	Frequency 5000	Percentage	%
Specialty	Frequency	Percentage	%

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Long Descriptor: Arteriovenous anastomosis, open; by upper arm cephalic vein transposition

Sample Size: N/A Response Rate (%): N/A Global Period: 090

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

Standard RUC/PEAC times for 90-day global period pre-service in-facility activities and post-procedure office visits were applied. This PE is similar to the other family members of hemodialysis codes e.g. 36891 and 36820.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Review test/exam results
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

Post-Service Clinical Labor Activities:

- Greet patient, escort to room
- Provide gowning
- Interval history & vital signs & chart
- Assemble previous test reports/results
- Assist physician during exam

Post-Service Clinical Labor Activities (continued):

- 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

Total Staff Time Out of Office: 135 minutes

Visits in Global Period: 1 X 99212; 1 X 99213

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 and Source (if applicable)
L037D	RN/LPN/MTA	60	6			2	63	

*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 2004. 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)
	Post-op incision care package (staple)	1		
	PEAC Multi-specialty Supply Pkg	2		

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

CMS's Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)
E11001	Exam table	

* From CMS'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: FACILITY

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 <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>5</u>	<u>RN/LPN/MTA</u> Other _____
Coordinate pre-surgery services/review test/exam results <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>20</u>	<u>RN/LPN/MTA</u> Other _____
Schedule space and equipment in facility <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>8</u>	<u>RN/LPN/MTA</u> Other _____
Office visit before surgery/procedure	_____	RN, LPN, MA, Other _____
Review test and exam results	_____	
Provide pre-service education/obtain consent <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>20</u>	<u>RN/LPN/MTA</u> Other _____
Follow-up phone calls & prescriptions <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>7</u>	<u>RN/LPN/MTA</u> Other _____
Other Activity (please specify)	_____	RN, LPN, MA, Other _____

End: When patient enters hospital for surgery/procedure

Service Period

*Start Patient admitted to hospital for surgery/procedure
Pre-service services*

Review charts	_____	RN, LPN, MA, Other _____
Greet patient and provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	_____	RN, LPN, MA, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____
<i>Intra-service</i>		
Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____

Post-service

Monitor pt. following service/check tubes, monitors, drains	_____	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	_____	RN, LPN, MA, Other _____
Assist with ICU or hospital visits	_____	RN, LPN, MA, Other _____
Total Number of ICU visits	_____	
Total Number of hospital visits	_____	
Complete diagnostic forms, lab & X-ray requisitions	_____	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MA, Other _____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	_____	RN, LPN, MA, Other _____
Coordination of care by staff in office	<u>6</u>	RN, LPN, MA, Other _____
Other Activity (please specify)	_____	
_____	_____	RN, LPN, MA, Other _____

End Patient discharge from hospital

Post-Service Period

Start. Patient discharge from hospital

Conduct phone calls/call in prescriptions	_____	RN, LPN, MA, 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		

OFFICE VISIT LEVEL

99212; standard 27 minutes per visit

99213; standard 36 minutes per visit

List total number of office visits

A 36

27

B 2

Total office visit time (A * B)

63

Conduct phone calls between office visits	_____	RN, LPN, MA, Other _____
Other Activity (please specify)	_____	
_____	_____	RN, LPN, MA, Other _____

End With last office visit before end of global period

	A	B	C	D	E
1					
2					368X1
3					Arteriovenous anastomosis, open; by upper arm cephalic vein transposition
4	LOCATION			Non Facility	Facility
5	GLOBAL PERIOD			90	90
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	129
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	60
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0	6
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	63
10	PRE-SERVICE				
11	Start: Following visit when decision for surgery or procedure made				
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7
17	Other Clinical Activity (please specify)				
18	End: When patient enters office/facility for surgery/procedure				
19	SERVICE PERIOD				
20	Start: When patient enters office/facility for surgery/procedure				
21	Pre-service services				
22	Review charts				
23	Greet patient and provide gowning				
24	Obtain vital signs				
25	Provide pre-service education/obtain consent				
26	Prepare room, equipment, supplies				
27	Setup scope (non facility setting only)				
28	Prepare and position patient/ monitor patient/ set up IV				
29	Sedate/apply anesthesia				
30	Intra-service				
31	Assist physician in performing procedure				
32	Post-Service				
33	Monitor pt following service/check tubes, monitors, drains				
34	Clean room/equipment by physician staff				
35	Clean Scope				
36	Clean Surgical Instrument Package				
37	Complete diagnostic forms, lab & X-ray requisitions				
38	Review/read X-ray, lab, and pathology reports				
39	Check dressings & wound/ home care instructions				
40	Coordinate office visits /prescriptions				
41	Discharge day management 99238 -12 minutes				6
42	99239 --15 minutes				
43	Other Clinical Activity (please specify)				
44	End: Patient leaves office				
45	POST-SERVICE Period				
46	Start: Patient leaves office/facility				
47	Conduct phone calls/call in prescriptions				
48	Office visits 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 X 1		27		27
52	99213 36 minutes x 1		36		36
53	99214 53 minutes		53		
54	99215 63 minutes		63		
55	Other				
56	Total Office Visit Time	L037D	RN/LPN/MTA		63
57	Other Activity (please specify)				
58	End: with last office visit before end of global period				
59	MEDICAL SUPPLIES				
60	PEAC multispecialty supply package				2
61	Post-op incision care (staple)				1
62	EQUIPMENT				
63	exam table		E11001		1

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Carotid Stenting

The CPT Editorial Panel created two new codes to report percutaneous stent placement in the cervical portion of the extracranial carotid artery, with and without use of an embolic protection system including all associated radiological supervision and interpretation. The RUC and the presenters agreed that both codes will be added to the conscious sedation list.

37215 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

The committee reviewed the survey data and supporting additional rationale. The presenters clarified that the typical patient would not have had a diagnostic angiography, but would have carotid duplex type studies as screening tests prior to this procedure. The presenters concluded that the survey median RVW of 21.78 is too high and recommended the 25th percentile work relative value of 18.86 based on the comparison with three similarly complex and intense percutaneous interventional procedures, all of which have been RUC-surveyed. The RUC examined this rationale but first revised the pre-service time resulting in a reduction in the RVU to 18.71 due to a reallocation and reduction in pre-service time. The pre-service RVUs were reduced from 1.95 to 1.80. The presenters explained the physician work involved focusing on the high level of intensity that is maintained throughout the intra-service period. The survey intensity results reflected the high intensity and patient risk associated with the procedure and also corresponded with the vignette. The RUC was concerned that the typical patient may change in the future but the committee agreed that for now the intensity measures and vignette were accurate. Due to ongoing trials, future applications may not be known for at least 5 years.

The RUC compared code 37215 to the reference service 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* (work RVU = 14.82, RUC surveyed, 000 day global). Although the intra-service time is lower for the new code (103 minutes vs 120 minutes) all of the intensity measures supported a higher intensity. The IWPUR for the new code and the reference code are .112 and .102 respectively. The committee felt that the differences in intensity was supported by the data and the vignette.

In addition, the RUC reviewed a variety of building block calculations that also supported the recommended value and placed the code in proper rank order and the RUC agreed that the adjusted 25th percentile survey work RVU of 18.71 is the most accurate relative value. **The RUC recommends a work RVU of 18.71 for code 37215.**

37216

The RUC reviewed the survey data and rationale for 37216 and concluded than the originally proposed value needed to be adjusted for the 8 minute reduction in pre-service time and a .15 RVU reduction in work to be consistent with the reduction in work for 37215. This resulted in a total RVU of 17.98. The committee was comfortable that this value reflected the difference of 6 minutes intra-service time between the two codes to reflect the value and time of deploying and removing the embolic protection device. This value maintains the incremental difference of .73 RVUs. **The RUC recommends a work RVU of 17.98 for code 37216.**

Practice Expense

The standard inputs for 90 day global period codes only performed in the facility were applied.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲37205		Transcatheter placement of an intravascular stent(s), (except coronary, non- eervical -carotid, <u>and vertebral</u> vessel), percutaneous; initial vessel (For radiological supervision and interpretation, use 75960)	000	8.27 (No Change)
+37206		<i>each additional vessel (List separately in addition to code for primary procedure)</i> (Use 37206 in conjunction with code 37205) For transcatheter placement of extracranial cerebrovascular <u>intravascular cervical carotid</u> artery stent(s), see Category III codes 0005T, 0006T <u>37215, 37216</u>) (For transcatheter placement of extracranial vertebral or intrathoracic	ZZZ	4.12 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>carotid artery stent(s), see Category III codes 0005T-0075T and, 0006T 0076T)</u> (For radiological supervision and interpretation, use 75960)		
● 37215	AB1	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection	090	18.71
● 37216	AB2	without distal embolic protection (37215 and 37216 include all ipsilateral selective carotid catheterization, all diagnostic imaging for ipsilateral, cervical and cerebral carotid arteriography, and all related radiological supervision and interpretation. When the ipsilateral carotid arteriogram (including imaging and selective catheterization) confirms the need for carotid stenting, codes 37215 and 37216 are inclusive of these services. If carotid stenting is not indicated, then the appropriate codes for carotid catheterization and imaging should be reported in lieu of code 37215 and 37216) (Do not report 37215, 37216 in conjunction with 75680, 75681) (For transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), see Category III codes 0075T and 0076T)	090	17.98
0005T		Transcatheter placement of extracranial cerebrovascular artery stent(s), percutaneous; initial vessel	XXX	N/A
+0006T		each additional vessel (List separately in addition to code for primary procedure) (Use 0006T in conjunction with code 0005T)	XXX	N/A

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(For radiological supervision and interpretation, use 0007T) (Codes 0005T and 0006T have been deleted. To report, see codes 0075T, 0076T)		
0007T		Transcatheter placement of extracranial cerebrovascular artery stent(s), percutaneous, radiological supervision and interpretation, each vessel (For procedure, see 0005T, 0006T) (Code 0007T has been deleted. To report, see codes 0075T, 0076T)	XXX	N/A
●007X1T		Transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiologic supervision and interpretation, percutaneous; initial vessel	XXX	N/A
+●007X2T		each additional vessel (List separately in addition to code for primary procedure) (Use 0075T in conjunction with 0076T) (0075T and 0076T include all ipsilateral extracranial vertebral or intrathoracic selective carotid catheterization, all diagnostic imaging for ipsilateral extracranial vertebral or intrathoracic carotid artery stenting, and all related radiological supervision and interpretation. When the ipsilateral extracranial vertebral or intrathoracic carotid arteriogram (including imaging and selective catheterization) confirms the need for stenting, 0076T is inclusive of these services. If stenting is not indicated, then the appropriate codes for selective	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>catheterization and imaging should be reported in lieu of 0076T)</u>		
▲ 75960		<p>Transcatheter introduction of intravascular stent(s), (except coronary, non-cervical carotid, and vertebral vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel</p> <p><i>(For procedure, see 37205-37208)</i></p> <p>(For radiologic supervision and interpretation for transcatheter placement of extracranial vertebral or intrathoracic carotid cerebrovascular artery stent(s), use see Category III code 0007T 0075T, 0076T)</p>	XXX	0.82 (No Change)
75961		<i>Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation</i>	XXX	4.24 (No Change)

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

Recommended Work Relative Value

CPT Code:37215 Tracking Number: AB1 Global Period: 090 Specialty Society RVU: **18.86** RUC RVU: **18.71**

CPT Descriptor: Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection.

(37215 and 37216 include all ipsilateral selective carotid catheterization, all diagnostic imaging for ipsilateral, cervical and cerebral carotid arteriography, and all related radiological supervision and interpretation. When the ipsilateral carotid arteriogram (including imaging and selective catheterization) confirms the need for carotid stenting, codes 37215 and 37216 are inclusive of these services. If carotid stenting is not indicated, then the appropriate codes for carotid catheterization and imaging should be reported in lieu of code 37215 and 37216)

(Do not report 37215, 37216 in conjunction with 75671, 75680)

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

A 66-year-old male has recurrent episodes of transient right hemiparesis while on aspirin. Neurologic evaluation reveals no fixed neurological deficit. Carotid ultrasound demonstrates an 80%-99% stenosis of his left internal carotid artery. Diagnostic cervico-cerebral arteriography confirms an 80% focal left internal carotid stenosis (NASCET measurement method). The patient is 10 years post coronary bypass surgery. He had a subendocardial MI two months ago with subsequent cath showing diffuse distal disease, and an ejection fraction of 30%. He has angina at low levels of exercise. Discussion with a surgeon who performs carotid endarterectomy leads to agreement that the patient is at high risk for open carotid surgery. Carotid stent placement with embolic protection is therefore recommended.

NOTE: The new code includes selective carotid access, all diagnostic imaging for ipsilateral common carotid, bifurcation and cerebral vessels, plus all radiological supervision and interpretation. Additionally, when the physician work of the initial ipsilateral carotid arteriogram (including imaging and access) confirms the need for carotid stenting, code 37215 is inclusive of these services. If carotid stenting is not indicated then the appropriate codes for carotid catheterization and imaging would be reported in lieu of code 37215.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 90%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work:

- The patient's history and pertinent non-invasive diagnostic studies are reviewed, with special attention to cerebrovascular symptoms, cardiac and other co-morbidities that would place the patient at high risk for surgery.
- Physical exam is reviewed to ensure that the patient has palpable femoral pulses, suitable for percutaneous access.
- Special attention is given to medications, including antiplatelet agents and anticoagulants that the patient may be taking or needs to be taking.
- All pre-procedural blood tests are reviewed, focusing on coagulation and renal function studies. If renal insufficiency is present, attention is given to whether patient has received appropriate renal protective agents and hydration.
- Based on review of all previous diagnostic studies, the physician estimates the range of guiding catheters/sheaths, guide wires, selective catheters, balloons, stents and embolic protection devices that may be required, and ensures that all are available for use. (This procedure requires a substantial inventory of equipment, and absence of any single piece can disable the effort. Thus, this task cannot be taken lightly.)

- Procedure details, including alternatives and risks, are discussed with patient and family. Finally, informed consent is reviewed with patient and family.
- Careful baseline neurological examination is performed.

PRE-SERVICE RADIOLOGICAL SUPERVISION AND INTERPRETATION WORK

- The interventional suite is checked to ensure proper function and configuration of the imaging equipment including compliance with all radiation safety issues.
- The physician ensures that all technical personnel have been familiarized with the carotid stent technique and are fully familiar with all required devices, especially the embolic protection system. Physician supervises selection of all equipment, including catheters, wires, balloons, stents, sheaths, protection device, contrast material, etc., and assures that all needed equipment is available.
- Prior films/studies are located and reviewed.
- Don radiation protection
- Position (or supervise proper positioning of) patient

Description of Intra-Service Work:

INITIAL ARTERIAL ACCESS AND MONITORING

- Ensure ECG and hemodynamic monitors are in place and functioning
- All following steps are performed under fluoroscopic guidance
- Puncture common femoral artery for insertion of 6F sheath

ALL RADIOLOGICAL SUPERVISION AND IMAGING WORK IS INCLUDED

- Direct technical personnel throughout procedure
- Interpretation of imaging of the vessel being treated, including complete intracranial and extracranial views of the target vessel in all views necessary
- Ensure accurate radiological views, exposures, shielding, image size, injection sequences, radiation protection and management for patient and staff
- Real-time analysis of all imaging during procedure, including pre-treatment imaging, fluoroscopic and angiographic imaging throughout the procedure as required to perform the procedure, and post-procedure fluoroscopic and angiographic imaging. This includes all imaging to manipulate the wires, catheters, devices, into position as well as correct positioning and deployment EPS, stable positioning of EPS throughout procedure, correct positioning and deployment of stent, opening balloon, assessing post-op success and complications, complete intra and extracranial study post-stent, recapture of protection device, and removal of catheters.
- Quantitative measurement of the lesion, target vessel and distal EPS landing zone to determine appropriate balloon, stent and EPS sizes
- Continuous fluoroscopic imaging during all catheter/stent manipulations to assess proper EPS position and adequate EPS performance throughout procedure

BASELINE CERVICAL & CEREBRAL ANGIOGRAPHY AND QUANTITATIVE MEASUREMENTS

- Advance standard .035 guidewire into aortic arch at base of great vessels
- Carotid configuration catheter advanced to aortic arch
- Roadmap common carotid artery origin and proximal segment
- Remove standard .035 wire and replace with .035 hydrophilic wire
- Insert carotid-selective reverse curve catheter into sheath over hydrophilic wire
- Administer IV heparin
- Reform shape of carotid-selective catheter in aortic arch
- Use this carotid catheter to selectively catheterize origin of common carotid artery
- Inject contrast to perform initial roadmap arteriogram of common carotid and bifurcation
- Perform cervical carotid angiography in AP and lateral views
- Perform quantitative measurements of vessels including area of stenosis & area of EPS landing zone
- Perform cerebral angiography including at minimum lateral and AP Towne views
- Place catheter to continuous heparin flush

SELECTION OF APPROPRIATE STENT AND EMBOLIC PROTECTION SYSTEM

- Choose equipment based on results of quantitative measurements
- Connect side-arm of long guiding sheath to arterial pressure transducer
- Perform focused arteriogram of bifurcation and distal internal carotid thru guiding sheath

PREP DISTAL EMBOLIC PROTECTION SYSTEM (EPS)

- Prep 0.014 wire on back table and ensure filter is completely air-free
- Assemble delivery system and assure it is air-free
- Assemble retrieval system and assure it is air-free

EXCHANGE FOR GUIDING CATHETER/SHEATH

- Advance .035 hydrophilic wire under roadmap into external carotid
- Advance catheter into external carotid
- Remove hydrophilic wire, insert stiff .035 exchange-length wire
- Exchange long guiding sheath/catheter into common carotid
- Remove wire and carotid-selective catheter
- Check ACT to ensure adequate anticoagulation

PLACEMENT OF DISTAL EMBOLIC PROTECTION SYSTEM (EPS)

- Load .014 wire/EPS/delivery system, advance into common carotid
- Perform high magnification pre-deployment arteriogram of carotid bifurcation
- Check patient neurological status now and throughout case at intervals
- Advance and maneuver .014 wire/EPS across lesion into distal extracranial internal carotid with careful positioning using confirmatory angiography and road-mapping
- Activate EPS by opening the filter umbrella in distal internal carotid
- Remove EPS deployment catheter
- Confirm deployed EPS position with angiogram to confirm good flow and filter/wall apposition. Reposition and repeat as necessary until proper position attained.

PRE-STENT CAROTID ANGIOPLASTY

- Prepare angioplasty balloon to be air-free
- Advance 3-4 mm low-profile balloon across lesion and check position
- Insufflate balloon to pre-dilate lesion
- Remove balloon

CAROTID STENT PLACEMENT

- Prepare stent delivery system to be air-free
- Load appropriately sized self-expanding stent into guiding catheter
- Advance stent delivery catheter very carefully across lesion
- Perform final angiographic check to ensure exact positioning
- Deploy stent
- Remove stent delivery device
- Load and advance 5-6 mm balloon
- Position balloon within stent and inflate for post dilatation
- Check ECG for bradycardia or other arrhythmia, treat as needed with IV meds

EPS REMOVAL

- Advance EPS retrieval system through stent to distal EPS position
- Deactivate EPS & Remove .014 wire / EPS

FINAL CAROTID AND CEREBRAL ANGIOGRAPHY

- Perform completion bifurcation arteriogram
- Check carefully for residual stenosis, dissection, vasospasm
- Treat any of above if present (e.g. nitroglycerin for vasospasm)

- Perform completion intra-cerebral arteriogram in AP, lateral, Towne views
- Review cerebral images in detail for emboli, vasospasm, cross-filling etc
- Insert soft-tip 035 guidewire into long guiding sheath/catheter
- Remove guiding sheath/catheter from common carotid
- Remove guiding sheath and guidewire from puncture site and attain hemostasis
- Final neurological check prior to transfer to recovery area

Description of Post-Service Work:

- Ensure BP, HR are stable and normal upon arrival to recovery area
- Thorough neurological exams at frequent intervals
- Write post-op orders & Communicate with family & referring physicians
- Review results of procedure with patient when sedation wears off
- Review and interpret all images
- Post-process all radiologic images and convert to archived form for permanent record
- Review and record patient fluoroscopic exposure time & contrast volume
- Dictate procedure note, including interpretation of diagnostic and therapeutic imaging
- Review, revise, sign final report
- Send formal report to PCP and referring providers
- Daily in-hospital E&M visits, orders, notes, communication, etc.
- Discharge day management including communication with PCP, family etc
- All post-procedure outpatient office visits within the global period

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2002				
Presenter(s):	ACC: Chris Cates MD, Ken Brin MD, and/or Joseph Babb MD; SIR: Bob Vogelzang MD and/or Kathy Krol MD; ACR: Bibb Allen MD; SVS: Gary Seabrook MD; ASITN: John Barr MD; AANS: John Wilson MD; AAN: Jim Anthony MD					
Specialty(s):	AAN, AANS, ACC, ACR ASITN, SCAI, SIR, SVS					
CPT Code:	37215					
Sample Size:	400	Resp n:	102	Response:	%	
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		12.83	18.86	21.78	27.83	41.83
Pre-Service Evaluation Time:				60.0		
Pre-Service Positioning Time:				15.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		40.00	85.00	103.00	120.00	207.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	30.00					
Critical Care time/visit(s):	0.0	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	30.0	99231x 0.0	99232x 1.0	99233x 0.0		
Discharge Day Mgmt:	36.0	99238x 1.00	99239x 0.00			
Office time/visit(s):	46.0	99211x 0.0	12x 0.0	13x 2.0	14x 0.0	15x 0.0

**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

92980

Global

000

Work RVU

14.82

CPT Descriptor Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

Other Reference CPT CodeGlobalWork RVUCPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 16.6 %

TIME ESTIMATES (Median)

New/Revised
CPT Code:
37215

Key
Reference
CPT Code:
92980

Median Pre-Service Time	90.00	45.00
Median Intra-Service Time	103.00	120.00
Median Immediate Post-service Time	30.00	60.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	0.00
Median Discharge Day Management Time	36.0	0.00
Median Office Visit Time	46.0	0.00
Median Total Time	335.00	225.00

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	4.41	3.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.59	3.65
Urgency of medical decision making	4.00	3.71

Technical Skill/Physical Effort (Mean)

Technical skill required	4.82	3.82
Physical effort required	4.65	3.53

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.82	3.53
Outcome depends on the skill and judgment of physician	5.00	3.76
Estimated risk of malpractice suit with poor outcome	4.76	3.35

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.59	3.47
Intra-Service intensity/complexity	4.88	3.59
Post-Service intensity/complexity	4.12	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.*

SUMMARY OF ADDITIONAL RATIONALE

The multispecialty Consensus Panel that reviewed the survey results determined that the median survey RVW of 21.78 is too high. We recommend the 25th percentile RVW of 18.86 based on comparison with three similarly complex and intense percutaneous interventional procedures, all of which have been RUC-surveyed. Building an RVW for carotid stent with embolic protection from key reference service coronary stent results in an RVW for the new service of 18.75. This comparison is based on a large number of survey responses provided by physicians who perform both services frequently. The comparison provides a period-by-period analysis of the new service to the established reference, including a comparison of intra-service intensity. Building RVWs for 372X1 from RUC-surveyed radiology reference service 37182 Transvenous Intrahepatic Portocaval Shunt (TIPS), and from cardiology 93580 Percutaneous ASD Closure, results in values of 17.12 and 20.12 respectively, thereby bracketing the 25th percentile survey RVW (18.86) of the new service. Overall, with the comparison to the coronary stent key reference service buttressed by RVW estimates from TIPS and Percutaneous ASD closure, we believe the 25th percentile survey RVW of 18.86 is the best relative value for this new service. Details of the analysis are provided below.

DETAILS:

Surveys were distributed to a large number of physicians representing specialties and sub-specialties of medicine (Cardiology & Neurology), surgery (Neurosurgery and Vascular Surgery, and radiology (General Radiology, Interventional Radiology and Neuroradiology). A large number of survey responses were collected, 43 from the medicine specialties, 34 from radiology specialties and 25 from surgical specialties. Analysis of these three datasets by standard median techniques revealed significant differences in median RVWs and times among the groups. Since there is

no available frequency data to predict accurately what percentage of these procedures will be performed by each specialty, the consensus panel felt the only fair method to analyze the survey data was to weigh the individually determined median values equally. This approach was used by the RUC in April 2000 when radiology and surgery submitted different numbers of surveys with different median data on the family of endovascular AAA repairs. This method was therefore used here to determine the RVU and time values in the data tables provided on previous pages.

With respect to choice of key reference service to be entered in the table above, the Panel chose 92980 percutaneous coronary stent placement rather than the more commonly cited, CPT 35301 carotid endarterectomy, for several reasons. First, it was determined that 18 of the 26 respondents (69%) who chose carotid endarterectomy as reference service were from cardiology, neurology or radiology, specialties where direct experience with carotid endarterectomy would most likely rely on medical school memories. Indeed, 14 of the medicine and radiology specialists who chose carotid endarterectomy as the reference service listed "0" as recent experience with the reference, two left that spot blank on the survey, and two noted recent experience of 10 & 27. Although the Panel agreed that it would be inappropriate to discard those surveys, we felt the lack of experience served to discredit carotid endarterectomy as an appropriate "key" reference service to be used in this analysis or entered in the RUC database. Second, we felt that CPT 92980 represented a strong key reference candidate from a clinical perspective. It was chosen as reference by 17 respondents, 88% of whom listed high levels of recent experience with both coronary stent and carotid stent. The ability to compare relative work is therefore more credible using coronary stent as key reference. Although 92980 is a 0-day global service, all other technical and clinical aspects of carotid stent and coronary stent are directly comparable. Both services require the utmost in catheter skills, and both have extreme intensity and complexity from start to finish. In addition, both carotid stent and coronary stent are very high risk in terms of consequences of a bad outcome, including catastrophes such as stroke, myocardial infarction, and death. For all these reasons we felt 92980 should be the key reference service despite being the second most commonly chosen reference.

In addition to 92980, survey respondents chose two other percutaneous reference services that our consensus panel felt were appropriate to merit consideration in valuing the new carotid stent service. These are the radiology service CPT 37182 Transvenous Intrahepatic Portocaval Shunt, and cardiology service CPT 93580 Percutaneous Closure of an Atrial-Septal Defect. Both of these reference services underwent RUC survey in 2002.

BUILDING AN RVW FOR 372X1 CAROTID STENT WITH EMBOLIC PROTECTION FROM 92980 CORONARY STENT

Coronary stent placement 92980 is a 0-day global service with a pre-service time of 45-minutes, intra-service time of 120-minutes, and a post-service time of 60-minutes. Coronary stent has an RVW of 14.82. Since it is a 0-day global, all in-hospital and office visits following the day of procedure are reported separately. In order to build an RVW for the 90-day carotid stent procedure from the coronary stent, we must start by comparing the pre- and intra-service components of the two services, then add the inpatient and outpatient visits established by survey for carotid stent. The following analysis provides that step-by-step calculation.

PRE-SERVICE WORK: Survey respondents said carotid stent has 51-minutes more evaluation time and 2-minutes more prep time than coronary stent. The difference represents 1.14 RVUs ($51 \times 0.022 + 2 \times 0.008$) in favor of carotid stent. Since Pre-service work for coronary stent is 0.79 RVUs (see IWPUT table on next page), the pre-service work for carotid stent is 1.93 RVUs.

INTRA-SERVICE WORK: Intra-service time is 120-minutes for coronary stent and 103-minutes for carotid stent. The seventeen respondents (88% Cardiologists) who chose coronary stent as their reference service rated a striking intra-service intensity difference of carotid stent at 4.88 compared to 3.59 for coronary stent (see "Intra-service intensity/complexity from table above). The RUC has never tested linearity of these intensity measures, but this represents a 36% increment in intra-service intensity/complexity of carotid stent > coronary stent. By building block method, 12.68 RVUs are assigned to intra-service work for coronary stent. Even if we estimate the quantitative intensity relationship to be less than half the 36% listed by survey respondents (assume a 15% intensity/complexity increment), this exercise can generate an appropriate intra-service work for carotid stent from coronary stent by first adjusting intra-service time (shorter for carotid), then adjusting intensity (higher for carotid). With a time adjustment factor of $103/120 = 0.858$, and an intensity factor of 15%, ($= 1.15$), the intra-service work of carotid stent may be calculated as follows. Intra-service work of carotid = intra-service work of coronary stent x time adjustment x intensity adjustment = $12.68 \times 0.858 \times 1.15 = 12.51$ RVUs.

POST-SERVICE WORK ON DAY OF SERVICE: Coronary stent has 60-minutes of post-service time to complete the 0-day global. Carotid stent has 30 minutes of immediate post-service time plus a 99232 a hospital visit at end of day. Thus, on the day of service coronary stent has 1.34 post-service RVUs, while carotid stent has 1.73 RVUs.

POST-SERVICE WORK AFTER DAY OF SERVICE: Coronary stent has none since it is a 0-day global. Carotid stent has a discharge visit and 2 outpatient visits. Post-service work following day-of-service is 0 RVUs for coronary stent, and 2.58 RVUs for carotid stent.

SUMMARY: BUILDING AN RVW FOR CAROTID STENT WITH EMBOLIC PROTECTION FROM CORONARY STENT:

	92980 Coronary stent	372X1 Carotid Stent built from coronary stent
Pre-service RVUs	0.79	1.93
Intra-service RVUs	12.68	12.51
Post-service RVUs, Day of Service	1.34	1.73
Post-service RVUs, after Day of Svce	0.00	2.58
Total Service	14.82 RVUs (=2004 MFS)	18.75 RVUs

This comparison results in an RVW of 18.75 for 372X1. It reflects both the intra-service time relationship and the intra-service intensity relationship of the new service compared to the key reference. It provides strong justification for the 25th percentile survey RVW of 18.86.

BUILDING AN RVW FOR 372X1 CAROTID STENT WITH EMBOLIC PROTECTION FROM CPT 37182 TIPS

This comparison determines an RVW for carotid stenting based on the RUC-surveyed radiology reference service CPT 37182, Transvenous Intrahepatic Portocaval Shunt (TIPS). TIPS is a complex multi-step percutaneous stenting procedure typically performed in extremely ill patients. TIPS includes all associated radiological supervision and interpretation, and in that sense it is equivalent to the new carotid stent service. The RUC surveyed TIPS in 2002.

CPT 37182 TIPS

Global Period: 0-days

2004 RVW = 16.97

Pre-service: 30-minutes

Intra-service: 150-minutes

Post-service: 30-minutes

IWPUT = 0.106

In order to construct an RVW for carotid stenting from TIPS, adjustments must be made in all 4 service compartments:

PRE-SERVICE WORK: TIPS has 30-minutes of pre-service time in the RUC database. Assuming that represents 15-minutes of evaluation and 15-minutes of scrub/prep/drape, then carotid stent has 66-minutes additional evaluation time and 2-minutes more prep time than TIPS. The difference represents 1.47 RVUs in favor of carotid stent ($66 \times 0.022 + 2 \times 0.008$). Total Pre-service work for TIPS is 0.46 RVUs, and based on that, Pre-service work for carotid stent is 1.93 RVUs.

INTRA-SERVICE WORK: Intra-service time for carotid stent is 103-minutes, while TIPS intra-service time is 150-minutes. We do not have a direct comparison of intra-service intensity of TIPS to carotid stent because insufficient survey respondents chose this service to determine a numerical intensity relationship (that's the primary reason why the coronary stent analysis is more robust than this one). Thus, the basic approach must assume intensity equivalence, making an adjustment for time only. Intra-service work of TIPS is 15.84. Based on a time adjustment (without intra-service intensity adjustment) the intra-service work of carotid stent may be estimated at $103/150 \times 15.84 = 10.88$.

POST-SERVICE WORK ON DAY OF SERVICE: TIPS has 30-minutes of post-service time to complete the 0-day global. Carotid stent has 30 minutes of immediate post-service time and one 99232 hospital visit. Thus, on the day of service TIPS has 0.67 post-service RVUs, while carotid stent has $0.67 + 1.06 = 1.73$ RVUs.

POST-SERVICE WORK AFTER DAY OF SERVICE: TIPS has none since it is a 0-day global. Carotid stent has a discharge visit and 2 outpatient visits. Thus, $1.28 + 0.65 + 0.65 = 2.58$ RVUs for carotid stent.

SUMMARY:

	37182 TIPS	372X1 CAROTID STENT built from TIPS
Pre-service:	0.46	1.93
Intra-service:	15.84	10.88
Post, Day of Service:	0.67	1.73
Post, following DoS:	0.00	2.58
Total Service	16.97 (=2004 MFS)	17.12

This comparison justifies an RVW for carotid stenting of 17.12 RVUs, somewhat less than our recommended value of 18.86, but the analysis lacks any adjustment for intra-service intensity of the carotid stent in comparison to TIPS. If, for instance, the complexity/intensity relativity of carotid stent compared to TIPS is just 5-10% greater, that would bring the total RVW very close to the 25th percentile survey value of 18.86.

BUILDING AN RVW FOR 372X1 CAROTID STENT WITH EMBOLIC PROTECTION FROM CPT 93580 Percutaneous ASD Closure

The following comparison relates carotid stenting to the RUC-surveyed cardiology service CPT 93580, Percutaneous catheter closure of congenital interatrial communication. Perc ASD is another complex multi-step percutaneous stenting procedure that was surveyed by the RUC in 2002.

CPT 93580 Percutaneous ASD
 Global Period: 0-days
 2004 RVW: 17.97
 Pre-service time: 30-minutes
 Intra-service time: 120-minutes
 Post-service time: 60 minutes
 IWPOT: 0.135

In order to construct an RVW for carotid stenting from Perc ASD, adjustments must be made in all 4 service compartments:

PRE-SERVICE WORK: Perc ASD has 30-minutes of pre-service time in the RUC database. Assuming that represents 15-minutes of pre-service evaluation and 15-minutes of scrub/prep/drape, then carotid stent has 66-minutes more evaluation time and 2-minutes more prep time than Perc ASD. The difference represents 1.47 RVUs in favor of carotid stent ($66 \times 0.022 + 2 \times 0.008$). Total Pre-service work for Perc ASD is 0.46 RVUs, and based on that, Pre-service work for carotid stent is 1.93 RVUs.

INTRA-SERVICE WORK: Intra-service time for carotid stent is 103-minutes, while Perc ASD intra-service time is 120-minutes. We do not have a direct comparison of intra-service intensity of Perc ASD to carotid stent because insufficient survey respondents chose this service to create a numerical intensity analysis (that's the primary reason why the coronary stent comparison is more robust). Thus, the basic approach must assume intensity equivalence, making an adjustment for time only. Intra-service work of Perc ASD is 16.17. Based on a time adjustment (without an intra-service intensity adjustment) the intra-service work of carotid stent may be estimated at $103/120 \times 16.17 = 13.88$.

POST-SERVICE WORK ON DAY OF SERVICE: Perc ASD has 60-minutes of post-service time to complete the 0-day global. Carotid stent has 30 minutes of immediate post-service time and one 99232 hospital visit. Thus, on the day of service Perc ASD has 1.34 post-service RVUs, while carotid stent has $0.67 + 1.06 = 1.73$ RVUs.

POST-SERVICE WORK AFTER DAY OF SERVICE: Perc ASD has none since it is a 0-day global. Carotid stent has a discharge visit and 2 outpatient visits. Thus, $1.28 + 0.65 + 0.65 = 2.58$ RVUs for carotid stent.

SUMMARY:

	93580 Perc ASD Closure	372x1 CAROTID STENT built from Perc ASD
Pre-service:	0.46	1.93
Intra-service:	16.17	13.88
Post, Day of Service:	1.34	1.73
Post, following DoS:	0.00	2.58
Total Service	17.97 (=2004 MFS)	20.12

This comparison justifies an RVW for carotid stenting of 20.12 RVUs, slightly greater than the 25th percentile survey RVW of 18.86. As provided above, building carotid stent with embolic protection from TIPS results in a value of

17.12, building it from key reference coronary stent results in an RVW of 18.75, and building it from Percutaneous ASD closure supports a value of 20.12. The 25th percentile survey RVW of 18.86 is comfortably nestled among these three, and therefore appears to be a solid RVW choice.

IWPUT COMPARISON OF 372X1 CAROTID STENT WITH EMBOLIC PROTECTION TO KEY REFERENCE 92980 CORONARY STENT

IWPUTs for complex percutaneous stenting and device deployment procedures range from 0.106 to 0.135. The following IWPUT analysis indicates that at the 25th percentile survey RVW of 18.86, carotid stent placement has an IWPUT of 0.122. This is 15% greater than coronary stent placement, but justifiable in light of the 36% increment in intra-service intensity/complexity documented by the 17 survey respondents who rated intra-service intensity and complexity of carotid stent at 4.88 compared to coronary stent at 3.59. It is clear that physicians who provide both services with high frequency believe carotid stenting is substantially more intense and complex than coronary stenting.

IWPUT OF CPT 372X1 CAROTID STENT WITH EMBOLIC PROTECTION AT THE RECOMMENDED 25th PERCENTILE SURVEY RVW

372X1 Carotid Stent with embolic protection at the 25th % RVW: 18.86

	25 th Percentile Svy Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	81	0.0224	1.81
Pre-service scrub, dress, wait	17	0.0081	0.14
Pre-service total			1.95
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	0	1.51	0.00
99232	1	1.06	1.06
99231	0	0.64	0.00
99238	1	1.28	1.28
99239	0	1.75	0.00
99215	0	1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	0	0.43	0.00
99211	0	0.17	0.00
Post-service total			4.31
Intra-service:	Time	IWPUT	INTRA-RVW
	103	0.122	12.60

IWPUT OF KEY REFERENCE CPT 92980 CORONARY STENT PLACEMENT:

92980 2004 MFS RVW: 14.82

	Survey time	Std RUC intensity	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	30	0.0224	0.67

Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			0.79

Post-service:	Time	Intensity	(=time x intensity)
Immediate post	60	0.0224	1.34

Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
99233	0	1.51	0.00
99232	0	1.06	0.00
99231	0	0.64	0.00
99238	0	1.28	0.00
99239	0	1.75	0.00
99215	0	1.73	0.00
99214	0	1.08	0.00
99213	0	0.65	0.00
99212	0	0.43	0.00
99211	0	0.17	0.00
Post-service work total			1.34

	Time	IWPUT	INTRA-RVW
Intra-service coronary stent IWPUT: 120		0.106	12.68

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) The typical carotid stent patient will be reported exclusively with this single new CPT code. There are clinical situations, however, when other CPT codes may be reported simultaneously. This will be determined by the clinical status of the patient, especially whether his or her symptoms lateralize exclusively to the hemisphere undergoing stent placement. There may be indications to selectively catheterize the contralateral carotid artery, the vertebral arteries, or to perform a formal full diagnostic study of the aortic arch.

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. Patient with classic right hemispheric TIAs and critical right internal carotid stenosis by duplex also has bothersome but less dramatic left hemispheric symptoms. Carotid duplex suggests ulceration of proximal left internal carotid, but duplex is not sensitive or specific for diagnosis of carotid ulceration. Pt will undergo right carotid stent placement, but she also needs a formal arch study and selective catheterization of the left carotid to assess source of left-sided symptoms.

3.

4. THIS IS NOT THE TYPICAL CAROTID STENT PATIENT:

5. CPT	Global	04 RVW	Mult Proc Pay Reduction
6. 372X1: Carotid stent w embolic protection	90	18.86	18.86
7. 36216 Selective 2 nd order cath left carotid	0	5.27	2.64
8. 75650 Arch S&I	XXX	1.49	1.49
9. 75676 Unilat cervical carotid S&I	XXX	1.31	1.31
10. 75665 Unilat cerebral S&I	XXX	1.31	1.31
11. Total RVW			25.25

12.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0005T Transcatheter placement of extracranial cerebrovascular artery stent(s) percutaneous; initial vessel

0006T Transcatheter placement of extracranial cerebrovascular artery stent(s) percutaneous; each additional vessel (List separately in addition to code for primary procedure)

0007T Transcatheter placement of extracranial cerebrovascular artery stent(s) percutaneous; radiological supervision and interpretation, each vessel

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology/Neurology

How often? Sometimes

Specialty Radiology/Interventional Radiology/Neuroradiology

How often? Sometimes

Specialty Vascular Surgery / Neurosurgery

How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 18000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Card/Neuro	Frequency 9000	Percentage 50.00 %
----------------------	----------------	--------------------

Specialty Rad/IR/NR	Frequency 4500	Percentage 25.00 %
---------------------	----------------	--------------------

Specialty VS/NS	Frequency 4500	Percentage 25.00 %
-----------------	----------------	--------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Card/Neuro	Frequency 7500	Percentage 50.00 %
----------------------	----------------	--------------------

Specialty Rad/IR/NR	Frequency 3750	Percentage 25.00 %
---------------------	----------------	--------------------

Specialty VS/NS	Frequency 3750	Percentage 25.00 %
-----------------	----------------	--------------------

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. 35301Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision (PLI RVU = 2.69) is a better crosswalk because the reference code is a 000 day lobal code and 35301 is a 90 day code, same as the new code.

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

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

Recommended Work Relative Value

CPT Code:37216 Tracking Number: AB2 Global Period: 090 Specialty Society RVU: **18.13** RUC RVU: **17.98**

CPT Descriptor: Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection.

(37215 and 37216 include all ipsilateral selective carotid catheterization, all diagnostic imaging for ipsilateral, cervical and cerebral carotid arteriography, and all related radiological supervision and interpretation. When the ipsilateral carotid arteriogram (including imaging and selective catheterization) confirms the need for carotid stenting, codes 37215 and 37216 are inclusive of these services. If carotid stenting is not indicated, then the appropriate codes for carotid catheterization and imaging should be reported in lieu of code 37215 and 37216)

(Do not report 37215, 37216 in conjunction with 75671, 75680)

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

A 66-year-old male underwent a left carotid endarterectomy one year ago. An initial postoperative duplex exam at one month demonstrated a widely patent carotid bifurcation, but follow-up at 6 months revealed early recurrent stenosis in the 50-79% range. Repeat duplex scanning at 12 months identified progression to 80-99% diameter reduction. The diagnosis is intimal hyperplasia at the endarterectomy site causing a severe to critical recurrent stenosis. The patient is 10 years post coronary bypass surgery. He developed recurrent angina recently and suffered a myocardial infarction one month ago. Cardiac catheterization revealed diffuse distal disease and an ejection fraction of 30%. He has angina at low levels of exercise. Discussion with a surgeon who performs carotid endarterectomy leads to agreement that the patient is at high risk for open surgery. Carotid stent placement is therefore recommended.

NOTE: The new code includes selective carotid access, all diagnostic imaging for ipsilateral common carotid, bifurcation and cerebral vessels, plus all radiological supervision and interpretation. Additionally, when the physician work of the initial ipsilateral carotid arteriogram (including imaging and access) confirms the need for carotid stenting, code 37216 is inclusive of these services. If carotid stenting is not indicated then the appropriate codes for carotid catheterization and imaging would be reported in lieu of code 37216

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 90%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work:

- The patient's history and pertinent non-invasive diagnostic studies are reviewed, with special attention to cerebrovascular symptoms, cardiac and other co-morbidities that would place the patient at high risk for surgery.
- Physical exam is reviewed to ensure that the patient has palpable femoral pulses, suitable for percutaneous access.
- Special attention is given to medications, including antiplatelet agents and anticoagulants that the patient may be taking or needs to be taking.
- All pre-procedural blood tests are reviewed, focusing on coagulation and renal function studies. If renal insufficiency is present, attention is given to whether patient has received appropriate renal protective agents and hydration.
- Based on review of all previous diagnostic studies, the physician estimates the range of guiding catheters/sheaths, guide wires, selective catheters, balloons, and stents that may be required, and ensures that all are available for use.

(This procedure requires a substantial inventory of equipment, and absence of any single piece can disable the effort. Thus, this task cannot be taken lightly.)

- Procedure details, including alternatives and risks, are discussed with patient and family. Finally, informed consent is reviewed with patient and family.
- Careful baseline neurological examination is performed.

PRE-SERVICE RADIOLOGICAL SUPERVISION AND INTERPRETATION WORK

- The interventional suite is checked to ensure proper function and configuration of the imaging equipment including compliance with all radiation safety issues.
- The physician ensures that all technical personnel have been familiarized with the carotid stent technique and are fully familiar with all required devices. Physician supervises selection of all equipment, including catheters, wires, balloons, stents, sheaths, contrast material, etc., and assures that all needed equipment is available.
- Prior films/studies are located and reviewed.
- Don radiation protection
- Position (or supervise proper positioning of) patient

Description of Intra-Service Work:

ALL RADIOLOGICAL IMAGING AND SUPERVISION WORK IS INCLUDED

- Direct technical personnel throughout procedure
- Interpretation of imaging of the vessel being treated, including complete intracranial and extracranial views of the target vessel in all views necessary
- Ensure accurate radiological views, exposures, shielding, image size, injection sequences, radiation protection and management for patient and staff
- Real-time analysis of all imaging during procedure, including pre-treatment imaging, fluoroscopic and angiographic imaging throughout the procedure as required to perform the procedure, and post-procedure fluoroscopic and angiographic imaging. This includes all imaging to manipulate the wires, catheters, and devices, into position, plus correct positioning and deployment of stent, opening balloon, assessing post-op success and complications, complete intra and extracranial study post-stent, and removal of catheters.
- Quantitative Measurement of the lesion and target vessel to determine appropriate balloon and stent sizes

INITIAL ARTERIAL ACCESS AND MONITORING

- Ensure ECG and hemodynamic monitors are in place and functioning
- All following steps are performed under fluoroscopic guidance
- Puncture common femoral artery for insertion of 6F sheath

BASELINE CERVICAL AND CEREBRAL ANGIOGRAPHY & QUANTITATIVE MEASUREMENT

- Advance standard .035 guidewire into aortic arch at base of great vessels
- Carotid configuration catheter advanced to aortic arch
- Roadmap common carotid artery origin and proximal segment
- Remove standard .035 wire and replace with .035 hydrophilic wire
- Insert carotid-selective reverse curve catheter into guiding sheath over hydrophilic wire
- Administer IV heparin
- Reform shape of carotid-selective catheter in aortic arch
- Use this carotid catheter to selectively catheterize origin of common carotid artery
- Inject contrast to perform initial roadmap arteriogram of common carotid and bifurcation
- Perform cervical carotid angiography in AP and lateral views
- Perform quantitative measurements of the vessels including area of stenosis
- Perform cerebral angiography including lateral and AP Towne views
- Place catheter to continuous heparin flush

SELECTION OF APPROPRIATE STENT

- Choose equipment based on results of quantitative measurements

- Connect side-arm of long guiding sheath to arterial pressure transducer
- Perform focused arteriogram of bifurcation and distal internal carotid thru guiding sheath

EXCHANGE FOR GUIDING CATHETER/SHEATH

- Advance .035 hydrophilic wire under roadmap into external carotid
- Advance catheter into external carotid
- Remove hydrophilic wire, insert stiff .035 wire
- Exchange long guiding sheath into common carotid, over the carotid-selective catheter
- Remove wire and carotid-selective catheter
- Check ACT to ensure adequate anticoagulation

PLACEMENT OF SMALL DIAMETER WIRE ACROSS LESION

- Load .014 wire, advance into common carotid
- Perform high magnification pre-deployment arteriogram of carotid bifurcation
- Check patient neurological status now and throughout case at intervals
- Advance and maneuver .014 wire across lesion into distal extracranial internal carotid with careful positioning using confirming angiography and road-mapping

PRE-STENT CAROTID ANGIOPLASTY

- Prepare angioplasty balloon to be air-free
- Advance 3-4 mm low-profile balloon across lesion and check position
- Administer Atropine
- Insufflate balloon to pre-dilate lesion
- Remove balloon

CAROTID STENT PLACEMENT

- Prepare stent delivery system to be air-free
- Load appropriately sized self-expanding stent into guiding catheter
- Advance stent delivery catheter very carefully across lesion
- Perform final angiographic check to ensure exact positioning
- Deploy stent
- Remove stent delivery device
- Load and advance 5-6 mm balloon
- Position balloon within stent and inflate for post dilatation
- Check ECG for bradycardia or other arrhythmia, treat as needed with IV meds

FINAL CAROTID AND CEREBRAL ANGIOGRAPHY

- Perform completion bifurcation arteriogram
- Check carefully for residual stenosis, dissection, vasospasm
- Treat any of above if present (e.g. nitroglycerin for vasospasm)
- Perform completion intra-cerebral arteriogram in lateral and Towne views
- Review cerebral images in detail for emboli, vasospasm, cross-filling etc
- Exchange .014 wire for .035 guidewire through guiding sheath
- Remove guiding sheath/catheter from common carotid
- Remove guiding sheath and guidewire from puncture site

GROIN MANAGEMENT

- Remove sheath and attain hemostasis

NEUROLOGIC ASSESMENT

- Final neurological check

Description of Post-Service Work:

- Ensure BP, HR are stable and normal upon arrival to recovery area
- Thorough neurological exams at frequent intervals
- Write post-op orders.
- Communicate with family & referring physicians
- Review results of procedure with patient when sedation wears off
- Review and interpret all images
- Review and record patient fluoroscopic exposure time & contrast administration volume
- Dictate procedure note
- Review, revise, sign final report
- Send formal report to PCP and referring providers
- Daily in-hospital E&M visits, orders, notes, communication, etc.
- Discharge day management including communication with PCP, family etc
- All post-procedure outpatient office visits within the global period

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2002				
Presenter(s):	ACC: Chris Cates MD, Ken Brin MD, and/or Joseph Babb MD; SIR: Bob Vogelzang MD and/or Kathy Krol MD; ACR: Bibb Allen MD; SVS: Gary Seabrook MD; ASITN: John Barr MD; AANS: John Wilson MD; AAN: Jim Anthony MD					
Specialty(s):	AAN, AANS, ACC, ACR ASITN, SCAI, SIR, SVS					
CPT Code:		37216				
Sample Size:	400	Resp n:	81	Response:	%	
Sample Type: Random						
		Low	25th pctl	Median*	75th pctl	High
Survey RVW:		13.07	18.53	21.06	26.21	37.67
Pre-Service Evaluation Time:				60.0		
Pre-Service Positioning Time:				15.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		50.00	80.00	97.00	120.00	207.00
Post-Service	Total Min**	CPT code / # of visits				
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>30.0</u>	99231x 0.0	99232x 1.0	99233x 0.0		
Discharge Day Mgmt:	<u>36.0</u>	99238x 1.00	99239x 0.00			
Office time/visit(s):	<u>46.0</u>	99211x 0.0	12x 0.0	13x 2.0	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
92980

Global
000

Work RVU
14.82

CPT Descriptor Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

Other Reference CPT Code
372X1

Global
090

Work RVU
18.86

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection.

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

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

Number of respondents who choose Key Reference Code: 18 % of respondents: 22.2 %

TIME ESTIMATES (Median)

New/Revised
CPT Code:
37216

Key
Reference
CPT Code:
92980

Median Pre-Service Time	90.00	45.00
Median Intra-Service Time	97.00	120.00
Median Immediate Post-service Time	30.00	60.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	0.00
Median Discharge Day Management Time	36.0	0.00
Median Office Visit Time	46.0	0.00
Median Total Time	329.00	225.00

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	4.06	3.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.47	3.59
Urgency of medical decision making	3.76	3.41

Technical Skill/Physical Effort (Mean)

Technical skill required	4.65	3.65
Physical effort required	4.65	3.41

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.71	3.18
Outcome depends on the skill and judgment of physician	4.76	3.47
Estimated risk of malpractice suit with poor outcome	4.71	3.18

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.65	3.35
Intra-Service intensity/complexity	4.82	3.35
Post-Service intensity/complexity	4.24	3.06

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.*

SUMMARY OF ADDITIONAL RATIONALE

The multispecialty Consensus Panel that reviewed the survey results determined that the median survey RVW of 21.06 is too high. We recommend an RVW of 18.13 slightly less than the 25th percentile RVW of 18.53. Our recommendation of 18.13 is based primarily on maintaining proper work and time relationships to the sister code 372X1, but it is also strongly validated in comparison to 3 RUC-surveyed reference services.

Building an RVW for carotid stent without embolic protection from key reference coronary stent (92980) results in an RVW for the new service of 18.39, slightly greater than our recommendation. This comparison is based on a large number of survey responses from physicians who perform both services frequently. Additional analyses building RVWs for 372X2 from RUC-surveyed reference services 37182 Transvenous Intrahepatic Portocaval Shunt (TIPS) and 93580 Percutaneous ASD Closure result in RVWs of 16.80 and 19.72 respectively, thereby bracketing our recommended value of 18.13. Overall, with comparison to the key reference coronary stent, buttressed by RVW estimates built from TIPS and Percutaneous ASD closure, the Panel believes an RVW of 18.13 is the best relative value for 372X2. Details of the analysis are provided below.

DETAILS:

Surveys were distributed to a large number of physicians representing specialties and sub-specialties of medicine (Cardiology & Neurology), surgery (Neurosurgery and Vascular Surgery, and radiology (Radiology, Interventional Radiology and Neuroradiology). A large number of survey responses were collected, 34 from the medicine specialties, 24 from radiology specialties and 23 from surgical specialties. Analysis of these three datasets by standard median

techniques revealed significant differences in median RVWs and times among the groups. Since there are no available frequency data to predict accurately what percentage of these procedures will be performed by each specialty, the consensus panel felt the only fair method to analyze the survey data was to weigh the individually determined median values equally. This approach was used by the RUC in April 2000 when radiology and surgery submitted different numbers of surveys with different median data on the family of endovascular AAA repairs. This method was therefore used here to determine the RVU and time values in the data tables provided on previous pages.

With respect to choice of key reference service to be entered in the table above, the Panel chose RUC-surveyed 92980 percutaneous coronary stent placement rather than the more commonly cited, CPT 35301 carotid endarterectomy, for several reasons. First, it was determined that 16 of the 22 respondents (73%) who chose carotid endarterectomy as reference service were from cardiology, neurology or radiology, specialties where experience with carotid endarterectomy would most likely rely on medical school memories. Indeed, of those 16 medical and radiology specialists who chose carotid endarterectomy as reference service, 12 listed "0" as their experience with the reference, two left that spot blank on the survey, while two cardiologists noted recent experience (n=10, 50) with carotid surgery. The Panel agreed that this general lack of experience discredited the choice of carotid endarterectomy as the "key" reference service to be used in this analysis or entered in the RUC database. Second, we felt that CPT 92980 represented a strong comparison service from a clinical perspective. It was chosen by almost as many survey respondents (18), 83% of whom listed high levels of experience with both coronary stent and carotid stent. The ability to compare relative work is therefore more credible using coronary stent as key reference. Although 92980 is a 0-day global service, all other technical and clinical aspects of carotid stent and coronary stent are directly comparable. Both services require the utmost in catheter skills, and both have extreme intensity and complexity from start to finish. In addition, both carotid stent and coronary stent are very high risk in terms of consequences of a bad outcome, including catastrophes such as stroke, myocardial infarction, and death. For all these reasons we felt 92980 should be the key reference service despite its status as second most commonly chosen reference.

In addition to 92980, survey respondents chose two other percutaneous reference services that our consensus panel felt were appropriate to merit consideration in valuing the new carotid stent service. These are the radiology service CPT 37182 Transvenous Intrahepatic Portocaval Shunt, and cardiology service CPT 93580 Percutaneous Closure of an Atrial-Septal Defect. Both of these reference services underwent RUC survey in 2002.

BUILDING AN RVW FOR 372X2 CAROTID STENT WITHOUT EMBOLIC PROTECTION FROM 92980 CORONARY STENT

Coronary stent placement 92980 is a 0-day global service with a pre-service time of 45-minutes, intra-service time of 120-minutes, and a post-service time of 60-minutes. Coronary stent has an RVW of 14.82. Since it is a 0-day global, all in-hospital and office visits following the day of procedure are reported separately. In order to build an RVW for the 90-day carotid stent procedure from the coronary stent, we must start by comparing the pre- and intra-service components of the two services, then add the inpatient and outpatient visits established by survey for carotid stent. The following analysis provides that step-by-step calculation.

PRE-SERVICE WORK: Assuming the 45-minutes of coronary stent pre-service time represents 30-minutes of evaluation and 15-minutes of scrub/prep/drape, the survey respondents felt carotid stent has 51-minutes more evaluation time and 2-minutes more prep time than coronary stent. The difference represents 1.14 RVUs ($51 \times 0.022 + 2 \times 0.008$) in favor of carotid stent. Since Pre-service work for coronary stent is 0.79 RVUs (see IWPUT table on next page), the pre-service work for carotid stent is 1.93 RVUs.

INTRA-SERVICE WORK: Intra-service time is 120-minutes for coronary stent and 100-minutes for carotid stent without embolic protection (Note, in this and the following analyses, we use the 100-minute intra-service time determined by survey respondents, rather than the 97-minute intra-service time that is our ultimate Panel recommendation). The 18 respondents (61% Cardiologists) who chose coronary stent as their reference service rated a striking intra-service intensity difference of carotid stent at 4.82 compared to 3.35 for coronary stent (see "Intra-service intensity/ complexity from table above). The RUC has never tested linearity of these intensity measures, but this represents a 44% increment in intra-service intensity/complexity of carotid stent > coronary stent. By building block method, 12.68 RVUs are assigned to intra-service work for coronary stent. Even if we estimate the quantitative intensity relationship to be less than half the 44% listed by survey respondents (assume a 15% intensity/complexity increment), this exercise can generate an appropriate intra-service work for carotid stent from coronary stent by first adjusting intra-service time (shorter for carotid), then adjusting intensity (higher for carotid). With a time adjustment factor of $100/120 = 0.833$, and an intensity factor of 15%, ($= 1.15$), the intra-service work of carotid stent may be calculated as follows. Intra-service work of carotid = intra-service work of coronary stent x time adjustment x intensity adjustment = $12.68 \times 0.833 \times 1.15 = 12.15$ RVUs.

POST-SERVICE WORK ON DAY OF SERVICE: Coronary stent has 60-minutes of post-service time to complete the 0-day global. Carotid stent has 30 minutes of immediate post-service time plus a 99232 a hospital visit at end of day. Thus, on the day of service coronary stent has 1.34 post-service RVUs, while carotid stent has 1.73 RVUs.

POST-SERVICE WORK AFTER DAY OF SERVICE: Coronary stent has none since it is a 0-day global. Carotid stent has a discharge visit and 2 outpatient visits. Post-service work following day-of-service is 0 RVUs for coronary stent, and 2.58 RVUs for carotid stent.

SUMMARY: BUILDING RVW FOR CAROTID STENT W/O EMBOLIC PROTECTION FROM CORONARY STENT:

	92980 Coronary stent	372X2 Carotid Stent without embolic protection
Pre-service RVUs	0.79	1.93
Intra-service RVUs	12.68	12.15
Post-service RVUs, Day of Service	1.34	1.73
Post-service RVUs, after Day of Svce	0.00	2.58
Total Service	14.82 RVUs (=2004 MFS)	18.39 RVUs

This comparison is sensitive to both the intra-service time discrepancy and the relative intra-service intensity of carotid stent compared to coronary stent. It builds an RVW of 18.39 for the new service based on the key reference service, and it provides strong justification for the recommended RVW of 18.13.

BUILDING AN RVW FOR 372X2 CAROTID STENT WITHOUT EMBOLIC PROTECTION FROM CPT 37182 TIPS

This comparison determines an RVW for carotid stenting based on the RUC-surveyed radiology service CPT 37182, Transvenous Intrahepatic Portocaval Shunt (TIPS). TIPS is a complex multi-step percutaneous stenting procedure typically performed in extremely ill patients. TIPS includes all associated radiological supervision and interpretation, and in that sense it is equivalent to the new carotid stent service. The RUC surveyed TIPS in 2002.

CPT 37182 TIPS

Global Period: 0-days

2004 RVW = 16.97

Pre-service: 30-minutes

Intra-service: 150-minutes

Post-service: 30-minutes

IWPUT = 0.106

In order to construct an RVW for carotid stent without embolic protection from TIPS, adjustments must be made in all 4 service compartments:

PRE-SERVICE WORK: TIPS has 30-minutes of pre-service time in the RUC database. Assuming that represents 15-minutes of evaluation and 15-minutes of scrub/prep/drape, then carotid stent has 66-minutes additional evaluation time and 2-minutes more prep time than TIPS. The difference represents 1.47 RVUs in favor of carotid stent ($66 \times 0.022 + 2 \times 0.008$). Total Pre-service work for TIPS is 0.46 RVUs, and based on that, Pre-service work for carotid stent is 1.93 RVUs.

INTRA-SERVICE WORK: Intra-service time for carotid stent without embolic protection is 100-minutes, while TIPS intra-service time is 150-minutes. We do not have a direct comparison of intra-service intensity of TIPS to carotid stent because insufficient survey respondents chose this service to determine a numerical intensity relationship (that's the primary reason why the coronary stent analysis is more robust than this one). Thus, the basic approach must assume intensity equivalence, making an adjustment for time only. Intra-service work of TIPS is 15.84. Based on a time adjustment (without intra-service intensity adjustment) the intra-service work of carotid stent without embolic protection may be estimated at $100/150 \times 15.84 = 10.56$.

POST-SERVICE WORK ON DAY OF SERVICE: TIPS has 30-minutes of post-service time to complete the 0-day global. Carotid stent has 30 minutes of immediate post-service time and one 99232 hospital visit. Thus, on the day of service TIPS has 0.67 post-service RVUs, while carotid stent has $0.67 + 1.06 = 1.73$ RVUs.

POST-SERVICE WORK AFTER DAY OF SERVICE: TIPS has none since it is a 0-day global. Carotid stent has a discharge visit and 2 outpatient visits. Thus, $1.28 + 0.65 + 0.65 = 2.58$ RVUs for carotid stent.

SUMMARY:

	37182 TIPS	372X2 CAROTID STENT WITHOUT EMBOLIC PROTECTION
Pre-service:	0.46	1.93
Intra-service:	15.84	10.56
Post, Day of Service:	0.67	1.73
Post, following DoS:	0.00	2.58
Total Service	16.97 (=2004 MFS)	16.80

This comparison justifies an RVW for carotid stenting of 16.80 RVUs, somewhat less than our recommended value of 18.13, but the analysis lacks any adjustment for intra-service intensity of the carotid stent in comparison to TIPS. If, for

instance, the complexity/intensity relativity of carotid stent compared to TIPS is just 5-10% greater, that would bring the total RVW very close to the recommended value of 18.13.

BUILDING AN RVW FOR 372X2 CAROTID STENT WITHOUT EMBOLIC PROTECTION FROM CPT 93580 Percutaneous ASD Closure

The following comparison relates carotid stenting to the RUC-surveyed cardiology service CPT 93580, Percutaneous catheter closure of congenital interatrial communication. Perc ASD is another complex multi-step percutaneous stenting procedure that was surveyed by the RUC in 2002.

CPT 93580 Percutaneous ASD
 Global Period: 0-days
 2004 RVW: 17.97
 Pre-service time: 30-minutes
 Intra-service time: 120-minutes
 Post-service time: 60 minutes
 IWPUT: 0.135

In order to construct an RVW for carotid stent without embolic protection from Perc ASD, adjustments must be made in all 4 service compartments:

PRE-SERVICE WORK: Perc ASD has 30-minutes of pre-service time in the RUC database. Assuming that represents 15-minutes of pre-service evaluation and 15-minutes of scrub/prep/drape, then carotid stent has 66-minutes more evaluation time and 2-minutes more prep time than Perc ASD. The difference represents 1.47 RVUs in favor of carotid stent ($66 \times 0.022 + 2 \times 0.008$). Total Pre-service work for Perc ASD is 0.46 RVUs, and based on that, Pre-service work for carotid stent is 1.93 RVUs.

INTRA-SERVICE WORK: Intra-service time for carotid stent without embolic protection is 100-minutes, while Perc ASD intra-service time is 120-minutes. We do not have a direct comparison of intra-service intensity of Perc ASD to carotid stent because insufficient survey respondents chose this service to create a numerical intensity analysis (that's the primary reason why the coronary stent comparison is more robust). Thus, the basic approach must assume intensity equivalence, making an adjustment for time only. Intra-service work of Perc ASD is 16.17. Based on a time adjustment (without an intra-service intensity adjustment) the intra-service work of carotid stent may be estimated at $100/120 \times 16.17 = 13.48$.

POST-SERVICE WORK ON DAY OF SERVICE: Perc ASD has 60-minutes of post-service time to complete the 0-day global. Carotid stent has 30 minutes of immediate post-service time and one 99232 hospital visit. Thus, on the day of service Perc ASD has 1.34 post-service RVUs, while carotid stent has $0.67 + 1.06 = 1.73$ RVUs.

POST-SERVICE WORK AFTER DAY OF SERVICE: Perc ASD has none since it is a 0-day global. Carotid stent has a discharge visit and 2 outpatient visits. Thus, $1.28 + 0.65 + 0.65 = 2.58$ RVUs for carotid stent.

SUMMARY:

	93580 Perc ASD Closure	372x1 CAROTID STENT
Pre-service:	0.46	1.93
Intra-service:	16.17	13.48
Post, Day of Service:	1.34	1.73
Post, following DoS:	0.00	2.58
Total Service	17.97 (=2004 MFS)	19.72

This comparison justifies an RVW for carotid stent without embolic protection of 19.72 RVUs, slightly greater than the RVW of 18.53 recommended by the Panel. As provided above, building carotid stent without embolic protection from

the TIPS reference service arrives at an RVW of 16.80, while building it from Perc ASD closure supports an RVW 19.72. The recommended RVW of 18.13 for carotid stent without embolic protection is comfortably nestled between these two, and therefore appears to be a solid choice.

BUILDING AN RVW FOR 372X2 CAROTID STENT WITHOUT EMBOLIC PROTECTION FROM CPT 372X1 CAROTID STENT WITH EMBOLIC PROTECTION

The Consensus Panel reviewed all the information and analyses presented above, and it would appear that the 25th percentile survey value of 18.53 is appropriate for 372X2 based on comparison with the three reference services. A concern was identified, however, that if we were to recommend 18.53, there would be only a 0.33 RVU difference between 372X1 and 372X2 ($18.86 - 18.53 = 0.33$). The delta represents the difference between providing the carotid stent with vs. without distal embolic protection, and as such, 0.33 RVUs seems an inadequate representation of the high intensity work of deploying and removing the embolic protection device. Likewise, the 3-minute intra-service time difference between 103-minutes for stent with embolic protection and 100-minutes for stent without embolic protection, seems too brief to represent the time of embolic protection deployment and removal. After some discussion, the Panel agreed that the time to deploy and remove the embolic protection device is more accurately represented at 6-minutes, and the work of embolic protection should be calculated as time x the IWPUT of the primary service (0.122), thus $6\text{-minutes} \times 0.122 = 0.73$ RVUs. As the final RVW recommendation for carotid stenting without embolic protection, we recommend that 372X2 be determined by subtracting 0.73 RVUs from the recommended value of the sister service 372X1 (carotid stent with embolic protection). Thus, the Panel recommends an RVW of $18.86 - 0.73 = 18.13$.

IWPUT COMPARISON OF 372X2 CAROTID STENT WITHOUT DISTAL EMBOLIC PROTECTION TO KEY REFERENCE 92980 CORONARY STENT

IWPUTs for complex percutaneous procedures range from 0.106 to 0.135. The following IWPUT analysis indicates that at the recommended RVW of 18.13 (less than the 25th percentile survey RVW), carotid stent placement without distal embolic protection has an IWPUT of 0.122. This is 15% greater than coronary stent placement, but justifiable in light of the 44% increment in intra-service intensity/complexity documented by the 18 survey respondents who rated intra-service intensity and complexity of carotid stent at 4.82 compared to coronary stent at 3.35. It is clear that physicians who provide both services with high frequency believe carotid stenting is substantially more intense and complex than coronary stenting. An IWPUT of 0.122 places carotid stent without embolic protection well within the range of RUC-surveyed percutaneous service IWPUTS of 0.106 to 0.135. In addition, at the recommended RVW of 18.13, carotid stent without embolic protection will have the same IWPUT as carotid stent with embolic protection. The Consensus Panel felt that is appropriate from a clinical perspective.

IWPUT OF KEY REFERENCE CPT 92980 CORONARY STENT PLACEMENT:

92980 2004 MFS RVW: 14.82

	Survey time	Std RUC intensity	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	30	0.0224	0.67
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			0.79
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	60	0.0224	1.34
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
99233	0	1.51	0.00
99232	0	1.06	0.00

99231	0	0.64	0.00
99238	0	1.28	0.00
99239	0	1.75	0.00
99215	0	1.73	0.00
99214	0	1.08	0.00
99213	0	0.65	0.00
99212	0	0.43	0.00
99211	0	0.17	0.00
Post-service work total			1.34

	Time	IWPUT	INTRA-RVW
Intra-service coronary stent IWPUT: 120		0.106	12.68

IWPUT OF CPT 372X2 CAROTID STENT WITHOUT DISTAL EMBOLIC PROTECTION AT THE RVW RECOMMENDED BY CONSENSUS PANEL, 18.13.

372X2 Carotid Stent without distal embolic protection at RVW 18.53 (less than 25th percentile)

	Time	RUC Std. Intensity	RVW (=time x intensity)
Pre-service:			
Pre-service eval & positioning	81	0.0224	1.81
Pre-service scrub, dress, wait	17	0.0081	0.14
Pre-service total			1.95
Post-service:			
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
99233	0	1.51	0.00
99232	1	1.06	1.06
99231	0	0.64	0.00
99238	1	1.28	1.28
99239	0	1.75	0.00
99215	0	1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	0	0.43	0.00
99211	0	0.17	0.00
Post-service total			4.31

	Time	IWPUT	INTRA-RVW
Intra-service:	97	0.122	11.87

CONCLUSION

Based on all considerations and data, the multispecialty Consensus Panel recommends an RVW of 18.13 as the best relative value for 372X2. The difference in RVUs and time between 371X1 and 372X2 represent the work of deploying and retrieving the embolic protection device, which is present in 372X1 but not in 372X2. In order for the times of 372X2 to also be consistent with those of 372X1, we recommend reduction of the survey median intra-service time listed in the table above from 100-minutes to 97-minutes, and reduction in total service minutes from 340 to 337.

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) The typical carotid stent patient will be reported exclusively with this single new CPT code. There are clinical situations, however, when other CPT codes may be reported simultaneously. This will be determined by the clinical status of the patient, especially whether his or her symptoms lateralize exclusively to the hemisphere undergoing stent placement. There may be indications to selectively catheterize the contralateral carotid artery, the vertebral arteries, or to perform a formal full diagnostic study of the aortic arch.

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. Patient with classic right hemispheric TIAs and critical right internal carotid stenosis by duplex also has bothersome but less dramatic left hemispheric symptoms. Carotid duplex suggests ulceration of proximal left internal carotid, but duplex is not sensitive or specific for diagnosis of carotid ulceration. Pt will undergo right carotid stent placement, but she also needs a formal arch study and selective catheterization of the left carotid to assess source of left-sided symptoms.

3.	THIS IS NOT THE TYPICAL CAROTID STENT PATIENT:			
4.				
5.	CPT	Global	04 RVW	Mult Proc Pay Reduction
6.	372X1: Carotid stent w embolic protection	90	18.86	18.86
7.	36216 Selective 2 nd order cath left carotid	0	5.27	2.64
8.	75650 Arch S&I	XXX	1.49	1.49
9.	75676 Unilat cervical carotid S&I	XXX	1.31	1.31
10.	75665 Unilat cerebral S&I	XXX	1.31	1.31
11.	Total RVW			25.25

12.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0005T Transcatheter placement of extracranial cerebrovascular artery stent(s) percutaneous; initial vessel

0006T Transcatheter placement of extracranial cerebrovascular artery stent(s) percutaneous; each additional vessel (List separately in addition to code for primary procedure)

0007T Transcatheter placement of extracranial cerebrovascular artery stent(s) percutaneous; radiological supervision and interpretation, each vessel

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology/Neurology How often? Sometimes

Specialty Radiology/Interventional Radiology/Neuroradiology How often? Sometimes

Specialty Vascular Surgery / Neurosurgery How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 18000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Card/Neuro	Frequency 9000	Percentage	%
Specialty Rad/IR/NR	Frequency 4500	Percentage	%
Specialty VS/NS	Frequency 4500	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Card/Neuro	Frequency 7500	Percentage	%
Specialty Rad/IR/NR	Frequency 3750	Percentage	%
Specialty VS/NS	Frequency 3750	Percentage	%

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Long Descriptor: 37215

Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

(37215 and 37216 include all ipsilateral selective carotid catheterization, all diagnostic imaging for ipsilateral, cervical and cerebral carotid arteriography, and all related radiological supervision and interpretation. When the ipsilateral carotid arteriogram (including imaging and selective catheterization) confirms the need for carotid stenting, codes 37215 and 37216 are inclusive of these services. If carotid stenting is not indicated, then the appropriate codes for carotid catheterization and imaging should be reported in lieu of code 37215 and 37216)

(Do not report 37215, 37216 in conjunction with 75680, 75681)

(For transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), see Category III codes 0075T and 0076T)

Sample Size: N/A Response Rate: (%): N/A Global Period: 090

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

Standard RUC/PEAC times for 90-day global period pre-service in-facility activities and post-procedure office visits were applied. Physician representatives from all eight of the sponsoring organizations reviewed and approved the recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Review test/exam results
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

Post-Service Clinical Labor Activities:

- Greet patient, escort to room
- Provide gowning
- Interval history & vital signs & chart
- Assemble previous test reports/results
- Assist physician during exam

Post-Service Clinical Labor Activities (continued):

- 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

Total Staff Time Out of Office: 132 minutes

Visits in Global Period: 2 X 99213

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 and Source (if applicable)
L037D	RN/LPN/MTA	60				2	72	

*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 2004. 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)
	PEAC Multi-specialty Supply Pkg	2		

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

CMS's Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)
E11001	Exam table	

* From CMS'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: FACILITY

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 <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>5</u>	<u>RN/LPN/MTA</u> Other _____
Coordinate pre-surgery services/review test/exam results <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>20</u>	<u>RN/LPN/MTA</u> Other _____
Schedule space and equipment in facility <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>8</u>	<u>RN/LPN/MTA</u> Other _____
Office visit before surgery/procedure	_____	RN, LPN, MA, Other _____
Review test and exam results	_____	
Provide pre-service education/obtain consent <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>20</u>	<u>RN/LPN/MTA</u> Other _____
Follow-up phone calls & prescriptions <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>7</u>	<u>RN/LPN/MTA</u> Other _____
Other Activity (please specify)	_____	RN, LPN, MA, Other _____

End: When patient enters hospital for surgery/procedure

Service Period

Start: Patient admitted to hospital for surgery/procedure

Pre-service services

Review charts	_____	RN, LPN, MA, Other _____
Greet patient and provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	_____	RN, LPN, MA, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____

Intra-service

Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____
--	-------	--------------------------

Post-service

Monitor pt. following service/check tubes, monitors, drains

RN, LPN, MA, Other _____

Clean room/equipment by physician staff

RN, LPN, MA, Other _____

Assist with ICU or hospital visits

RN, LPN, MA, Other _____

Total Number of ICU visits**Total Number of hospital visits**

Complete diagnostic forms, lab & X-ray requisitions

RN, LPN, MA, Other _____

Review/read X-ray, lab, and pathology reports

RN, LPN, MA, Other _____

Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions

12**RN/LPN/MTA** Other _____

Coordination of care by staff in office

RN, LPN, MA, Other _____

Other Activity (please specify)

RN, LPN, MA, Other _____

*End Patient discharge from hospital***Post-Service Period***Start: Patient discharge from hospital*

Conduct phone calls/call in prescriptions

RN, LPN, MA, 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

*OFFICE VISIT LEVEL 99213; standard 36 minutes per visit***RN/LPN/MTA** Other _____**List total number of office visits****A 36****B 2****Total office visit time (A * B)****72**

Conduct phone calls between office visits

RN, LPN, MA, Other _____

Other Activity (please specify)

RN, LPN, MA, 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
Facility Direct Inputs**

CPT Long Descriptor: 37216

Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection

(37215 and 37216 include all ipsilateral selective carotid catheterization, all diagnostic imaging for ipsilateral, cervical and cerebral carotid arteriography, and all related radiological supervision and interpretation. When the ipsilateral carotid arteriogram (including imaging and selective catheterization) confirms the need for carotid stenting, codes 37215 and 37216 are inclusive of these services. If carotid stenting is not indicated, then the appropriate codes for carotid catheterization and imaging should be reported in lieu of code 37215 and 37216

(Do not report 37215, 37216 in conjunction with 75680, 75681)

(For transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), see Category III codes 0075T and 0076T)

Sample Size: N/A Response Rate: (%): N/A Global Period: 090

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

Standard RUC/PEAC times for 90-day global period pre-service in-facility activities and post-procedure office visits were applied. Physician representatives from all eight of the sponsoring organizations reviewed and approved the recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Review test/exam results
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

Post-Service Clinical Labor Activities:

- Greet patient, escort to room
- Provide gowning
- Interval history & vital signs & chart
- Assemble previous test reports/results
- Assist physician during exam

Post-Service Clinical Labor Activities (continued):

- 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

Total Staff Time Out of Office: 132 minutes

Visits in Global Period: 2 X 99213

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 and Source (if applicable)
L037D	RN/LPN/MTA	60				2	72	

*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 2004. 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)
	PEAC Multi-specialty Supply Pkg	2		

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

CMS's Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)
E11001	Exam table	

* From CMS'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: FACILITY

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 <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>5</u>	<u>RN/LPN/MTA</u> Other _____
Coordinate pre-surgery services/review test/exam results <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>20</u>	<u>RN/LPN/MTA</u> Other _____
Schedule space and equipment in facility <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>8</u>	<u>RN/LPN/MTA</u> Other _____
Office visit before surgery/procedure	_____	RN, LPN, MA, Other _____
Review test and exam results	_____	_____
Provide pre-service education/obtain consent <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>20</u>	<u>RN/LPN/MTA</u> Other _____
Follow-up phone calls & prescriptions <i>STANDARD 90 Day Global Pre-service staff time</i>	<u>7</u>	<u>RN/LPN/MTA</u> Other _____
Other Activity (please specify)	_____	RN, LPN, MA, Other _____

End: When patient enters hospital for surgery/procedure

Service Period

Start: Patient admitted to hospital for surgery/procedure

Pre-service services

Review charts	_____	RN, LPN, MA, Other _____
Greet patient and provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	_____	RN, LPN, MA, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____

Intra-service

Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____
--	-------	--------------------------

Post-service

Monitor pt. following service/check tubes, monitors, drains _____ RN, LPN, MA, Other _____

Clean room/equipment by physician staff _____ RN, LPN, MA, Other _____

Assist with ICU or hospital visits _____ RN, LPN, MA, Other _____

Total Number of ICU visits _____

Total Number of hospital visits _____

Complete diagnostic forms, lab & X-ray requisitions _____ RN, LPN, MA, Other _____

Review/read X-ray, lab, and pathology reports _____ RN, LPN, MA, Other _____

Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions 12 **RN/LPN/MTA** Other _____

Coordination of care by staff in office _____ RN, LPN, MA, Other _____

Other Activity (please specify) _____
 _____ RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period

Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions _____ RN, LPN, MA, 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

OFFICE VISIT LEVEL 99213; standard 36 minutes per visit

RN/LPN/MTA Other _____

List total number of office visits

A 36
B 2

Total office visit time (A * B)

72

Conduct phone calls between office visits _____ RN, LPN, MA, Other _____

Other Activity (please specify) _____
 _____ RN, LPN, MA, Other _____

End With last office visit before end of global period

	A	B	C	D	E	F	G
1							
2				37215		37216	
				Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous, without distal embolic protection		Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous, without distal embolic protection	
3			CMS 2004 STAFF TYPE, MED SUPPLY, OR EQUIP CODE				
4	LOCATION			Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			90	90	90	90
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	144	0	144
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	60	0	60
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0	12	0	12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	72	0	72
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7
17	Other Clinical Activity (please specify)						
18	End: When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters office/facility for surgery/procedure						
21	Pre-service services						
22	Review charts						
23	Greet patient and provide gowning						
24	Obtain vital signs						
25	Provide pre-service education/obtain consent						
26	Prepare room, equipment, supplies						
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV						
29	Sedate/apply anesthesia						
30	Intra-service						
31	Assist physician in performing procedure						
32	Post-Service						
33	Monitor pt following service/check tubes, monitors, drains						
34	Clean room/equipment by physician staff						
35	Clean Scope						
36	Clean Surgical Instrument Package						
37	Complete diagnostic forms, lab & X-ray requisitions						
38	Review/read X-ray, lab, and pathology reports						
39	Check dressings & wound/ home care instructions						
40	Coordinate office visits /prescriptions						
41	Discharge day management 99238 -12 minutes	L037D	RN/LPN/MTA		12		12
42	99239 --15 minutes						
43	Other Clinical Activity (please specify)						
44	End: Patient leaves office						
45	POST-SERVICE Period						
46	Start: Patient leaves office/facility						
47	Conduct phone calls/call in prescriptions						
48	Office visits 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 36 minutes x 2		36		72		72
53	99214 53 minutes		53				
54	99215 63 minutes		63				
55	Other						
56	Total Office Visit Time	L037D	RN/LPN/MTA		72		72
57	Other Activity (please specify)						
58	End: with last office visit before end of global period						
59	MEDICAL SUPPLIES						
60	PEAC multispecialty supply package				2		2
61	EQUIPMENT						
62	exam table		E11001		1		1

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.

Code 43257

The RUC reviewed the survey results of 43257 *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* 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 43257 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 25th percentile of the survey data. **The RUC recommends a work RVU of 5.50 for CPT code 43257.**

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
▲0057T	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	XXX	N/A

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

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
	sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease (0057T has been deleted. To report, use 43257)		
43255	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	4.81 (No Change)
•43257	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 Code: 43257 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, LES pressure > 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

Presenter(s):	Joel Brill, MD (AGA) Michael Levy, MD (ASGE) Michael Edye, MD (SAGES)				
Specialty(s):	American Gastroenterological Association (AGA) American Society for Gastrointestinal Endoscopy (ASGE) Society of American Gastrointestinal Endoscopic Surgeons (SAGES)				
CPT Code:	43257				
Sample Size:	50	Resp n:	37	Resp %:	74%
Sample Type:	Random – mailed to random selection of surgeons and gastroenterologists who completed Stretta training course				
		Low	25th pctl	Median	75th pctl
Survey RVW:		3.63	5.50	7.00	8.50
Pre-Service Evaluation Time:				45 15	
Pre-Service Positioning Time:				10	
Pre-Service Scrub, Dress, Wait Time:				10	
Intra-Service Time:		20	50	60	60
Post-Service	Total Min*	CPT code / # of visits			
Immed. Post-time:	0				
Critical Care time/visit(s):	0				
Other Hospital time/visit(s):	0				
Discharge Day Mgmt:	18	99238 x 0.5			
Office time/visit(s):	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
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	7.39	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 43257	Ref CPT 43262(Hvd)
Response count for time medians	37	17
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
TOTAL TIME	143 113	153

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 43257 and 43262 are very similar although the exact work performed is different. 43257 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/papilotomy). 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 43257. This is slightly less than the RVW for 43262, reflecting the slightly less intra/total time.

<u>Building Block Analysis</u>		43257 RVW	
		Svy RVW:	7.00 5.50
	Svy Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)
eval & positioning	55 25	0.0224	1.23 0.56
scrub, dress, wait	10	0.0081	0.08
Pre-service total			1.31 0.64

43262 Ref RVW		
MFS RVW:		7.39
Svy Data	RUC Std.	RVW
Time	Intensity	(=time x intensity)
25	0.0224	0.56
25	0.0081	0.20
		0.76

<u>Post-service:</u>	Time	Intensity	(=time x intensity)
Immediate post		0.0224	0.00
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
Discharge 99238	0.5	1.28	0.64
Post-service total			0.64

Time	Intensity	(=time x intensity)
	0.0224	0.00
Visit n	E/M RVW	(=n x RVW)
0.5	1.28	0.64
		0.64

	Time	IWPUT	INTRA-RVW
<u>Intra-service:</u>	60	0.084 0.070	5.05 4.22

Time	IWPUT	INTRA-RVW
75	0.080	5.99

Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? **NO**
2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. **N/A**

FREQUENCY INFORMATION

How was this service previously reported

43499 Unlisted procedure, esophagus
 43999 Unlisted procedure, stomach

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

Specialty: general surgery/gastroenterology 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 and general surgery
 Frequency: From the time of 501(k) clearance in April 2000 through October 2002, approximately 3,000 procedures were performed. This is in comparison to approximately 70,000 anti-reflux surgical procedures performed in 2001. Based on the less-invasive nature of this procedure, offset by the exclusions (i.e., patients with a 3 cm hiatal hernia or larger or Barrett's esophagus are excluded), between 5-40% of surgery patients may be candidates for this procedure. However, because of the novel and unique nature of the procedure and the limited number of physicians and surgeons trained to provide this therapy, we anticipate that only a very small subset of these patients will undergo therapy.

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
43257	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 43257. 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	RUC September 2003 <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	43257 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		PEAC APPROVED Jan 2003
2					43262
3					ERCP, with sphincterotomy and/or papillotomy
4	LOCATION		Facility Only		Facility Only
5	GLOBAL PERIOD		0		0
6	TOTAL NON-CS CLINICAL LABOR TIME	RN/LPN/MTA	25		25
7	TOTAL PRE-SERV CLINICAL LABOR TIME	RN/LPN/MTA	19		19
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	RN/LPN/MTA	6		6
9	TOTAL POST-SERV CLINICAL LABOR TIME	RN/LPN/MTA	0		0
10	PRE-SERVICE				
11	Start: Following visit when decision for procedure				
12	Complete pre-service diagnostic & referral forms	RN/LPN/MTA	3		3
13	Coordinate pre-surgery services	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	Follow-up phone calls & prescriptions	RN/LPN/MTA	3		3
17	Other Clinical Activity (please specify)	RN/LPN/MTA			
18	End: When pt enters office/facility for surgery				
19	SERVICE PERIOD				
40	Dischg day mgmt 99238 –12 min; 99239 –15 min	RN/LPN/MTA	6		6
41	End: Patient leaves facility				
42	POST-SERVICE Period		N/A		N/A

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
February and April 2004

Gastric Restrictive Procedures

CPT created three new codes to describe gastric restrictive procedures. The specialty presented only two of the codes and will present the remaining code in the future. These two procedures, 43644 *Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption* and 43645 *Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption* achieve the same results as the open procedures 43846 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy* (work RVU = 24.01) and 43847 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption* (work RVU = 26.88) but there is considerably less post operative pain for the patient and a less lengthy incision. Over the past 10 years, the field of bariatric surgery has rapidly expanded and the new codes revise and enhance the existing code set for bariatric surgery.

43845 Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)

The specialty was not able to conduct a survey for this service during the current 2005 cycle. It is anticipated that a survey will be completed in the future, perhaps by the September 2004 RUC meeting. The RUC understands that this is an infrequently performed surgery, particularly to Medicare patients. Therefore, the RUC recommends that this code be carrier priced for 2005.

43645 Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption

The presenters discussed code 43645 first and stated that although the survey respondents chose the corresponding open codes 43846 and 43847 as the reference code, the presenters felt that a better comparison would be between the new codes and other laparoscopic codes. The presenters felt that the open codes may be misvalued and were not based on complete RUC survey data, while the laparoscopic codes do have complete RUC survey data. The presenters stated that code 43645 is very similar in terms of breadth and depth and total work to another laparoscopic procedure, CPT 44207 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)* (work RVU= 29.96). New code 43645 involves dividing both stomach and small intestine and completing two anastomoses in the technically challenging surgical terrain of the morbidly obese. The pre-, intra-, and post-times

and work are very similar to 44207. Also a value of 29.96 correctly places 43645 greater than another similar laparoscopic code, 44204 *Laparoscopy, surgical; colectomy, partial, with anastomosis* (RVW=25.04), which includes only one anastomosis. The RUC also discussed the pre-service time for this code and felt that the evaluation time and the positioning time needed to be redistributed so that 45 minutes was assigned to evaluation and 30 minutes for positioning. This would not change the total pre-service time.

The RUC recommends a physician work RVU of 29.96 for code 43645.

43644 *Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)* was reviewed in comparison to 43645. The RUC agreed that code 43644 has the same intraoperative complexity/intensity as 43645 however, there is 20 minutes less intraoperative time. The presenters recommended an RVU of 27.83 based on subtracting 20 minutes of intraservice time (at an intensity of .106 from code 43645) from the recommended value for 43645 of 29.96 (20×0.106). This RVW correctly places new code 43644 less than 43645 and relative to 44207. The RUC agreed with this methodology. The RUC also discussed the pre-service time for this code and felt that the evaluation time and the positioning time needed to be redistributed so that 30 minutes was assigned to evaluation and 30 minutes for positioning. This would not change the total pre-service time.

The RUC recommends a physician work RVU of 27.83 for code 43644.

Practice Expense

The RUC recommended the standard inputs for a 90 day global period code that is performed only in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<u>Bariatric surgical procedures may involve the stomach, duodenum, jejunum and/or ileum.</u>				
●43845	L1	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch) <u>(Do not report 43845 in conjunction with 43633, 43847, 44130, 49000)</u>	090	Carrier Price (RUC to review in September 2004)
<u>Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (separate procedure), use 49320</u>				
●43644	L2	Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and Roux-en Y gastroenterostomy (roux limb 150 cm or less) <u>(Do not report 43644 in conjunction with 43846, 49320)</u> <u>(Esophagogastroduodenoscopy (EGD) performed for a separate condition should be reported with the modifier '59')</u>	090	27.83
●43645	L3	with gastric bypass and small intestine reconstruction to limit absorption <u>(Do not report 43645 in conjunction with 49320, 43847)</u>	090	29.96

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(Jan. 2004)

CPT Code: 43644**Tracking No:** L2**Global:** 90**Recommended RVW:** 27.83

Descriptor: Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)

Vignette Used in Survey:

A 44-year-old man (height: 5ft-11in; weight 390 lbs; BMI 55 kg/m²) presents with a history of Type II diabetes controlled with three oral hypoglycemic medications and hypertension controlled with two medications. A recent sleep study showed severe obstructive sleep apnea for which he was placed on CPAP with subjective improvement, but complaints of poor tolerance of the mask. His gastroesophageal reflux is controlled with an H2-blocker, but his mobility is compromised due to severe arthritis of his lower back and right knee. Family and diet history confirm morbid obesity began at age nine. The patient underwent multiple weight loss programs, losing up to 75 pounds three times. However, the weight loss was never maintained for more than six months and each weight regain was more than what was originally lost. Weight loss programs utilized included very low calorie diets, Weight Watchers, exercise, appetite suppressants, and meal replacements. At operation, he undergoes a laparoscopic gastric restrictive procedure with gastric bypass and Roux-en Y gastroenterostomy.

Percentage of Survey Respondents who found Vignette to be Typical: 87% of the respondents indicated vignette to be typical. Those that responded "no" indicated their patients would be female and/or have a higher BMI.

Clinical Description Of Service:**Preoperative work:**

- Review pre-operative hospital admission work-up, with special attention to cardiopulmonary status including management of C-PAP and oximetry, and skin care with antiseptic showers and antibiotics, and thromboembolic prophylaxis
- Review films, cardiogram and laboratory studies
- 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 OR, including special stretcher
- Monitor patient positioning and draping, and assist with positioning as needed to prevent neuropraxias and pressure necrosis of skin
- Scrub and gown

Intra-operative Work:

Under general anesthesia, the abdomen is entered under direct vision or using a Veress needle technique to obtain access for pneumoperitoneum. Carbon dioxide is pumped into the abdominal cavity through tubing connected to an insufflator, to expand the abdominal cavity. A laparoscopic camera is introduced into the abdomen to allow visualization of the internal organs. Four to six trocar ports are placed in the anterior abdominal wall above the umbilicus. The liver is retracted to expose the upper stomach. (Because the liver is typically fatty, it must be handled with extra care to avoid tearing, puncture or cracking.) The gastroesophageal junction is identified and a 2 cm incision is made in the gastrohepatic ligament along the edge of the lesser curve between the first and second vessel caudad to the gastroesophageal junction. Using blunt and ultrasonic dissection, a retrogastric tunnel is made cephalad, toward the angle of His. A small (15-20 cc) gastric pouch is made after the stomach is transected with repeated firings of an endoscopic linear stapler. An orogastric tube may be used to calibrate the

size of the pouch. Minor bleeding from the staple lines are controlled using hemoclips. The Ligament of Treitz is identified, and the small intestine measured distally for a short distance and transected with a linear stapler. The distal limb is brought up to the proximal gastric pouch; either anterior to the transverse colon (ante-colic) or posterior to the transverse colon (retro-colic). The omentum may be divided longitudinally with an ultrasonic scalpel or endoscopic stapler, to allow for decreased tension for passage of the Roux limb in an ante-colic position. The transverse mesocolon is incised to create a tunnel for a retro-colic Roux limb position, as indicated.

Care must be taken to avoid twisting of the Roux limb to avoid obstruction or ischemia of the intestine. The mesenteric defect is closed to prevent internal herniation. A gastrojejunal anastomosis is performed between the Roux limb and the gastric pouch, by using either hand-sewn technique, stapled technique or a combination of both. The Roux limb is then measured up to 150 cm distal from the gastrojejunal anastomosis and marked. A jejunojejunostomy is performed between the bypassed biliopancreatic limb and the marked segment of the Roux limb. This anastomosis is performed by using either hand-sewn technique, stapled technique, or combination of both. Intra-operative testing for anastomotic leak may be performed as clinically indicated, utilizing air, intra-operative endoscopy or methylene blue. Drains(s) are placed and/or distal gastrostomy performed as indicated. Fascia and skin are closed.

Postoperative hospital work:

- Apply dressings
- Check patient's vital signs and transfer patient to recovery room, then ICU
- 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
- Write orders for C-PAP and continuous oximetry and strip recording and blood gases
- Vigorous pulmonary reinflation measures are stressed due to marked intra-abdominal obesity and high diaphragms;
- Thromboembolic prophylaxis, drain(s) and tube losses are monitored at wound checks and dressing changes
- Review post-operative Upper GI radiograms for absence of leak(s) from and progression of contrast through the anastomosed elements
- Monitor patient for signs of complications (airway obstruction, hemorrhage, intestinal leak or obstruction, pulmonary embolus, atelectasis, etc)
- Drain(s) removed as appropriate
- Oral fluids are started when appropriate with special instructions in the markedly altered intake/gastric physiology with a 30 ml stomach capacity (including the inability to take food and fluids at the same time, with the avoidance of true solids for several weeks)
- Confer with nutritionist and patient regarding post-operative food preparation and caloric goals
- 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

Postoperative office visit work:

- Examine patient; check heart sounds, breath sounds, lower extremities, and wounds. Weigh patient.
- Review details of diet, supplements, and activity.
- Evaluate for weight loss, appetite, hunger, nausea, vomiting or complications. Evaluate for diet and food intolerance or non-compliance.
- Order and review labs, specifically comprehensive electrolytes, hepatic panel, hematology, iron panel, fat-soluble nutrient panel, B12 and folate. Adjust dose of nutritional supplements according to deficient lab values.
- Discuss/review techniques for advancing from liquids to solid foods, and assuring protein intake of greater than or equal to 30 grams a day

SURVEY DATA

Presenter(s):	Michael Edye, MD (SAGES) Christine Ren, MD (ASBS)				
Specialty(s):	Society of American Gastrointestinal Endoscopic Surgeons (SAGES) American Society of Bariatric Surgeons (ASBS)				
CPT Code:	43644				
Sample Size:	124	Resp n:	60	Resp %:	48%
Sample Type:	Random to ASBS/SAGES membership				
	Low	25th pctl	Median	75th pctl	High
Survey RVW:	23.91	30.00	33.96	38.88	60.00
Pre-Service Evaluation Time:			30		
Pre-Service Positioning Time:			30		
Pre-Service Scrub, Dress, Wait Time:			15		
Intra-Service Time:	100	130	180	205	240
Post-Service	Total Min*	CPT code / # of visits			
Immed. Post-time:	30				
Critical Care time/visit(s):	30	99232* x 1			
Other Hospital time/visit(s):	49	99232 x 1 99231 x 1			
Discharge Day Mgmt:	36	99238			
Office time/visit(s):	76	99214 x 1 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).

KEY REFERENCE SERVICE(S):

CPT	Descriptor	new '04 RVW	Glob
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy	24.01	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT 43644	Ref CPT 43846
Pre-service	75	60
Intra-service	180	180
Same Day Immediate Post-service	30	30
Critical care	30	63
Other hospital visit	49	180
Discharge day management	36	
Office visit	76	84
<i>TOTAL TIME</i>	<i>476</i>	<i>633</i>

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below	29	29
--	----	----

TIME SEGMENTS

Pre-service	4.07	3.89
Intra-service	4.83	3.89
Post-service	4.21	4.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.21	4.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.62	4.45
Urgency of medical decision making	3.17	3.14

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.79	3.83
Physical effort required	4.55	3.86

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.69	4.31
Outcome depends on the skill and judgment of physician	4.79	4.31
Estimated risk of malpractice suit with poor outcome	4.83	4.59

ADDITIONAL RATIONALE

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

New code 43644 has the same intraoperative complexity/intensity as 43645. However, there is 20 minutes less intraoperative time. For the same reasons addressed in the rationale for 43645, the open code 43846 is not a good reference for valuing this new laparoscopic procedure. – Please see rationale section of Work Summary Form for 43645.

An RVW of 27.83 is being recommended for new code 43644. This RVW is based on subtracting 20 minutes of intraservice time from the recommended value for 43645 of 29.96 (20 x 0.106) (see Attachment 1). This RVW correctly places new code 43644 less than 43645 and relative to 44207.

Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? NO
2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. N/A

FREQUENCY INFORMATION

How was this service previously reported? 43999 Unlisted procedure, stomach

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

Specialty: 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: general surgery
Frequency: 50,000 for both L2 and L3 (with a decrease in reporting of the open procedure)

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: general surgery
Frequency: 5,000 for both L2 and L3 (with a decrease in reporting of the open procedure)

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

ATTACHMENT 1

ATTACHMENT 1

<u>Building Block Analysis</u>							
	L2	Rec'd RVW	27.83		L3	Rec'd RVW	29.96
	Svy Data	RUC Std.	RVW		Svy Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)		Time	Intensity	(=time x intensity)
Pre-service eval & positioning	60	0.0224	1.34		75	0.0224	1.68
Pre-service scrub, dress, wait	15	0.0081	0.12		15	0.0081	0.12
Pre-service total			1.47				1.80
<u>Post-service:</u>	Time	Intensity	(=time x intensity)		Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67		30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)		Visit n	E/M RVW	(=n x RVW)
99232	2	1.06	2.12		2	1.06	2.12
99231	1	0.64	0.64		1	0.64	0.64
Discharge 99238	1	1.28	1.28		1	1.28	1.28
Discharge 99239		1.75	0.00			1.75	0.00
99215		1.73	0.00			1.73	0.00
99214	1	1.08	1.08		1	1.08	1.08
99213	1	0.65	0.65		1	0.65	0.65
99212	1	0.43	0.43		1	0.43	0.43
99211		0.17	0.00			0.17	0.00
Post-service total			6.87				6.87
	Time	IWPUT	INTRA-RVW		Time	IWPUT	INTRA-RVW
<u>Intra-service:</u>	180	0.106	19.49	200	0.106	21.29	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(Jan. 2004)

CPT Code: 43645

Tracking No: L3

Global: 90

Recommended RVW: 29.96

Descriptor: Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption

Vignette Used in Survey:

A 44-year-old man (height: 5ft-11in; weight 420 lbs; BMI 60 kg/m²) presents with a history of Type II diabetes controlled with three oral hypoglycemic medications and hypertension controlled with two medications. A recent sleep study showed severe obstructive sleep apnea for which he was placed on CPAP with subjective improvement, but complaints of poor tolerance of the mask. His gastroesophageal reflux is controlled with an H2-blocker, but his mobility is compromised due to severe arthritis of his lower back and right knee. Family and diet history confirm morbid obesity began at age nine. The patient underwent multiple weight loss programs, losing up to 75 pounds three times. However, the weight loss was never maintained for more than six months and each weight regain was more than what was originally lost. Weight loss programs utilized included very low calorie diets, Weight Watchers, exercise, appetite suppressants, and meal replacements. At operation, he undergoes a laparoscopic gastric restrictive procedure with gastric bypass and small intestine reconstruction to limit absorption.

Percentage of Survey Respondents who found Vignette to be Typical: 91% of the respondents indicated vignette to be typical. Those that responded "no" indicated their patients would be female and/or have a weight greater than 450 lbs.

Clinical Description Of Service:

Preoperative work:

- Review pre-operative hospital admission work-up, with special attention to cardiopulmonary status including management of C-PAP and oximetry, and skin care with antiseptic showers and antibiotics, and thromboembolic prophylaxis
- Review films, cardiogram and laboratory studies
- 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 OR, including special stretcher
- Monitor patient positioning and draping, and assist with positioning as needed to prevent neuropraxias and pressure necrosis of skin
- Scrub and gown

Intra-operative Work:

Under general anesthesia, the abdomen is entered under direct vision or using a Veress needle technique to obtain access for pneumoperitoneum. Carbon dioxide is pumped into the abdominal cavity through tubing connected to an insufflator, to expand the abdominal cavity. A laparoscopic camera is introduced into the abdomen to allow visualization of the internal organs. Four to six trocar ports are placed in the anterior abdominal wall above the umbilicus. The liver is retracted to expose the upper stomach. (Because the liver is typically fatty, it must be handled with extra care to avoid tearing, puncture or cracking.) The gastroesophageal junction is identified and a 2 cm incision is made in the gastrohepatic ligament along the edge of the lesser curve between the first and second vessel caudad to the gastroesophageal junction. Using blunt and ultrasonic dissection, a retrogastric tunnel is made cephalad, toward the angle of His. A small (15-20 cc) gastric pouch is made after the stomach is

transected with repeated firings of an endoscopic linear stapler. An orogastric tube may be used to calibrate the size of the pouch. Minor bleeding from the staple lines are controlled using hemoclips. The small bowel is transected using a specialized endoscopic linear stapler at a measured distance from the Ligament of Treitz or the ileocecal valve. The distal limb is brought up to the proximal gastric pouch; either anterior to the transverse colon (ante-colic) or posterior to the transverse colon (retro-colic). The omentum may be divided longitudinally using an ultrasonic scalpel or endoscopic stapler, to allow for decreased tension for passage of the Roux limb in an ante-colic position. The transverse mesocolon is incised to create a tunnel for a retro-colic Roux limb position, if indicated. Care must be taken to avoid twisting of the Roux limb to avoid obstruction or ischemia of the intestine. The mesenteric defect is closed to prevent internal herniation. A gastrojejunal anastomosis is performed between the Roux limb and the gastric pouch, by using either hand-sewn technique, stapled technique, or a combination of both. The Roux limb is then measured greater than 150 cm distal from the gastrojejunal anastomosis and marked. An enteroenterostomy is performed between the bypassed biliopancreatic limb and the marked segment of the Roux limb. This anastomosis is performed by using either hand-sewn technique, stapled technique, or a combination of both. The length of the biliopancreatic limb and the Roux limb may vary in order to produce malabsorption of variable nutrients. The variations may include: (1) a short biliopancreatic limb measuring between 20-90 cm with a very long Roux limb measuring between 150-250 cm from the gastrojejunostomy; or (2) transection of the small intestine at a point 250-360 cm proximal to the ileocecal valve, to create a 151- 250 cm Roux limb, with a distal enteroenterostomy anastomosis at a point 50-150 cm proximal to the ileocecal valve. Both techniques result in fat malabsorption. Intra-operative testing for anastomotic leak may be performed as clinically indicated, utilizing air, intra-operative endoscopy or methylene blue. Drains(s) are placed and/or distal gastrostomy performed as indicated. Fascia and skin are closed.

Postoperative hospital work:

- Apply dressings
- Check patient's vital signs and transfer patient to recovery room, then ICU
- 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
- Write orders for C-PAP and continuous oximetry and strip recording and blood gases
- Vigorous pulmonary reinflation measures are stressed due to marked intra-abdominal obesity and high diaphragms;
- Thromboembolic prophylaxis, drain(s) and tube losses are monitored at wound checks and dressing changes
- Review post-operative Upper GI radiograms for absence of leak(s) from and progression of contrast through the anastomosed elements
- Monitor patient for signs of complications (airway obstruction, hemorrhage, intestinal leak or obstruction, pulmonary embolus, atelectasis etc)
- Drain(s) removed as appropriate
- Oral fluids are started when appropriate with special instructions in the markedly altered intake/gastric physiology with a 30 ml stomach capacity (including the inability to take food and fluids at the same time, with the avoidance of true solids for several weeks)
- Confer with nutritionist and patient regarding post-operative food preparation and caloric goals
- 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

Postoperative office visit work:

- Examine patient; check heart sounds, breath sounds, lower extremities, and wounds. Weigh patient.
- Review details of diet, supplements, and activity.
- Evaluate for weight loss, appetite, hunger, nausea, vomiting or complications. Evaluate for diet and food intolerance or non-compliance.

- Order and review labs, specifically comprehensive electrolytes, hepatic panel, hematology, iron panel, fat-soluble nutrient panel, B12 and folate. Adjust dose of nutritional supplements according to deficient lab values.
- Discuss/review techniques for advancing from liquids to solid foods, and assuring protein intake of greater than or equal to 30 grams a day

SURVEY DATA

Presenter(s):	Michael Edye, MD (SAGES) Christine Ren, MD (ASBS)				
Specialty(s):	Society of American Gastrointestinal Endoscopic Surgeons (SAGES) American Society of Bariatric Surgeons (ASBS)				
CPT Code:	43645				
Sample Size:	121	Resp n:	43	Resp %:	36%
Sample Type:	Random to ASBS/SAGES membership				
	Low	25th pctl	Median	75th pctl	High
Survey RVW:	26.50	30.00	35.00	38.00	62.00
Pre-Service Evaluation Time:			45		
Pre-Service Positioning Time:			30		
Pre-Service Scrub, Dress, Wait Time:			15		
Intra-Service Time:	120	150	200	240	310
Post-Service	Total Min*	CPT code / # of visits			
Immed. Post-time:	30				
Critical Care time/visit(s):	30	99232* x 1			
Other Hospital time/visit(s):	49	99232 x 1 99231 x 1			
Discharge Day Mgmt:	36	99238			
Office time/visit(s):	76	99214 x 1 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).

KEY REFERENCE SERVICE(S):

CPT	Descriptor	new '04 RVW	Glob
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	26.88	090
44207	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)	29.96	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT 43645	Ref CPT 43847
Pre-service	90	60
Intra-service	200	220
Same Day Immediate Post-service	30	30
Critical care	30	63
Other hospital visit	49	180
Discharge day management	36	
Office visit	76	84
TOTAL TIME	511	673

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below	32	32
--	----	----

TIME SEGMENTS

Pre-service	4.48	4.33
Intra-service	4.93	4.23
Post-service	4.38	4.23

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.43	4.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.71	4.63
Urgency of medical decision making	3.42	3.25

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.94	4.19
Physical effort required	4.87	4.34

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.97	4.69
Outcome depends on the skill and judgment of physician	5.00	4.69
Estimated risk of malpractice suit with poor outcome	4.97	4.81

ADDITIONAL RATIONALE

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

Thirty-two of 43 respondents chose 43847 as a reference procedure for new code 43645. Although this is the comparable open code to 43645 in terms of the anatomic end result, the consensus committee believes that this code is NOT the best reference code for valuing this new laparoscopic procedure, for several reasons.

1. The original interim recommended RVW by the RUC for 43847 was based on a survey with wide variations of data and few respondents
2. CMS changed the RUC interim recommendation using an intensity similar to repair of an abdominal aortic aneurysm (CPT 34802) (Fed Reg Dec 8, 1994). Then, in 2000, the Society of Vascular Surgeons brought 34802

and other similar codes to the RUC during the second five year review process, resulting in an increase in RVWs and a corresponding increase in intra-operative intensity (IWPUT=0.100) as shown on Attachment 1.

3. The American College of Surgeons brought 43847 to the RUC during the second five year review in 2000, resulting in an increased RVW based on a percentage increase to the anchor code of the family, instead of the specific recommendation made by the College for the family of codes, resulting in family anomalies.

Given these issues with the value for the open procedure 43847, we believe that this new laparoscopic procedure is better compared with other laparoscopic codes. New code 43645 is very similar in terms of breadth and depth and total work to another laparoscopic procedure, CPT 44207, a code that has been reviewed recently by the RUC. New code 43645 involves dividing both stomach and small intestine and completing 2 anastomoses in the technically challenging surgical terrain of the morbidly obese. The pre-, intra-, and post-times and work are very similar to 44207.

TIME ESTIMATES (MEDIAN)	Svy CPT 43645	Ref CPT 44207
Pre-service	90	75
Intra-service	200	195
Same Day Immediate Post-service	30	35
Critical care	30	120
Other hospital visit	49	
Discharge day management	36	
Office visit	76	61
TOTAL TIME	511	486

An RVW of 29.96 is being recommended for new code 43645. This value is slightly less than the survey 25th percentile RVW, but corresponds to a very comparable procedure in terms of total work. This value also gives credit to the 43 survey respondents RVW estimates, based on magnitude estimation, and this value is consistent with the intraoperative intensity of other laparoscopic codes that have gone through the RUC process. For example, this value correctly places 43645 greater than another similar laparoscopic code, 44204 (RVW=25.04), which includes only one anastomosis. (See Attachment 1)

Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? **NO**
2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. **N/A**

FREQUENCY INFORMATION

How was this service previously reported? 43999 Unlisted procedure, stomach

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

Specialty: 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: general surgery

Frequency: 50,000 for both 43645 L2 and 43645 L3 (with a decrease in reporting of the open procedure)

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: general surgery

Frequency: 5,000 for both 43645 L2 and 43645 L3 (with a decrease in reporting of the open procedure)

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

ATTACHMENT 1

ATTACHMENT 1														
			2004 MFS		Pre	Intra	Post	Hospital Visits (992-)				Office Visits (992-)		
CPT	Long	GLOB	RVW (new)	IWPUT	min	min	min	(91) 33	32	31	38	14	13	12
34802	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)	090	22.97	0.100	135	150	40		1	1	1		1	1
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy	090	24.01	0.044	60	180	30	(1) 2	2	2	1		3	1
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	090	26.88	0.049	60	220	30	(1) 2	2	2	1		3	1
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	090	25.04	0.097	45	180	30		1	3	1		2	1
43645	Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption	090	29.96	0.106	90	200	30		2	2	1	1	1	1
44207	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)	090	29.96	0.104	75	195	35	1	2	1	1		2	1
50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	090	23.96	0.071	60	240	30			3	1	1	1	
51992	Laparoscopy, surgical; sling operation for stress incontinence (eg, fascia or synthetic)	090	13.99	0.070	60	120	20			2	1		2	

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

CPT	DESCRIPTION	GLOBAL
43644	Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	090
43645	Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption	090

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

The Society of American Gastrointestinal Endoscopic Surgeons (SAGES) and the American Society of Bariatric Surgeons (ASBS) jointly reviewed the facility direct inputs for these new services.

CLINICAL STAFF TIME:

Pre-service period clinical staff time (prior to admission): The standard 90-day global facility pre-service time of 60 minutes is indicated.

Service period clinical staff time (admission to discharge): Twelve minutes (1 x 99238) is indicated for facility discharge management activities for this typically inpatient service.

Post-service period clinical staff time (post discharge): Standard times for each office visit are indicated for each service.

SUPPLIES AND EQUIPMENT:

Supplies and equipment necessary on the day of service and for post-op visits are indicated on the spreadsheet

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D	E	F	G
1		staff, supply, equip		43644		43645	
2	Meeting Date: January 2004 Specialty: ASBS, SAGES			Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)		Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption	
		CODE	DESC				
3	LOCATION			Non Fac	Facility	Non Fac	Facility
4	GLOBAL PERIOD			N/A	90	N/A	90
5	TOTAL TIME	L037D	RN/LPN/MTA	0	188	0	188
6	PRE-service time	L037D	RN/LPN/MTA	0	60	0	60
7	SERVICE time	L037D	RN/LPN/MTA	0	12	0	12
8	POST-service time	L037D	RN/LPN/MTA	0	116	0	116
9	PRE-SERVICE - BEFORE ADMISSION						
10	Start: Following decision for surgery visit						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7
16	Other Clinical Activity:	L037D	RN/LPN/MTA				
17	End: When pt enters site for service						
18	SERVICE PERIOD - ADMISSION TO DISCHARGE						
19	Start: When pt enters site for procedure						
39	Dischg day mgmt outpt=6" 99238=12" 99239=15"	L037D	RN/LPN/MTA		12		12
41	End: Patient leaves office/facility						
42	POST-SERVICE Period - AFTER DISCHARGE						
43	Start: Patient leaves office/facility						
46	List Number and Level of Office Visits						
47	99211 16 minutes		16				
48	99212 27 minutes		27		1.0		1.0
49	99213 36 minutes		36		1.0		1.0
50	99214 53 minutes		53		1.0		1.0
51	99215 63 minutes		63				
52	Other:						
53	Total Office Visit Time	L037D	RN/LPN/MTA		116		116
55	End: last office visit - end of global period						
56	MEDICAL SUPPLIES						
57	pack, minimum multi-specialty visit	SA048	pack		3		3
58	pack, post-op incision care (staple)	SA052	pack		1		1
59							
60	Equipment						
61	exam lamp	E30006			x		x
62	exam table	E11001			x		x
63	scale, high capacity (800 lb)	new item	1726.33		X		X
64	3 Sources for scale costs						
65	Dyanamic Living \$ 1,899.99						
66	Miami Medical \$ 1,650.00						
67	RehabOutlet \$ 1,629.00						

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Intestine Transplantation

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes 44132 *Donor enterectomy (including cold preservation), open, ~~with preparation and maintenance of allograft~~; from cadaver donor*; 44133 *Donor enterectomy (including cold preservation, open, ~~with preparation and maintenance of allograft~~; partial, from living donor*; 44135 *Intestinal allotransplantation; from cadaver donor*; 44136 *Intestinal allotransplantation; from living donor*; and 44715 *Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein* are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at the time the **RUC does not submit any recommendations for codes 44132; 44133; 44135; 44136; and 44715.**

The CPT Editorial Panel created a new code 44137 *Removal of transplanted intestinal allograft; complete*. The specialty society informed the RUC that this service is infrequently performed (approximately 10 times annually) and is performed by a limited number of transplant surgeons in the country. A survey was attempted, but was not successful. **The RUC, therefore, recommends that CPT code 44137 be carrier priced in 2005.**

Backbench Reconstruction Codes (44720 and 44721)

The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts, including CPT codes 44720 *Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each* and 441721 *Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each*. These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

The RUC understands that there were no existing codes to describe reconstructive backbench work. The extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers is unknown. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, the specialty has indicated that these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who

performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team.

The specialty discussed the significant intensity and complexity of the backbench reconstruction. The RUC understands that the three-dimensional visualization is difficult and the surgeon must guess as to what it is going to look like when it is placed in the recipient. The impact of complications of these anastomoses will affect the mortality rate for the patient and the surgeon who is performing the anastomoses is aware at that time the importance of making certain that the organ is perfect. In addition, the specialty clarified that although venous anastomoses are often viewed as more work than arterial anastomoses, the opposite is true for this backbench reconstruction. The veins are typically easier than the artery as these anastomoses are in the arterial branches and are smaller than the vein.

The RUC reviewed survey data from more than twenty transplant surgeons for these two services. The RUC understands that these are essentially add-on codes and only include intra-service work. These services should be modifier -51 exempt. CPT code 44720 requires 50 minutes of intra-service time and 44721 requires 70 minutes of intra-service time. The RUC agreed that the survey medians of 5.00 for 44720 and 7.00 for 44721 were appropriate based on comparison with the reference services 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (work relative value = 4.04 and 45 minutes intra-service time) and 35682 *Bypass graft; autogenous composite, two segments of veins from two locations* (work relative value = 7.19 and 78 minutes intra-service time). The RUC agreed that these new codes were more intense than the reference services, as indicated by the survey results. **The RUC recommends 5.00 for CPT code 44720 and 7.00 for CPT code 44721.**

Practice Expense

CPT codes 44720 and 44721 essentially add-on services performed in the facility. Therefore, there are no additional direct practice expense inputs.

Intestinal allotransplantation involves three distinct components of physician work:

1) A cadaver donor enterectomy which includes harvesting the intestine graft and cold preservation of the graft (perfusing with cold preservation solution and cold maintenance) (see 44132). A living donor enterectomy includes harvesting the intestine graft, cold preservation of the graft (perfusing with cold preservation solution and cold maintenance), and care of the donor (see 44133).

2) Backbench work.

Backbench standard preparation of an intestine allograft prior to transplantation includes (see 44715).

Backbench additional reconstruction of an intestine allograft prior to transplantation may include venous and/or arterial anastomosis (-es) (see 44720-44721).

3) Recipient intestinal allotransplantation with or without recipient enterectomy, transplantation of allograft, and care of the recipient (see 44135, 44136).

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 44132	AC1	Donor enterectomy (including cold preservation); open, with preparation and maintenance of allograft; from cadaver donor	XXX	Currently not on the MFS, No RUC Recommendation at this time.
▲ 44133	AC2	<i>partial, from living donor</i>	090	Currently not on the MFS, No RUC Recommendation at this time.
44135		<i>Intestinal allotransplantation; from cadaver donor</i>	090	Currently not on the MFS, No RUC Recommendation at this time.
44136		<i>from living donor</i>	090	Currently not on the MFS, No RUC Recommendation at this time.
● 44137	AC6	Removal of transplanted intestinal allograft; complete (For partial removal of transplant allograft, see 44120, 44121, 44140)	YYY	Carrier Price
● 44715	AC3	Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein	XXX	Currently not on the MFS, No RUC Recommendation at this time.
● 44720	AC4	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each	XXX	5.00
● 44721	AC5	arterial anastomosis, each	XXX	7.00

Practice Expense for 78811-X6

The RUC reviewed the practice expense inputs for codes 78811-X6 in relation to codes 78306 *Bone and/or joint imaging; whole body* and 78803 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)*. The RUC lowered some clinical staff times to eliminate any duplication in clinical staff activities. The RUC also adjusted the medical supplies to only those necessary for the procedures. **The revised RUC recommended practice expense inputs are attached.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●78811	AS1	Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck) (Report 78811-78816 only once per imaging session)	XXX	1.54
●78812	AS2	skull base to mid-thigh (Report 78811-78816 only once per imaging session)	XXX	1.93
●78813	AS3	whole body (Report 78811-78816 only once per imaging session)	XXX	2.00
78810		Tumor imaging, positron emission tomography (PET), metabolic evaluation <u>(78810 has been deleted. To report, see 78811-78813)</u> <u>(For PET of brain, see 78608, 78609)</u> <u>(For PET myocardial imaging, see 78491, 78492)</u>	XXX	N/A
●78814	AS4	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg, chest, head/neck)	XXX	2.20

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Report 78811-78816 only once per imaging session)		
•78815	AS5	skull base to mid-thigh (Report 78811-78816 only once per imaging session)	XXX	2.44
•78816	AS6	whole body (Report 78811-78816 only once per imaging session) (CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site specific CT code with modifier 59)	XXX	2.50

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

CPT Code:78811 Tracking Number: AS1 Global Period: XXX

Recommended Work Relative Value

Specialty Society RVU: **1.54**

RUC RVU: **1.54**

CPT Descriptor: Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck)

(Report 78811-78816 only once per imaging session)

(78810 has been deleted. To report, see 78811-78813)

(For PET of brain, see 78608, 78609)

(For PET myocardial imaging, see 78491, 78492)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 42-year-old female with a history of invasive ductal carcinoma of the left breast. The initial tumor was 4.5 centimeters in largest diameter by mammography. She has now completed neoadjuvant chemotherapy and assessment of treatment response is requested prior to surgical resection. A limited PET scan of the chest is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 10%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the technologist in the acquisition and reconstruction of the data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The physician reviewws the study for adequacy and need for additional aquisitions. All images are interpreted by the physician with correlation with prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Bibb Allen, Jr., M.D. (ACR), Kenneth McKusick, M.D. (SNM)				
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)				
CPT Code:	78811				
Sample Size:	450	Resp n:	52	Response: 11.55%	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.96	1.80	1.93	2.51	5.00
Pre-Service Evaluation Time:			0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Pre-Service Time:			10.0		
Intra-Service Time:	4.00	10.00	20.00	30.00	70.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	10.00				
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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 24 % of respondents: 46.1 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78811	Key Reference CPT Code: 78810
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	20.00	68.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	40.00	68.00
		(RUC TIME)

INTENSITY/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	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.42	3.50
Urgency of medical decision making	3.04	3.04

Technical Skill/Physical Effort (Mean)

Technical skill required	2.08	2.08
Physical effort required	3.08	2.58

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.58	2.50
Outcome depends on the skill and judgment of physician	3.67	3.46
Estimated risk of malpractice suit with poor outcome	3.13	3.13

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.04	3.13
Intra-Service intensity/complexity	3.38	3.42
Post-Service intensity/complexity	3.21	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.*

Background Information

PET imaging for tumor evaluation, (78810, Tumor imaging, positron emission tomography, metabolic evaluation) was initially reviewed by the RUC in September 1994. Since that time the natural evolution of PET imaging has led to three typical scenarios for PET imaging in oncology patients as described by the three new codes in this family that will replace code 78810.

New code 78811 (Tumor imaging, positron emission tomography (PET); limited area (e.g. chest, head and neck)) is designed to evaluate a pulmonary nodule, local recurrence or regional disease and was the typical examination when 78810 was valued in 1994. New code 7881X2 (Tumor imaging, positron emission tomography (PET); skull base to mid thigh) is typically used for initial staging and evaluating the result of therapy. New code 78813 (Tumor imaging, positron emission tomography (PET); whole body) is reserved for patients with neoplasms such as melanoma that have a propensity for metastases to unusual locations.

7881X2 and 78813 Represent New Physician Work

In 1994, the RUC approved a work value of 1.95 RVU for 78810. As noted above, and supported by the clinical vignettes in the RUC database for 78810, the typical examination and valuation at that time was the 78811 vignette. It is therefore the opinion of the ACR and SNM that 7881X2 and 78813 represent new physician work and that budget neutrality should not be applied to this family of codes. We request that the RUC formally concur that based on the vignettes in the RUC database for 78810 that 7881X2 and 78813 represent new physician work.

There are additional issues that must be considered. CMS does not reimburse PET imaging under CPT code 78810. CMS has established a series HCPCS G Codes for providers to report PET. These codes based on the site and/or pathologic diagnosis of the primary tumor, such as colon cancer or lymphoma, rather than the complexity of the examination. As such, there are no claims data available to determine the distribution of 78811, 7881X2 and 78813. Surveys of the members of the ACR and SNM suggest that the vast majority of PET examinations will be 7881X2.

Valuation of 78811

78811 is considered by the ACR and SNM to represent the service valued by the RUC in 1994, and the median value of 1.93 from the survey suggests that the respondents considered this to be the case as well. However, the RUC committees of the ACR and SNM have evaluated the survey data and have concluded that the survey median RVU cannot be supported by the time. Therefore, we have recommended the 25 percentile value of 1.80 for 78811.

Valuation of 7881X2 and 78813

For 7881X2 and 78813, the ACR and SNM believe that the median values of 2.00 and 2.10 are supported by the survey data. Although the respondents indicate that the intra-service work requires a similar amount of time for 7881X2 and 78813, the pre-service work is more complex for the whole body scan due to the increased time required for review of studies, determining that a whole body scan is necessary and the time spent with the technologist for setting up a whole body scan as compared to the torso scan. This additional 5 minutes justifies the slightly higher work RVU for 78813.

Comparison To 78810

The RUC will note that 78810 was presented to the RUC in 1994 with total time of 68 minutes, all of which has been assigned to the intra-service period. Since there were only 18 survey respondents in 1994, one could legitimately question the validity of the time data in the RUC database. However, there are additional explanations as well. In 1994, most physicians doing PET stayed at the console during image acquisition for monitoring and review of the data sets on the monitor. This was associated with a considerable period

(typically 30 to 45 minutes) of waiting for the images to be acquired. This may have resulted in the relatively low intensity per unit time for PET imaging seen in the RUC database for 78810. Furthermore, in 1994, PET interpretation was largely qualitative.

In current practice, the expectations for PET imaging are significantly higher requiring detailed correlation of both anatomic and functional information. Compared to current practice, the intensity per unit time of 78810 is significantly underestimated by the RUC database. In current practice, the physician time for performing and interpreting PET is less than indicated in 1994. In our current surveys, total times are 40 minutes for 78811, 50 minutes for 7881X2 and 55 minutes for 78813. It is no longer the practice of physicians performing PET to stay at the acquisition console during the entire examination. Independent consoles are available for monitoring the examination and for review and interpretation of the data. As compared to 1994, the number imaging planes reviewed and the number of images reviewed and interpreted has increased dramatically.

Improvements in spatial resolution have made highly accurate anatomic correlation possible and this has become the clinical expectation of PET imaging. Without question, the intensity per unit time has significantly increased since 1994 with a conversion from time spent waiting for images to be acquired to time spent in active interpretation of more complex PET images as well as more difficult correlation with CT and MR images. This increase in intensity is only partially captured in the intensity questions on the current surveys because there is no venue for respondents to compare PET in 1994 to PET in 2004. In the current survey, respondents are merely comparing limited, torso and whole body PET to 78810 as it is performed today, not as to how it was performed in 1994.

Comparison To Other RUC Surveyed Imaging Codes

Some respondents chose codes other than 78810 as their key reference service. CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes with 20 minutes being the intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 788X1, 13 additional minutes for 7881X2, and 18 additional minutes for 78813.

Comparison To RUC Surveyed Non-Radiology Imaging Codes

Although none of the respondents chose 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) as a key reference service code, the code was surveyed for the RUC valuation in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the probe in the esophagus but otherwise, and the recommended values for the PET codes compare favorably with this code as well.

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) : 78810, G0125, G0210-G0222, G0224-G0234, G0236, G0252-G0254, G0296

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

Specialty: Radiology How often? Commonly

Specialty: Nuclear Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 33,000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty: Radiology Frequency 23,100 Percentage 70 %

Specialty: Nuclear Medicine Frequency 9,900 Percentage 30 %

Specialty Frequency 0 Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
13,200 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty: Radiology Frequency 9,240 Percentage 70 %

Specialty: Nuclear Medicine Frequency 3,960 Percentage 30 %

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. Non-Surgical

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

CPT Code: Tracking Number: AS2 Global Period: XXX

Recommended Work Relative ValueSpecialty Society RVU: **1.93**RUC RVU: **1.93**

CPT Descriptor: Tumor imaging, positron emission tomography (PET); skull base to mid-thigh

(Report 78811-78816 only once per imaging session)

(78810 has been deleted. To report, see 78811-78813)

(For PET myocardial imaging, see 78491, 78492)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year-old man with a long history of smoking presents with a new 2.0 cm nodule on chest x-ray. A chest CT scan is performed and demonstrates an indeterminate solitary pulmonary nodule. A transthoracic needle aspiration biopsy demonstrates a non-small cell lung cancer. A PET scan is performed from skull base to mid thigh for initial staging of lung cancer.

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? 8%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the technologist in the acquisition and reconstruction of the data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The physician reviews the study for adequacy and need for additional acquisitions. All images are interpreted by the physician with correlation with prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Bibb Allen, Jr., M.D. (ACR), Kenneth McKusick, M.D. (SNM)				
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)				
CPT Code:	7881X2				
Sample Size:	450	Resp n:	50	Response: 11.11 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.18	1.93	2.00	3.00	7.20
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Pre-Service Time:			10.0		
Intra-Service Time:	5.00	15.00	30.00	35.00	80.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	10.00				
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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 26 % of respondents: 52.0 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78812	Key Reference CPT Code: 78810
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	30.00	68.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	50.00	68.00
		(RUC Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.46	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.54
Urgency of medical decision making	3.15	3.19

Technical Skill/Physical Effort (Mean)

Technical skill required	3.23	3.31
Physical effort required	2.12	2.15

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.65	2.62
Outcome depends on the skill and judgment of physician	3.69	3.58
Estimated risk of malpractice suit with poor outcome	3.08	3.04

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.15	3.15
Intra-Service intensity/complexity	3.65	3.54
Post-Service intensity/complexity	3.27	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.*

Background Information

PET imaging for tumor evaluation, (78810, Tumor imaging, positron emission tomography, metabolic evaluation) was initially reviewed by the RUC in September 1994. Since that time the natural evolution of PET imaging has led to three typical scenarios for PET imaging in oncology patients as described by the three new codes in this family that will replace code 78810.

New code 78811 (Tumor imaging, positron emission tomography (PET); limited area (e.g. chest, head and neck)) is designed to evaluate a pulmonary nodule, local recurrence or regional disease and was the typical examination when 78810 was valued in 1994. New code 78812 (Tumor imaging, positron emission tomography (PET); skull base to mid thigh) is typically used for initial staging and evaluating the result of therapy. New code 78813 (Tumor imaging, positron emission tomography (PET); whole body) is reserved for patients with neoplasms such as melanoma that have a propensity for metastases to unusual locations.

7881X2 and 78813 Represent New Physician Work

In 1994, the RUC approved a work value of 1.95 RVU for 78810. As noted above, and supported by the clinical vignettes in the RUC database for 78810, the typical examination and valuation at that time was the 78811 vignette. It is therefore the opinion of the ACR and SNM that 7881X2 and 78813 represent new physician work and that budget neutrality should not be applied to this family of codes. We request that the RUC formally concur that based on the vignettes in the RUC database for 78810 that 7881X2 and 78813 represent new physician work.

There are additional issues that must be considered. CMS does not reimburse PET imaging under CPT code 78810. CMS has established a series HCPCS G Codes for providers to report PET. These codes based on the site and/or pathologic diagnosis of the primary tumor, such as colon cancer or lymphoma, rather than the complexity of the examination. As such, there are no claims data available to determine the distribution of 78811, 7881X2 and 78813. Surveys of the members of the ACR and SNM suggest that the vast majority of PET examinations will be 7881X2.

Valuation of 78811

78811 is considered by the ACR and SNM to represent the service valued by the RUC in 1994, and the median value of 1.93 from the survey suggests that the respondents considered this to be the case as well. However, the RUC committees of the ACR and SNM have evaluated the survey data and have concluded that the survey median RVU cannot be supported by the time. Therefore, we have recommended the 25 percentile value of 1.80 for 78811.

Valuation of 7881X2 and 78813

For 7881X2 and 78813, the ACR and SNM believe that the median values of 2.00 and 2.10 are supported by the survey data. Although the respondents indicate that the intra-service work requires a similar amount of time for 7881X2 and 78813, the pre-service work is more complex for the whole body scan due to the increased time required for review of studies, determining that a whole body scan is necessary and the time spent with the technologist for setting up a whole body scan as compared to the torso scan. This additional 5 minutes justifies the slightly higher work RVU for 78813.

Comparison To 78810

The RUC will note that 78810 was presented to the RUC in 1994 with total time of 68 minutes, all of which has been assigned to the intra-service period. Since there were only 18 survey respondents in 1994, one could

legitimately question the validity of the time data in the RUC database. However, there are additional explanations as well. In 1994, most physicians doing PET stayed at the console during image acquisition for monitoring and review of the data sets on the monitor. This was associated with a considerable period (typically 30 to 45 minutes) of waiting for the images to be acquired. This may have resulted in the relatively low intensity per unit time for PET imaging seen in the RUC database for 78810. Furthermore, in 1994, PET interpretation was largely qualitative.

In current practice, the expectations for PET imaging are significantly higher requiring detailed correlation of both anatomic and functional information. Compared to current practice, the intensity per unit time of 78810 is significantly underestimated by the RUC database. In current practice, the physician time for performing and interpreting PET is less than indicated in 1994. In our current surveys, total times are 40 minutes for 78811, 50 minutes for 7881X2 and 55 minutes for 78813. It is no longer the practice of physicians performing PET to stay at the acquisition console during the entire examination. Independent consoles are available for monitoring the examination and for review and interpretation of the data. As compared to 1994, the number imaging planes reviewed and the number of images reviewed and interpreted has increased dramatically.

Improvements in spatial resolution have made highly accurate anatomic correlation possible and this has become the clinical expectation of PET imaging. Without question, the intensity per unit time has significantly increased since 1994 with a conversion from time spent waiting for images to be acquired to time spent in active interpretation of more complex PET images as well as more difficult correlation with CT and MR images. This increase in intensity is only partially captured in the intensity questions on the current surveys because there is no venue for respondents to compare PET in 1994 to PET in 2004. In the current survey, respondents are merely comparing limited, torso and whole body PET to 78810 as it is performed today, not as to how it was performed in 1994.

Comparison To Other RUC Surveyed Imaging Codes

Some respondents chose codes other than 78810 as their key reference service. CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes with 20 minutes being the intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 788X1, 13 additional minutes for 7881X2, and 18 additional minutes for 78813.

Comparison To RUC Surveyed Non-Radiology Imaging Codes

Although none of the respondents chose 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) as a key reference service code, the code was surveyed for the RUC valuation in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the probe in the esophagus but otherwise, and the recommended values for the PET codes compare favorably with this code as well.

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.

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

CPT Code:78813 Tracking Number: AS3 Global Period: XXX

Recommended Work Relative ValueSpecialty Society RVU: **2.00**RUC RVU: **2.00**

CPT Descriptor: Tumor imaging, positron emission tomography (PET); whole body

(Report 78811-78816 only once per imaging session)

(78810 has been deleted. To report, see 78811-78813)

(For PET of brain, see 78608, 78609)

(For PET myocardial imaging, see 78491, 78492)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 33-year-old man with a history of a malignant melanoma resected from his back, inferior to the right scapula, eight months previously. A small non-painful left axillary lymph node has developed in the previous month. All recent laboratory and imaging studies have been unremarkable. He is referred for staging prior to left axillary resection. A whole body PET scan is performed.

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? 7%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the technologist in the acquisition and reconstruction of the data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The physician reviews the study for adequacy and need for additional acquisitions. All images are interpreted by the physician with correlation with prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Bibb Allen, Jr., M.D. (ACR), Kenneth McKusick, M.D. (SNM)				
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)				
CPT Code:	78813				
Sample Size:	450	Resp n:	50	Response: 11.11 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.30	2.00	2.10	2.87	9.00
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Pre-Service Time:			15.0		
Intra-Service Time:	5.00	16.00	30.00	40.00	90.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	10.00				
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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 27 % of respondents: 54.0 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78813	Key Reference CPT Code: 78810
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	30.00	68.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	55.00	68.00
		(RUC Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.58	3.54
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.54	3.46
Urgency of medical decision making	3.19	3.19

Technical Skill/Physical Effort (Mean)

Technical skill required	3.31	3.23
Physical effort required	2.12	2.08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.65	2.62
Outcome depends on the skill and judgment of physician	3.65	3.58
Estimated risk of malpractice suit with poor outcome	3.12	3.08

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.44	3.37
Intra-Service intensity/complexity	3.81	3.67
Post-Service intensity/complexity	3.41	3.26

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.*

Background Information

PET imaging for tumor evaluation, (78810, Tumor imaging, positron emission tomography, metabolic evaluation) was initially reviewed by the RUC in September 1994. Since that time the natural evolution of PET imaging has led to three typical scenarios for PET imaging in oncology patients as described by the three new codes in this family that will replace code 78810.

New code 78811 (Tumor imaging, positron emission tomography (PET); limited area (e.g. chest, head and neck)) is designed to evaluate a pulmonary nodule, local recurrence or regional disease and was the typical examination when 78810 was valued in 1994. New code 7881X2 (Tumor imaging, positron emission tomography (PET); skull base to mid thigh) is typically used for initial staging and evaluating the result of therapy. New code 78813 (Tumor imaging, positron emission tomography (PET); whole body) is reserved for patients with neoplasms such as melanoma that have a propensity for metastases to unusual locations.

7881X2 and 78813 Represent New Physician Work

In 1994, the RUC approved a work value of 1.95 RVU for 78810. As noted above, and supported by the clinical vignettes in the RUC database for 78810, the typical examination and valuation at that time was the 78811 vignette. It is therefore the opinion of the ACR and SNM that 7881X2 and 78813 represent new physician work and that budget neutrality should not be applied to this family of codes. We request that the RUC formally concur that based on the vignettes in the RUC database for 78810 that 7881X2 and 78813 represent new physician work.

There are additional issues that must be considered. CMS does not reimburse PET imaging under CPT code 78810. CMS has established a series HCPCS G Codes for providers to report PET. These codes based on the site and/or pathologic diagnosis of the primary tumor, such as colon cancer or lymphoma, rather than the complexity of the examination. As such, there are no claims data available to determine the distribution of 78811, 7881X2 and 78813. Surveys of the members of the ACR and SNM suggest that the vast majority of PET examinations will be 7881X2.

Valuation of 78811

78811 is considered by the ACR and SNM to represent the service valued by the RUC in 1994, and the median value of 1.93 from the survey suggests that the respondents considered this to be the case as well. However, the RUC committees of the ACR and SNM have evaluated the survey data and have concluded that the survey median RVU cannot be supported by the time. Therefore, we have recommended the 25 percentile value of 1.80 for 78811.

Valuation of 7881X2 and 78813

For 7881X2 and 78813, the ACR and SNM believe that the median values of 2.00 and 2.10 are supported by the survey data. Although the respondents indicate that the intra-service work requires a similar amount of time for 7881X2 and 78813, the pre-service work is more complex for the whole body scan due to the increased time required for review of studies, determining that a whole body scan is necessary and the time spent with the technologist for setting up a whole body scan as compared to the torso scan. This additional 5 minutes justifies the slightly higher work RVU for 78813.

Comparison To 78810

The RUC will note that 78810 was presented to the RUC in 1994 with total time of 68 minutes, all of which has been assigned to the intra-service period. Since there were only 18 survey respondents in 1994, one could

legitimately question the validity of the time data in the RUC database. However, there are additional explanations as well. In 1994, most physicians doing PET stayed at the console during image acquisition for monitoring and review of the data sets on the monitor. This was associated with a considerable period (typically 30 to 45 minutes) of waiting for the images to be acquired. This may have resulted in the relatively low intensity per unit time for PET imaging seen in the RUC database for 78810. Furthermore, in 1994, PET interpretation was largely qualitative.

In current practice, the expectations for PET imaging are significantly higher requiring detailed correlation of both anatomic and functional information. Compared to current practice, the intensity per unit time of 78810 is significantly underestimated by the RUC database. In current practice, the physician time for performing and interpreting PET is less than indicated in 1994. In our current surveys, total times are 40 minutes for 78811, 50 minutes for 7881X2 and 55 minutes for 78813. It is no longer the practice of physicians performing PET to stay at the acquisition console during the entire examination. Independent consoles are available for monitoring the examination and for review and interpretation of the data. As compared to 1994, the number imaging planes reviewed and the number of images reviewed and interpreted have increased dramatically.

Improvements in spatial resolution have made highly accurate anatomic correlation possible and this has become the clinical expectation of PET imaging. Without question, the intensity per unit time has significantly increased since 1994 with a conversion from time spent waiting for images to be acquired to time spent in active interpretation of more complex PET images as well as more difficult correlation with CT and MR images. This increase in intensity is only partially captured in the intensity questions on the current surveys because there is no venue for respondents to compare PET in 1994 to PET in 2004. In the current survey, respondents are merely comparing limited, torso and whole body PET to 78810 as it is performed today, not as to how it was performed in 1994.

Comparison To Other RUC Surveyed Imaging Codes

Some respondents chose codes other than 78810 as their key reference service. CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes with 20 minutes being the intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 788X1, 13 additional minutes for 7881X2, and 18 additional minutes for 78813.

Comparison To RUC Surveyed Non-Radiology Imaging Codes

Although none of the respondents chose 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) as a key reference service code, the code was surveyed for the RUC valuation in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the probe in the esophagus but otherwise, and the recommended values for the PET codes compare favorably with this code as well.

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.

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

CPT Code:78814 Tracking Number: AS4 Global Period: XXX

Recommended Work Relative Value

Specialty Society RVU: 2.20

RUC RVU: 2.20

CPT Descriptor:

Tumor imaging, positron emission tomography (PET) with concurrently acquired CT for attenuation correction and anatomical localization; limited area (eg, chest, head/neck)

(Report 78811-78816 only once per imaging session)

(CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site specific CT code with modifier 59)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 52-year old man with a remote history of adenoid cystic carcinoma of the left parotid gland. The patient recently re-presents with facial weakness and paresthesia. MRI shows abnormal tissue in the parotid bed, but it is unclear whether this is recurrent tumor or post-operative scar. A PET-CT scan of the head / neck and chest is performed to evaluate the extent of recurrent tumor and document precise anatomic distribution prior to consideration for surgery and/or radiation therapy.

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? 13%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the acquisition of CT data in the areas of interest. The physician supervises the technologist in the acquisition and reconstruction of the PET data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The interpreting physician, using a computer workstation, creates or directly supervises the creation of composite images for anatomic correlation by precisely overlying PET and CT images. The physician reviews 3 sets of images - emission PET scans, the CT anatomical localization data, and a fusion of the two images which contain the PET and CT data anatomically superimposed over each other. PET images are interpreted by the physician and correlated with the CT localization data obtained as well as to relevant prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2004				
Presenter(s):	Bibb Allen, Jr., M.D. (ACR), Kenneth McKusick, M.D. (SNM)				
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)				
CPT Code:	78814				
Sample Size:	450	Resp n:	45	Response:	10.0 %
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.40	2.20	2.40	3.78	6.00
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Pre-Service Time:			15.0		
Intra-Service Time:	5.00	20.00	30.00	45.00	90.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	15.00				
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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 51.1 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78814	Key Reference CPT Code: 78810
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	30.00	68.00
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	60.00	68.00
		(RUC Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.65	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.83
Urgency of medical decision making	3.13	3.30

Technical Skill/Physical Effort (Mean)

Technical skill required	3.48	3.57
Physical effort required	2.17	2.39

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.91	3.04
Outcome depends on the skill and judgment of physician	3.74	3.87
Estimated risk of malpractice suit with poor outcome	3.09	3.26

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.30	3.43
Intra-Service intensity/complexity	3.96	3.78
Post-Service intensity/complexity	3.39	3.57

ADDITIONAL RATIONALE

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

Background

Three new codes, 78814, 7881X5 and 78816 have been approved that describe the additional physician work and practice expense of performing PET imaging with the concomitant acquisition of data that is used for attenuation correction and anatomic localization. Anatomic localization, also known as PET-CT fusion, provides highly accurate anatomic localization of foci of abnormal uptake on PET imaging. The additional physician work associated with PET-CT fusion includes not only the recognition of the anatomic areas of abnormal uptake but more importantly the ability to localize disease in anatomically normal lymph nodes and solid organs that can be problematic in comparison of PET images to CT studies without anatomic fusion. Additionally, anatomic abnormalities that are not associated with abnormal uptake must be recognized, and as such the anatomic localization data must be reviewed and evaluated by the physician even in the absence of abnormal uptake on PET imaging. It must be noted that the typical CT data acquired as part of the PET-CT examination is not of similar diagnostic quality to standard CT examinations as slice thickness tends to be greater and oral and IV contrast are typically not administered as this may interfere with the attenuation correction process.

Evaluation of the Survey Data

The RUC committees of the ACR and the SNM reviewed the survey results and believe that the median RVU values of 2.40 RVU for 78814, 2.73 RVU for 7881X5 and 3.00 for 78816. These are supported by the higher survey times compared to PET imaging alone for each of the codes. Using the median values from the survey data, the respondents considered the additional physician work of CT localization over PET imaging alone to be 0.6 RVU for 78814, 0.73 RVU for 7881X5 and 0.9 RVU for 78816. This incremental increase is explained by the progressive increase in volume of the CT data that must be reviewed for each code. 78814 requires review of CT data from one body area, 7881X5 requires review of CT data from 4 body areas and 78816 requires review of CT data from 6 body areas. The survey respondents indicated that there is an increase in the pre-service, intra-service, and post-service time required for interpretation of the PET-CT studies. They are 20 minutes for 78814, 15 minutes for 7881X5 and 20 minutes for 78816, which supports the additional physician work RVUs for this family of codes.

Comparison to the Reference Service and Other RUC Surveyed Imaging Codes

Most respondents chose 78810 as the reference service, and the issues surrounding the changing service since 1994 are described in the rationale for 78811 through 7881X3 and will not be repeated here. As before, some respondents chose codes other than 78810 as their key reference service. As noted in the rationale for the PET codes, CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes and 20 minutes intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 78811, 13 additional minutes for 7881X2, and 18 additional minutes for 7881X3. Comparison to 93312 provides a cross-specialty comparison for an imaging code not used by radiology. Code 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) was surveyed by the RUC in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the probe in the esophagus but otherwise, and the recommended values for the PET-CT codes compare favorably with this code as well.

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.

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

Recommended Work Relative Value

CPT Code:78815 Tracking Number: AS5 Global Period: XXX

Specialty Society RVU: **2.44**RUC RVU: **2.44****CPT Descriptor:**

Tumor imaging, positron emission tomography (PET) with concurrently acquired CT for attenuation correction and anatomical localization; skull base to mid-thigh

(Report 78811-78816 only once per imaging session)

(CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site specific CT code with modifier 59)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old woman with colon carcinoma, has had a right hemicolectomy, radiation and chemotherapy, is asymptomatic but now has rising CEA tumor markers. A PET-CT scan from skull base to mid thigh is performed to assess tumor recurrence and document precise anatomic distribution.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 6%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the acquisition of CT data in the areas of interest. The physician supervises the technologist in the acquisition and reconstruction of the PET data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The interpreting physician, using a computer workstation, creates or directly supervises the creation of composite images for anatomic correlation by precisely overlying PET and CT images. The physician reviews 3 sets of images - emission PET scans, the CT anatomical localization data, and a fusion of the two images which contain the PET and CT data anatomically superimposed over each other. PET images are interpreted by the physician and correlated with the CT localization data obtained as well as to relevant prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Bibb Allen, Jr., M.D. (ACR), Kenneth McKusick, M.D. (SNM)				
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)				
CPT Code:	78815				
Sample Size:	450	Resp n:	49	Response: 10.88 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.40	2.44	2.73	3.93	11.01
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Pre-Service Time:			15.0		
Intra-Service Time:	5.00	26.00	35.00	50.00	100.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	15.00				
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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 26 % of respondents: 53.0 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78815	Key Reference CPT Code: 78810
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	35.00	68.00
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	70.00	68.00
		(RUC Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.04	3.81
Urgency of medical decision making	3.19	3.31

Technical Skill/Physical Effort (Mean)

Technical skill required	3.65	3.65
Physical effort required	2.15	2.31

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.28	3.00
Outcome depends on the skill and judgment of physician	4.08	3.92
Estimated risk of malpractice suit with poor outcome	3.23	3.35

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.24	3.44
Intra-Service intensity/complexity	4.20	3.92
Post-Service intensity/complexity	3.44	3.52

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.*

Background

Three new codes, 7881X4, 78815 and 78816 have been approved that describe the additional physician work and practice expense of performing PET imaging with the concomitant acquisition of data that is used for attenuation correction and anatomic localization. Anatomic localization, also known as PET-CT fusion, provides highly accurate anatomic localization of foci of abnormal uptake on PET imaging. The additional physician work associated with PET-CT fusion includes not only the recognition of the anatomic areas of abnormal uptake but more importantly the ability to localize disease in anatomically normal lymph nodes and solid organs that can be problematic in comparison of PET images to CT studies without anatomic fusion. Additionally, anatomic abnormalities that are not associated with abnormal uptake must be recognized, and as such the anatomic localization data must be reviewed and evaluated by the physician even in the absence of abnormal uptake on PET imaging. It must be noted that the typical CT data acquired as part of the PET-CT examination is not of similar diagnostic quality to standard CT examinations as slice thickness tends to be greater and oral and IV contrast are typically not administered as this may interfere with the attenuation correction process.

Evaluation of the Survey Data

The RUC committees of the ACR and the SNM reviewed the survey results and believe that the median RVU values of 2.40 RVU for 7881X4, 2.73 RVU for 78815 and 3.00 for 78816. These are supported by the higher survey times compared to PET imaging alone for each of the codes. Using the median values from the survey data, the respondents considered the additional physician work of CT localization over PET imaging alone to be 0.6 RVU for 7881X4, 0.73 RVU for 78815 and 0.9 RVU for 78816. This incremental increase is explained by the progressive increase in volume of the CT data that must be reviewed for each code. 7881X4 requires review of CT data from one body area, 78815 requires review of CT data from 4 body areas and 78816 requires review of CT data from 6 body areas. The survey respondents indicated that there is an increase in the pre-service, intra-service, and post-service time required for interpretation of the PET-CT studies. They are 20 minutes for 7881X4, 15 minutes for 78815 and 20 minutes for 78816, which supports the additional physician work RVUs for this family of codes.

Comparison to the Reference Service and Other RUC Surveyed Imaging Codes

Most respondents chose 78810 as the reference service, and the issues surrounding the changing service since 1994 are described in the rationale for 78811 through 7881X3 and will not be repeated here. As before, some respondents chose codes other than 78810 as their key reference service. As noted in the rationale for the PET codes, CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes and 20 minutes intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 78811, 13 additional minutes for 7881X2, and 18 additional minutes for 7881X3. Comparison to 93312 provides a cross-specialty comparison for an imaging code not used by radiology. Code 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) was surveyed by the RUC in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the probe in the esophagus but otherwise, and the recommended values for the PET-CT codes compare favorably with this code as well.

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.
-

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

CPT Code:78816 Tracking Number: AS6 Global Period: XXX

Recommended Work Relative Value

Specialty Society RVU: **2.50**

RUC RVU: **2.50**

CPT Descriptor:

Tumor imaging, positron emission tomography (PET) with concurrently acquired CT for attenuation correction and anatomical localization; whole body

(Report 78811-78816 only once per imaging session)

(CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site specific CT code with modifier 59)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old woman had a malignant melanoma resected from her scalp 14 months previously, followed by right supraclavicular nodal recurrence eight months later. Imaging studies, including PET were abnormal only in that known recurrence site. She has undergone further resection and is now referred for evaluation of her response to chemotherapy and for whole body restaging. A whole body PET-CT scan is performed

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 9%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the acquisition of CT data in the areas of interest. The physician supervises the technologist in the acquisition and reconstruction of the PET data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The interpreting physician, using a computer workstation, creates or directly supervises the creation of composite images for anatomic correlation by precisely overlying PET and CT images. The physician reviews 3 sets of images - emission PET scans, the CT anatomical localization data, and a fusion of the two images which contain the PET and CT data anatomically superimposed over each other. PET images are interpreted by the physician and correlated with the CT localization data obtained as well as to relevant prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2004				
Presenter(s):	Bibb Allen, Jr., M.D. (ACR), Kenneth McKusick, M.D. (SNM)				
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)				
CPT Code:	78816				
Sample Size:	450	Resp n:	47	Response: 10.44 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.40	2.50	3.00	4.20	12.60
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Pre-Service Time:			15.0		
Intra-Service Time:	5.00	30.00	40.00	50.00	120.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	15.00				
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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 49 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78816	Key Reference CPT Code: 78810
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	40.00	68.00
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	70.00	68.00
		(RUC Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.82	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.78
Urgency of medical decision making	3.22	3.39

Technical Skill/Physical Effort (Mean)

Technical skill required	3.52	3.52
Physical effort required	2.26	2.43

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.96	2.96
Outcome depends on the skill and judgment of physician	3.96	3.87
Estimated risk of malpractice suit with poor outcome	3.35	3.35

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.35	3.43
Intra-Service intensity/complexity	4.26	3.83
Post-Service intensity/complexity	3.48	3.57

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.*

Background

Three new codes, 78814, 78815 and 78816 have been approved that describe the additional physician work and practice expense of performing PET imaging with the concomitant acquisition of data that is used for attenuation correction and anatomic localization. Anatomic localization, also known as PET-CT fusion, provides highly accurate anatomic localization of foci of abnormal uptake on PET imaging. The additional physician work associated with PET-CT fusion includes not only the recognition of the anatomic areas of abnormal uptake but more importantly the ability to localize disease in anatomically normal lymph nodes and solid organs that can be problematic in comparison of PET images to CT studies without anatomic fusion. Additionally, anatomic abnormalities that are not associated with abnormal uptake must be recognized, and as such the anatomic localization data must be reviewed and evaluated by the physician even in the absence of abnormal uptake on PET imaging. It must be noted that the typical CT data acquired as part of the PET-CT examination is not of similar diagnostic quality to standard CT examinations as slice thickness tends to be greater and oral and IV contrast are typically not administered as this may interfere with the attenuation correction process.

Evaluation of the Survey Data

The RUC committees of the ACR and the SNM reviewed the survey results and believe that the median RVU values of 2.40 RVU for 78814, 2.73 RVU for 78815 and 3.00 for 78816. These are supported by the higher survey times compared to PET imaging alone for each of the codes. Using the median values from the survey data, the respondents considered the additional physician work of CT localization over PET imaging alone to be 0.6 RVU for 78814, 0.73 RVU for 78815 and 0.9 RVU for 78816. This incremental increase is explained by the progressive increase in volume of the CT data that must be reviewed for each code. 78814 requires review of CT data from one body area, 78815 requires review of CT data from 4 body areas and 78816 requires review of CT data from 6 body areas. The survey respondents indicated that there is an increase in the pre-service, intra-service, and post-service time required for interpretation of the PET-CT studies. They are minutes for 78814, 15 minutes for 78815 and 20 minutes for 78816, which supports the additional physician work RVUs for this family of codes.

Comparison to the Reference Service and Other RUC Surveyed Imaging Codes

Most respondents chose 78810 as the reference service, and the issues surrounding the changing service since 1994 are described in the rationale for 78811 through 7881X3 and will not be repeated here. As before, some respondents chose codes other than 78810 as their key reference service. As noted in the rationale for the PET codes, CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes and 20 minutes intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 78811, 13 additional minutes for 7881X2, and 18 additional minutes for 7881X3. Comparison to 93312 provides a cross-specialty comparison for an imaging code not used by radiology. Code 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) was surveyed by the RUC in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the probe in the esophagus but otherwise, and the recommended values for the PET-CT codes compare favorably with this code as well.

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.

	A	B	C	D	E
1	Positron Emission Tomography (PET) Family (*)Modified and/or Specific to Nuclear Medicine	CMS STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78811 PET Limited area	78812 PET skull base to mid-thigh	78813 PET whole body
2	GLOBAL PERIOD		XXX	XXX	XXX
3	LOCATION		In Office	In Office	In Office
4	TOTAL CLINICAL TIME		120	129	137
5	PRE-SERVICE TIME		26	26	26
6	SERVICE PERIOD		76	85	93
7	POST SERVICE TOTAL		18	18	18
8	Start: Following visit when decision for procedure is made.				
9	(*) 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	6	6	6
10	QC Planar/SPECT Scanner Equipment to be used in scan	NMT			
11	QC PET Scanner Equipment to be used in scan	NMT	7	7	7
12	QC CT Equipment to be used in scan	NMT			
13	Prepare radiopharmaceutical delivered by central pharmacy with state radiation requirements fulfilled. Ready dose for potential infusion/injection with in-house labels and records, and later resurvey and arrange disposal of syringe.	NMT	13	13	13
14	Total Pre-Service Time	NMT	26	26	26
15	End: Patient enters office for procedure				
16	SERVICE PERIOD				
17	Start: When patient enters office for surgery/procedure				
18	Review charts				
19	(*) Greet patient, provide gowning if appropriate, and take to injection/isolation area	NMT	3	3	3
21	(*) Prepare imaging room, equipment, supplies, and set up protocol on computer console.	NMT	0	0	0
22	(*) Prep and position patient in reclining chair/scanner while explaining procedure.	NMT	3	3	3
23	(*) Check glucose, administer ativan (sedative).	NMT	3	3	3
24	Intra-service				
30	(*) Education/Instruction/Counseling as patient is taken back to waiting area after scanning session with emphasis on radiation risk to those at home	NMT	3	3	3
31	(*) Clean scan rooms/equipment after each scanning session	NMT	3	3	3
33	(*) Specific room clean up of injection area with defacement of labels, and comply with state radiation requirements.	NMT	4	4	4
35	Other Clinical Activity (please specify)				
37	(*) Obtain RP dose from radiopharmaceutical receiving and storage area,				
38	reassay and record dose data, ensure dose would be appropriate for				
39	the patient based on the written directive (correct test and patient weight)	NMT	7	7	7
40	(*) Take patient to injection area, set up IV, infuse/inject radiopharmaceutical, review radiation risks, escort to radioactive resting area.	NMT	10	10	10
41	(*) Acquire images and review each set of raw data for completeness, include time between acquisition of images.	NMT	40	49	57
43	Service Period Total	NMT	76	85	93
44	End: Patient leaves office				
45	Post-Service Period				
46	Start: Patient leaves office				
50	(*) Post processing of raw data into final format, development of hard copy, archiving .	NMT	15	15	15
53	(*) Regulatory compliance – wipe tests, surveys of areas used, and documentation to comply with state radiation requirements	NMT	3	3	3
54					
55	Post Service Total	NMT	18	18	18
56	End: With last office visit before end of global period				
57	MEDICAL SUPPLIES				
58	RADIOPHARMACEUTICAL - STORAGE AND RECEIVING AREA				
59	Minimum Supply Pack/Multi Spec	SA048	1	1	1
60	11102 Chux 2ft X 3ft	SB044	1	1	1
61	Sanitizing cloth-wipe (surface, instruments, equipment)	SM021	5	5	5
63	INJECTION AREA				
64	Alcohol Swabs	SJ053	1	1	1
65	Angiocatheter 14g-24g	SC001	1	1	1
66	Stop cock, 3 way	SC049	1	1	1
67	Band aid strip 0.75in X 3 in	SG021	1	1	1

	A	B	C	D	E
1	Positron Emission Tomography (PET) Family (*Modified and/or Specific to Nuclear Medicine)	CMS STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78811 PET Limited area	78812 PET skull base to mid-thigh	78813 PET whole body
2	GLOBAL PERIOD		XXX	XXX	XXX
3	LOCATION		In Office	In Office	In Office
4	TOTAL CLINICAL TIME		120	129	137
5	PRE-SERVICE TIME		26	26	26
6	SERVICE PERIOD		76	85	93
7	POST SERVICE TOTAL		18	18	18
68	Chux	SB044	1	1	1
69	Gauze, 2x2	SG050	1	1	1
70	Sodium chloride 0.9% inj. Bacteriostatic (30ml uou)	SH068	1	1	1
71	Heparin flush	SH040	1	1	1
72	Syringe, 20cc	SC053	1	1	1
73	Needles, 20 g	SC029	1	1	1
75	IMAGING AREA				
79	Drape sheet	SB007			
80	Film 11 X 17	SK022	1	3	5
81	Photographic developer	SK063	1	1	1
82	Photographic Fixer	SK064	1	1	1
83	x-ray envelope	SK091	1	1	1
84	Film Jacket (11x17 inch) for this scan	* \$0.28 ea	*0.28 ea	*0.28 ea	*0.28 ea
85	Equipment				
86	Radiopharmaceutical Receiving Area				
87	Dose Calibrator	E51064	1	1	1
88	Dedicated pharmacy computer and printer (CMS price)	\$13,400	1	1	1
89	Calibration Source Vial Set & Check Sleeves (CMS \$1159 for CSVS w/o check sleeves)	\$1,505	1	1	1
90	Autogamma Counter (Siemens)	\$27,534	1	1	1
91	Survey meter	E53004	1	1	1
92	L-Block and interlocking lead bricks for shielding (Pinestar NMC-2014/NMC-7410)	\$5,260	1	1	1
93	Syringe Shields & Lead Pig Holders (6) (Pinestar 007-970)	1,860.00	1	1	1
94	Lead-lined radioactive waste and lead lined Sharps box (Pinestar F-325)	\$1,500	1	1	1
95	Lead shielding	* \$2,150	1	1	1
99	PET Imaging System with operators console (GE Advance NXi)	1.75 mil	1	1	1
100	Pet Dose Injector 007-0997 Biodex	\$595	1	1	1
101					
102	Injection Area				
103	Phlebotomy-Injection Chair (reclining) NM Catalog	\$2,647	1	1	1
104	Blood sugar tester (one touch ultra GE) and scale	\$200	1	1	1
105	Imaging Area				
106	Co-57 flood source \$2,790 One Year Life	E53002	1	1	1
107	Replaceable Rod Source Life 9-10 month Life	\$20,000	1	1	1
108	L-Block and interlocking lead bricks for shielding (Pinestar NMC-2014/NMC-7410)	\$5,260	1	1	1
109	Physician Analysis & Viewing Station (CMS price)	\$35,000	1	1	1
110	Film processor \$26,832	E51002	1	1	1
111	View Boxes \$909	E51001	1	1	1
112					

	A	B	C	D	E
1	Positron Emission Tomography (PET) - CT Family (*)Modified and/or Specific to Nuclear Medicine	CMS STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78814 PET/CT Limited area (limited area (eg, chest, head/neck)	78815 PET/CT skull base to mid-thigh	78816 PET/CT whole body
2	GLOBAL PERIOD		XXX	XXX	XXX
3	LOCATION		In Office	In Office	In Office
4	TOTAL CLINICAL TIME		115	123	131
5	PRE-SERVICE TIME		30	30	30
6	SERVICE PERIOD		67	75	83
7	POST SERVICE TOTAL		18	18	18
8	Start: Following visit when decision for procedure is made.				
9	(*) 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	6	6	6
10	QC Planar/SPECT Scanner Equipment to be used in scan	NMT			
11	QC PET Scanner Equipment to be used in scan	NMT	7	7	7
12	QC CT Equipment to be used in scan	NMT	4	4	4
13	Prepare radiopharmaceutical delivered by central pharmacy with state radiation requirements fulfilled. Ready dose for potential infusion/injection with in-house labels and records, and later resurvey and arrange disposal of syringe.	NMT	13	13	13
14	Total Pre-Service Time	NMT	30	30	30
15	End: Patient enters office for procedure				
16	SERVICE PERIOD				
17	Start: When patient enters office for surgery/procedure				
18	Review charts				
19	(*) Greet patient, provide gowning if appropriate, and take to injection/isolation area	NMT	3	3	3
20					
21	(*) Prepare imaging room, equipment, supplies, and set up protocol on computer console.	NMT	3	3	3
22	(*) Prep and position patient in reclining chair/scanner while explaining procedure.	NMT			
23	(*) Check glucose, administer ativan (sedative).	NMT	3	3	3
24	Intra-service				
25	(*) Education/Instruction/Counseling as patient is taken back to waiting area after scanning session with emphasis on radiation risk to those at home	NMT	3	3	3
26	(*) Clean scan rooms/equipment after each scanning session	NMT	3	3	3
27	(*) Specific room clean up of injection area with defacement of labels, and comply with state radiation requirements.	NMT	4	4	4
28	Other Clinical Activity (please specify)				
29	(*) 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	7
30	(*) Take patient to injection area, set up IV, infuse/inject radiopharmaceutical, review radiation risks, escort to radioactive resting area.	NMT	10	10	10
31	(*) Acquire images and review each set of raw data for completeness, include time between acquisition of images.	NMT	31	39	47
32					
33	Service Period Total	NMT	67	75	83
34	End: Patient leaves office				
35	Post-Service Period				
36	Start: Patient leaves office				
37	(*) Post processing of raw data into final format, development of hard copy, archiving.	NMT	15	15	15
38	(*) Regulatory compliance – wipe tests, surveys of areas used, and documentation to comply with state radiation requirements	NMT	3	3	3
39					
40	Post Service Total	NMT	18	18	18
41	End: With last office visit before end of global period				
42	MEDICAL SUPPLIES				
43	RADIOPHARMACEUTICAL - STORAGE AND RECEIVING AREA				
44	Minimum Supply Pack/Multi Spec	SA048	1	1	1
45	11102 Chux 2ft X 3ft	SB044	1	1	1
46	Sanitizing cloth-wipe (surface, instruments, equipment)	SM021	5	5	5
47					
48	INJECTION AREA				

	A	B	C	D	E
	Positron Emission Tomography (PET) - CT Family (*Modified and/or Specific to Nuclear Medicine)	CMS STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78814 PET/CT Limited area (limited area (eg, chest, head/neck)	78815 PET/CT skull base to mid-thigh	78816 PET/CT whole body
1					
2	GLOBAL PERIOD		XXX	XXX	XXX
3	LOCATION		In Office	In Office	In Office
4	TOTAL CLINICAL TIME		115	123	131
5	PRE-SERVICE TIME		30	30	30
6	SERVICE PERIOD		67	75	83
7	POST SERVICE TOTAL		18	18	18
49	Alcohol Swabs	SJ053	1	1	1
50	Angiocatheter 14g-24g	SC001	1	1	1
51	Stop cock, 3 way	SC049	1	1	1
52	Band aid strip 0.75in X 3 in	SG021	1	1	1
53	Chux	SB044	1	1	1
54	Gauze, 2x2	SG050	1	1	1
55	Sodium chloride 0.9% inj. Bacteriostatic (30ml uou)	SH068	1	1	1
56	Heparin flush	SH040	1	1	1
57	Syringe, 20cc	SC053	1	1	1
58	Needles, 20 g	SC029	1	1	1
59	Glucose test strips \$.75 each		1	1	
60	IMAGING AREA				
61	Disposable patient gown	SB026	1	1	
62	Paper, table	SB036	7 feet	7 feet	
63	Pillow case - disposable	SB037	1	1	
64	Drape sheet	SB007	0	0	0
65	Film 11 X 17	SK022	1	3	5
66	Photographic developer	SK063	1	1	1
67	Photographic Fixer	SK064	1	1	1
68	x-ray envelope	SK091	1	1	1
69	Film Jacket (11x17 inch) for this scan	* \$0.28 ea	*0.28 ea	*0.28 ea	*0.28 ea
70	Equipment				
71	Radiopharmaceutical Receiving Area				
72	Dose Calibrator	E51064	1	1	1
73	Dedicated pharmacy computer and printer (CMS Pirce)	\$13,400	1	1	1
74	Calibration Source Vial Set & Check Sleeves (CMS \$1,159 for CSVS w/o check)	\$1,505	1	1	1
75	Autogamma Counter (Siemens)	\$27,534	1	1	1
76	Survey meter	E53004	1	1	1
77	L-Block and interlocking lead bricks for shielding (Pinestar NMC-2014/NMC-7410)	\$5,260	1	1	1
78	PET Syringe Shields & Lead Pig Holders (6) (Pinestar 007-970)	2,250.00	1	1	1
79	Lead-lined radioactive waste and lead lined Sharps box (Pinestar F-325)	\$1,500	1	1	1
80	Lead shielding	* \$2,150	1	1	1
81	Y-90 Syringe Shields (2)	\$0	1	1	1
82					
83	PET/CT Room				
84	PET Imaging System with operators console (GE Advance Nxi)	1.75 mil			
85	PET/CT scanner with operator's console (GE Discovery ST4)	2.3 mil	1	1	1
86	Pet Dose Injector 007-0997 Biodex	\$595	1	1	1
87					
88	Injection Area				
89	Phlebotomy-Injection Chair (reclining) NM Catalog	\$2,647	1	1	1
90	Blood sugar tester (one touch ultra GE) and scale	\$200	1	1	1
91	Imaging Area				
92	Co-57 flood source \$2,790 One Year Life	E53002	1	1	1
93	L-Block and interlocking lead bricks for shielding (Pinestar NMC-2014/NMC-7410)	\$5,260	1	1	1
94	Physician Analysis & Viewing Station (CMS price)	\$35,000	1	1	1
95	Film processor \$26,832	E51002	1	1	1
96	View Boxes \$909	E51001	1	1	1
97					
98					



American Society of Transplant Surgeons
1020 North Fairfax Street, #200, Alexandria, VA 22314
Telephone: (703) 684-5990
Fax: (703) 684-6303

April 1, 2004

William L. Rich III, MD, FACS
Chair, AMA/Relative Value Update Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Re: Organ Transplantation Codes

Dear Dr. Rich:

At its February 2004 meeting, the AMA's CPT Editorial Panel approved the American Society of Transplant Surgeons' (ASTS) proposal for organ transplantation coding changes in CPT.

Specifically, the Panel approved:

- New explanatory text for each of the six transplantation sections in CPT (Lung, Heart/Lung, Liver, Pancreas, Intestine, and Kidney);
- Editorial revisions to a number of current code descriptors;
- Eleven new codes describing standard backbench work for organ grafts;
- Eight new codes describing reconstructive backbench work for organ grafts; and
- One new code describing complete removal of a transplanted intestinal allograft.

ASTS has completed the AMA/RUC survey for physician relative work for the eight new codes describing reconstructive backbench work. The AMA/RUC Summary of Recommendation Forms are attached. Practice expense recommendations are also attached. The discussion that follows presents the ASTS' rationale for surveying only these eight new codes.

1. Donor Excision Codes

(RUC Tracking numbers: X1, X2, X3, AC1, AC2, AE1, AE3, AE4, AE5, AE6, AE7, AF1, AG1, AG2, AG8)

The CPT Panel approved editorial revisions to both cadaver and living donor excision codes. For 12 codes, the phrase *including cold preservation* replaced the phrase *with preparation and maintenance of allograft*. For one code, the editorial revision removes the language *excluding preparation and maintenance of allograft*.

Cadaver donor excision services are not paid under the Medicare physician fee schedule (MFS). Instead, these services are considered organ acquisition costs to the hospital and are reimbursed under Part A of Medicare through a payment to the hospital. Medicare regulation at 42 CFR, Section 412.100 provides that certain costs related to inpatient hospital services including, specifically, *organ acquisition costs incurred by hospitals with approved organ transplantation centers . . .* are made on a reasonable

cost basis. *Organ acquisition costs* are defined at 42 CFR, Section 412.100 to include, among other things, the surgeon's fee for excising cadaver organs. Although this regulation refers to kidney excision, CMS has stated elsewhere that this regulation applies to all organs, not just kidney. The Medicare Provider Reimbursement Manual, Part III §3625.3 specifically instructs hospitals to include *surgeon's (sic) fees for excising cadaveric organs* in reporting organ acquisition costs on the hospital cost report.

Additionally, we note that in 1994, ASTS attempted to perform RUC surveys for the extremely variable work of cadaver donor excision services. The values that the RUC recommended to CMS were not based on the survey results, but on facilitation, in an attempt to standardize a non-standard service. The following text, taken from the *Federal Register* (December 8, 1994, p. 63453), presents the CMS decision regarding the RUC recommendations:

We reviewed the RUC recommendation for these cadaver donor codes as a group with representatives of the RUC, our CMDs, and representatives of the specialty societies involved with transplant surgery. We have concluded that the assignment of RVUs to these codes could lead to inequitable payment to some physicians because of the marked variations in time associated with organ acquisitions. Therefore, payment for these services will not be made under the physician fee schedule. Rather, the services furnished by a surgeon who retrieves a cadaveric donor organ that is intended for a Medicare-covered transplant will continue to be paid outside the hospital prospective payment system at 100 percent of the reasonable cost under Part A on a retrospective basis, as set forth at 42 CFR 412.100. These costs are included in the organ acquisition charge of the Certified Transplant Center or the Independent Organ Procurement Organization. (emphasis added)

ASTS did not conduct a RUC survey for the cadaver donor excision codes, which were assigned AMA tracking numbers, for two reasons. First, the revisions to nomenclature were editorial in nature. Second, the RUC survey is designed for work-RVU recommendations for new and revised codes for payment under the MFS. Since excision of cadaveric organs may not be reimbursed under the MFS, by law, and since these services still involve *marked variations in time*, it is not appropriate for these codes to be reviewed through the RUC survey process.

Living donor excision services are reimbursed under the MFS. However, ASTS did not survey these codes because the changes were editorial and did not alter the underlying work. For transplant surgeons, the phrase *preparation and maintenance of allograft*, as it relates to the donor procedures, refers to *perfusion with cold preservation solution and cold maintenance*. For the transplant surgeon, in no instance, would *preparation and maintenance* have included backbench standard graft preparation or additional reconstructive work. The revised descriptors are meant to more clearly describe the work related to the donor procedure and not to change the work. We articulated this to the CPT Panel and the RUC just last year, when the new living liver donor codes were created and reviewed. At that time, CPT (and the RUC) indicated that we should pursue revising the language for all donor codes to make this consistent and clear to everyone. The CPT proposals, reviewed and accepted in February 2004, presented these editorial revisions.

2. Standard Backbench Codes

(RUC Tracking numbers: X2, X3, Y2, Y4, AC3, AE2, AF2, AG3, AG4)

The CPT Panel approved eleven new codes describing standard backbench work. ASTS did not survey these codes at this time because CMS and ASTS are in discussions regarding whether standard backbench

work should be considered an organ acquisition cost which is reimbursed under Part A, or whether these services should be treated as a Part B service paid under the MFS. Current Medicare regulations and guidance do not specifically address this issue.

ASTS has written to CMS stating its views that backbench work should be treated as a hospital organ acquisition cost because of the nature of the work. Briefly, the standard backbench codes describe work that is always necessary to prepare a graft for implantation. However, this work is extremely variable in its execution, as shown by the following examples: 1) The standard backbench graft preparation can be performed at either the donor or recipient site of service; 2) The recipient may die and the prepared graft will need to be sent to a different site for a different recipient; or 3) The grafts may be “split” and then transplanted in one or more recipients at one or more locations. Because of the marked variability in this work, similar to cadaver organ acquisition, it makes most sense to consider this work as a hospital organ acquisition cost. The ASTS has asked CMS to issue definitive guidance on this subject. If CMS determines that backbench work is part of hospital organ acquisition costs reimbursed under Part A, it would not be appropriate for these codes to be reviewed through the RUC survey process. However, if CMS determines that these new codes are new Part B services to be paid under the MFS, then ASTS will conduct AMA/RUC surveys.

3. Backbench Reconstruction Codes

(RUC Tracking numbers: AC4, AC5, AE8, AE9, AF3, AG5, AG6, AG7)

The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts. These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

ASTS has conducted RUC surveys for these codes. As we stated in our CPT proposal, there were no existing codes to describe reconstructive backbench work. We do not know the extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, ASTS believes these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team. It is appropriate that these new backbench reconstruction codes be reviewed by the RUC for MFS RVW recommendations to CMS.

4. Removal of Intestinal Allograft

(RUC Tracking number: AC6)

The CPT Panel approved one new code to describe removal of a transplanted intestinal allograft. ASTS attempted to survey this code, but only received a few responses. This service is infrequently performed (approximately 10 times annually), and is performed by a limited number of transplant surgeons in the country. Our discussions with these surgeons revealed the fact that total postoperative patient care is extensive. These patients will be hospitalized for 21 or more days, followed by two to three office visits weekly. Although there are codes in the MFS that have extensive hospital care (e.g. 39503 with LOS=30 days) or that have extensive outpatient care (e.g. 66172 with 12 office visits), there are no codes in the MFS that have the combination of significant hospital and office work through a 90-day global period.

Dr. William Rich

April 1, 2004

Page 4

Valuing a code with this extensive total work using a survey of magnitude estimation is not possible because there are no good references for "total work."

Additionally, the surgeons who perform this service correctly point out that the intestinal transplantation codes (44135 and 44136) are restricted services under Part B and do not have assigned work-RVUs. Restricted status means that special coverage instructions apply. If a restrictive service is covered and no RVUs are shown, the service is carrier-priced. ASTS recommends that new code 441X4 for removal of intestinal allograft be listed as carrier priced. We also suggest that the global period assignment be 000 instead of 090, since there is so much variability in the post-service work for these patients.

5. Direct Practice Expense

For the eight backbench donor organ reconstruction codes (441X2, 441X3, 471X4, 471X5, 485X2, 503X3, 503X4, and 503X5), ASTS recommends zero direct practice expense inputs. Any necessary clinical staff labor is already included with the primary procedure. There would be no office supplies or office equipment utilized for these facility-only codes.

ASTS appreciates the opportunity to submit this information to the RUC, along with our physician work recommendations for the eight new reconstructive backbench codes. If you have any questions prior to the RUC meeting, please contact me at 312-695-0254 or Ms. Gail Durant, ASTS Executive Director, at 703-684-5990

Sincerely,

A handwritten signature in black ink, appearing to read "M. Abecassis".

Michael M. Abecassis, MD, FACS
RUC Advisor, ASTS

cc: Abraham Shaked, MD, PhD, FACS
President, ASTS

Attachments

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

Recommended Work Relative Value

CPT Code:44720 Tracking Number: AC4 Global Period: XXX Specialty Society RVU: **5.00** RUC RVU: **5.00**

CPT Descriptor: Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A vein of an intestine allograft is too short or is damaged in such a way that it is not suitable for anastomosis with the intended transplant recipient artery. Using a vein graft procured from the donor (or properly preserved vein graft procured from another ABO compatible donor allograft), backbench venous anastomosis is performed on the allograft to create an extension graft.

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: On ice, with continuous bathing in cold preservation solution, a vein graft is procured from the donor (or properly preserved vein graft procured from another ABO compatible donor). The ends of the extension graft and the superior mesenteric vein are brought in close apposition. Using 5-0 or 6-0 prolene suture, the two vessels are sewn together end-to-end to create an extension graft. [Alternatively, if no vein graft is available, a comparably sized arterial graft obtained from the donor, the recipient, or another ABO compatible donor may be used.]

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Michael Abecassis, MD, FACS				
Specialty(s):	American Society of Transplant Surgeons				
CPT Code:	44720				
Sample Size:	250	Resp n:	22	Response:	%
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	4.00	4.56	5.00	6.88	9.00
Pre-Service Evaluation Time:			0.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	22.00	45.00	50.00	60.00	90.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	<u>0.00</u>				
Critical Care time/visit(s):	0.0	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>
35685	ZZZ	4.04

CPT Descriptor Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
35682	ZZZ	7.19

CPT Descriptor Bypass graft; autogenous composite, two segments of veins from two locations

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 68.1 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 44720	Key Reference CPT Code: 35685
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	50.00	0.00
Median Immediate Post-service Time	0.00	45.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	50.00	45.00

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

The number of possible diagnosis and/or the number of management options that must be considered	3.71	2.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.47	3.27
Urgency of medical decision making	3.79	2.71

Technical Skill/Physical Effort (Mean)

Technical skill required	4.13	2.73
Physical effort required	4.07	2.53

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.56	3.27
Outcome depends on the skill and judgment of physician	4.53	3.47
Estimated risk of malpractice suit with poor outcome	3.87	2.60

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.67	3.33
Intra-Service intensity/complexity	4.80	3.53
Post-Service intensity/complexity	4.33	3.27

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.*

In order to maximize the use of organs from deceased donors, organs that in previous decades would not have been considered optimal, are currently being utilized. These include organs with anomalous vascular anatomy (multiple arteries and veins in kidneys, aberrant arteries in livers and pancreas, etc.). In addition, with increasing technology such as microvascular suture techniques, and with better surgical skills, transplant surgeons have been able to utilize previously discarded organs and partial organs from living donors. These developments have resulted in more complex backbench procedures required to render these organs usable.

Transplant surgeons have rated the complexity and intensity of the physician work for the surveyed backbench donor organ reconstructive procedures greater than the reference codes 35685 or 35682. These reconstructions are essential to the successful completion of the transplantation procedure and carry the same significant intensity/complexity of the primary transplantation procedure. In the case of vascular anastomoses necessary for either vascular anomalies or other circumstances, the risk to a less than perfect procedure is graft thrombosis, which will either require graft removal or retransplantation. With respect to the liver, retransplantation carries a 50% mortality rate. In the case of ureteral anastomoses, the risk of a less than perfect procedure is a significant urinary leak that can lead to significant post-transplant morbidity and possible mortality.

Attached is a table that presents the work, time, and intensity/complexity comparison for all surveyed reconstructive backbench codes and reference codes. The codes on this table are listed in descending intensity/complexity families, with the liver backbench reconstructive codes at the highest level, followed by intestine, pancreas, and finally kidney. The table also shows the comparative reference code information (35685, 35682, and 35686). For each of these eight new codes, the survey median RVW is recommended. This results in correct relativity between the codes and compared with similar references.

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 ASTS Estimate: <20% of total national intestinal transplantations. [UNOS data: 759 intestinal transplants have been performed since 1990.]

Frequency 0

Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

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

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

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

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

Recommended Work Relative Value

CPT Code:44721 Tracking Number: AC5 Global Period: XXX Specialty Society RVU: **7.00** RUC RVU: **7.00**

CPT Descriptor: Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An artery of an intestine allograft is too short or is damaged in such a way that it is not suitable for anastomosis with the intended transplant recipient artery. Using an arterial graft procured from the donor (or properly preserved arterial graft procured from another ABO compatible donor allograft), a backbench arterial anastomosis is performed on the allograft to create an extension graft.

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: On ice, with continuous bathing in cold preservation solution, an arterial graft is procured from the donor (or properly preserved arterial graft procured from another ABO compatible donor). The ends of the extension graft and the superior mesenteric artery are brought in close apposition. Using 6-0 or 7-0 prolene suture, the two vessels are sewn together end-to-end to create an extension graft. [Alternatively, if no arterial graft is available, a comparably sized vein graft obtained from the donor, the recipient, or another ABO compatible donor may be used.]

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):		Michael Abecassis, MD, FACS				
Specialty(s):		American Society of Transplant Surgeons				
CPT Code:		44721				
Sample Size: 250		Resp n: 21		Response: 8.40 %		
Sample Type: Random						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		4.00	6.00	7.00	8.00	11.00
Pre-Service Evaluation Time:				0.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		22.00	60.00	70.00	75.00	90.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		0.00				

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>
35685	ZZZ	4.04

CPT Descriptor Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
35682	ZZZ	7.19

CPT Descriptor Bypass graft; autogenous composite, two segments of veins from two locations

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 47.6 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 44721	Key Reference CPT Code: 35685
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	70.00	45.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	70.00	45.00

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

The number of possible diagnosis and/or the number of management options that must be considered	4.44	3.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.90	3.30
Urgency of medical decision making	4.22	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	2.90
Physical effort required	4.60	2.70

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.80	3.40
Outcome depends on the skill and judgment of physician	5.00	3.70
Estimated risk of malpractice suit with poor outcome	3.80	2.60

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.80	3.40
Intra-Service intensity/complexity	4.80	3.50
Post-Service intensity/complexity	4.50	3.40

ADDITIONAL RATIONALE

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

In order to maximize the use of organs from deceased donors, organs that in previous decades would not have been considered optimal, are currently being utilized. These include organs with anomalous vascular anatomy (multiple arteries and veins in kidneys, aberrant arteries in livers and pancreas, etc.). In addition, with increasing technology such as microvascular suture techniques, and with better surgical skills, transplant surgeons have been able to utilize previously discarded organs and partial organs from living donors. These developments have resulted in more complex backbench procedures required to render these organs usable.

Transplant surgeons have rated the complexity and intensity of the physician work for the surveyed backbench donor organ reconstructive procedures greater than the reference codes 35685 or 35682. These reconstructions are essential to the successful completion of the transplantation procedure and carry the same significant intensity/complexity of the primary transplantation procedure. In the case of vascular anastomoses necessary for either vascular anomalies or other circumstances, the risk to a less than perfect procedure is graft thrombosis, which will either require graft removal or retransplantation. With respect to the liver, retransplantation carries a 50% mortality rate. In the case of ureteral anastomoses, the risk of a less than perfect procedure is a significant urinary leak that can lead to significant post-transplant morbidity and possible mortality.

Attached is a table that presents the work, time, and intensity/complexity comparison for all surveyed reconstructive backbench codes and reference codes. The codes on this table are listed in descending intensity/complexity families, with the liver backbench reconstructive codes at the highest level, followed by intestine, pancreas, and finally kidney. The table also shows the comparative reference code information (35685, 35682, and 35686). For each of these eight new codes, the survey median RVW is recommended. This results in correct relativity between the codes and compared with similar references.

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. If necessary, AC5 would be reported as an add-on procedure to 44135 or 44136 (intestinal allotransplantation).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There is no existing code which describes backbench reconstructive work on donor organs. We do not know the extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers.

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

Specialty transplant surgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty ASTS Estimate: <40% of total national intestinal transplantations. [UNOS data: 759 intestinal transplants have been performed since 1990.] Frequency 0 Percentage 0.00 %

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?

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

Specialty ASTS Estimate: <20% of total national intestinal transplantations. [UNOS data: 759 intestinal transplants have been performed since 1990.]

Frequency 0

Percentage

%

Specialty

Frequency 0

Percentage

%

Specialty

Frequency 0

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. Surgical

Svy N	DESC	STAT	RVW	IWPUT	INTRA
47146 42	Liver vein	MIN	2.57		20
		25th	4.50		45
		MED	6.00	0.100	60
		75th	7.19		75
		MAX	13.00		135
47149 43	Liver artery	MIN	3.20		25
		25th	4.84		45
		MED	7.00	0.108	65
		75th	8.00		75
		MAX	14.00		180
44720 22	Intestine vein	MIN	4.00		22
		25th	4.56		45
		MED	5.00	0.100	50
		75th	6.88		60
		MAX	9.00		90
44721 21	Intestine artery	MIN	4.00		22
		25th	6.00		60
		MED	7.00	0.100	70
		75th	8.00		75
		MAX	11.00		90
48552 31	Pancreas vein	MIN	1.75		20
		25th	3.34		42
		MED	4.17	0.083	50
		75th	5.38		73
		MAX	7.50		95
50327 36	Kidney vein	MIN	2.56		20
		25th	4.00		44
		MED	4.04	0.070	58
		75th	4.83		65
		MAX	7.20		90
50328 41	Kidney artery	MIN	1.75		20
		25th	3.50		45
		MED	4.50	0.075	60
		75th	7.00		80
		MAX	7.50		95
50329 37	Kidney ureter	MIN	2.40		20
		25th	3.34		45
		MED	4.30	0.078	55
		75th	5.00		70
		MAX	6.50		90

Svy / Ref	N	COMPLEXITY			INTENSITY								
		Pre	Intra	Post	ME1	ME2	ME3	TS1	TS2	PS1	PS2	PS3	
47146 35685	22	3.71	4.32	3.55	3.86	3.67	4.27	4.45	3.23	4.68	4.68	4.00	
	22	2.67	3.32	2.65	2.73	2.67	3.50	3.50	2.68	3.27	3.50	3.36	
47149 35682	16	4.50	4.60	4.45	4.27	4.07	4.73	4.75	3.63	4.81	4.93	4.25	
	16	2.77	3.25	2.83	2.73	2.57	3.40	3.63	2.63	3.38	3.53	3.50	
44720 35685	15	3.71	4.47	3.79	4.13	4.07	4.53	4.53	3.87	4.67	4.80	4.33	
	15	2.79	3.27	2.71	2.73	2.53	3.27	3.47	2.60	3.33	3.53	3.27	
44721 35685	10	4.44	4.90	4.22	4.50	4.60	4.80	5.00	3.80	4.80	4.80	4.50	
	10	3.11	3.30	3.00	2.90	2.70	3.40	3.70	2.60	3.40	3.50	3.40	
48552 35685	20	3.21	4.14	3.22	3.23	2.47	3.82	4.02	2.73	4.27	4.23	3.59	
	20	2.79	3.50	2.67	2.64	2.47	3.32	3.66	2.41	3.45	3.68	3.45	
50327 35685	20	2.63	3.75	2.65	2.90	2.44	4.00	4.00	2.75	3.90	4.25	3.40	
	20	2.47	3.45	2.61	2.95	2.44	4.00	3.90	2.70	3.85	4.00	3.55	
50328 35685	15	3.46	4.33	3.58	4.13	3.29	4.47	4.40	2.87	4.47	4.33	3.93	
	15	3.08	3.67	3.17	3.07	2.79	4.07	4.03	2.47	3.73	3.73	3.40	
50329 35685	14	3.46	4.36	3.31	3.57	2.85	4.21	4.36	2.57	4.43	4.43	3.79	
	14	3.15	3.79	3.31	3.07	2.85	3.93	4.07	2.50	3.64	3.86	3.43	

References		RVW	IWPUT	INTRA	
35685	1st	4.04	0.090	45	Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit
35682	2nd	7.19	0.092	78	Bypass graft; autogenous composite, two segments of veins from two locations
35686	3rd	3.34	0.095	35	Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Proximal to Splenic Flexure Colonoscopy Aspiration - Biopsy

The CPT Editorial Panel added two new codes to describe a colonoscopy with ultrasound examination, with or without a biopsy. While two codes (45342 and 45341) are adequate to report the endoscopic examination of the rectum and sigmoid colon in combination with endoscopic ultrasound evaluations, they do not adequately describe the endoscopic examination of the entire colon in combination with an endoscopic ultrasound evaluation. Performing colonoscopy and endoscopic ultrasound evaluation of a detected abnormality with or without transendoscopic ultrasound guided fine needle aspiration/biopsy(s) during the same procedure is clinically useful to expedite the diagnostic work-up and to spare patients the added risk, discomfort, inconvenience and expense of multiple procedures.

45391

When the specialty society reviewed the physician work involved in code 45391 *Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination*, the proposed increment was 1.64. The increment was through the RUC's comparison of the work value for the base sigmoidoscopy code 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = .96) and compared this to code 45341 *Sigmoidoscopy, flexible; with endoscopic ultrasound examination* (work RVU= 2.60) for a difference of 1.64 RVUs for the ultrasound examination. This value of 1.64 was then added to the base colonoscopy code 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* (3.69 + 1.64) for a total value of 5.33 RVUs. However, the RUC felt that this increment (1.64) was too large and reduced the increment to 1.40, based on the same rationale to extract the ultrasound portion of work of a similar code under review, 31620 *Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s)*. In this code the RUC recommended subtracting the intra-service work of 43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (Work RVU = 1.59) from 43231 *Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination* (Work RVU = 3.19) to capture only the ultrasound portion of work, resulting in a work RVU of 1.40. For code 45391, the RUC recommends to add the base colonoscopy code, 45378, plus the new increment (3.69 + 1.40 = 5.09). **Therefore, the RUC recommends a 5.09 work RVU for 45391.**

45392

After extensive discussion the RUC felt that in order to maintain relativity between 45391 and 45392 using the 1.40 increment method of valuation for code 45392 *Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)* was appropriate and was consistent with previous RUC efforts to value a family of GI transendoscopic ultrasound and the needle/aspiration/biopsy codes. Therefore the specialty society recommended work RVU of 6.54 was also decreased by 0.24 applying the same 1.40 increment as 45391. There is also a difference of 20 minutes of intra-service time between 45391 and 45392 which the RUC felt that it was reasonable to apply the 1.40 increment to code 45392 in order to keep maintain the proper rank order. **The RUC recommends a 6.54 work RVU for 45392.**

In addition, the RUC understood that these procedures typically required conscious sedation in a facility setting, and therefore should on the conscious sedation list.

Practice Expense

The RUC assessed and modified the practice expense. Since these two codes are conducted in-facility only, a 000 day global would not have discharge day management time. Therefore, the RUC removed six minutes in each code for discharge day management time and added a three minute call in the post-op time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
45378		<i>Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)</i>	000	3.69 (No Change)
•45391	AD1	with endoscopic ultrasound examination <u>(Do not report 45391 in conjunction with 45330, 45341, 45342, 45378 or 76872)</u>	000	5.09
•45392	AD2	with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s) <u>(Do not report 45392 in conjunction with 45330, 45341, 45342, 45378 or 76872)</u>	000	6.54

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

Recommended Work Relative Value

CPT Code:45391 Tracking Number: AD1 Global Period: 000 Specialty Society RVU: 5.33 RUC RVU: 5.09

CPT Descriptor: Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Physical examination in a 52-year-old woman reveals guaiac positive stools and a rectal mass identified on digital rectal examination. A CT scan reveals rectal wall thickening but no metastatic disease. Colonoscopy with endoscopic ultrasound is requested to evaluate and further stage the suspected tumor, and to assess the remainder of the colon for additional lesions.

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

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: 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: A standard colonoscope is inserted into the rectum and advanced through the colon to the cecum. The colonic mucosa appears normal except for an ulcerated 2cm lesion which is seen in the lower rectum. A dedicated echoendoscope is prepared with a balloon placed over the transducer housing. The echoendoscope is inserted into the rectum and advanced under direct visualization. In the area of the mucosal lesion, the balloon is filled with water to achieve acoustic coupling. Continuous imaging with ultrasound is performed and visualization of the lesion, the colonic wall layers, and the peri-colonic structures is procured. No regional lymph node enlargement is identified. The echoendoscope is withdrawn.

Description of Post-Service Work: The patient is transferred to the recovery suite. Post-procedure vital signs are assessed. The radiographs generated during the exam are reviewed. A procedure report is dictated. When stable for discharge, the findings are reviewed with patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):		Drs. Michael Levy (ASGE) and Joel Brill (AGA)			
Specialty(s):		Gastroenterology			
CPT Code:		45391			
Sample Size:	60	Resp n:	35	Response: 58.33 %	
Sample Type: Convenience					
		Low	25th pctl	Median*	75th pctl
Survey RVW:		4.50	5.98	6.00	13.00
Pre-Service Evaluation Time:				25.0	
Pre-Service Positioning Time:				5.0	
Pre-Service Scrub, Dress, Wait Time:				5.0	
Intra-Service Time:		25.00	42.50	55.00	120.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	<u>20.00</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>
45383	000	5.86

CPT Descriptor Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
43261	000	6.26

CPT Descriptor Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple

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

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

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

TIME ESTIMATES (Median)

	New/Revised CPT Code: 45391	Key Reference CPT Code: 45383
Median Pre-Service Time	35.00	22.00
Median Intra-Service Time	55.00	65.00
Median Immediate Post-service Time	20.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	110.00	107.00

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	4.00	4.00
Urgency of medical decision making	4.00	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.00
Physical effort required	4.00	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	4.00
Outcome depends on the skill and judgment of physician	5.00	4.00
Estimated risk of malpractice suit with poor outcome	4.00	4.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity	4.00	4.00

ADDITIONAL RATIONALE

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

Our societies conducted a survey and received an appropriate number of responses and the data were tightly distributed around the median. Despite doing so we felt that the resulting recommended work values were inappropriately high and inconsistent with the values of similar procedures in the family of codes even if adjusted to the 25th percentile work value of the survey data. Instead, we are recommending a work value of 5.33 for code 45391 and a work value of 6.78 for code 45392. The recommended work values were derived by taking the work value for the base colonoscopy code and adding to this value the incremental work values assigned to the sigmoidoscopy EUS codes (codes 45341 and 45342). The base colonoscopy code, 45378 has a work value of 3.69. The base sigmoidoscopy code, 45330, has a work value of 0.96. Code 45341, sigmoidoscopy with EUS, has a work value of 2.60 or an incremental value of 1.64 RVUs above the base sigmoidoscopy. Thus, we are recommending a work value of 5.33 RVUs for code 45341; i.e., $3.69 + 1.64 = 5.33$ RVUs. The work value assigned to code 45342, EUS with biopsy or fine needle aspiration, is 4.05 RVUs or 3.09 RVUs above the base code. Using this amount as the incremental work value for performing a colonoscopy with EUS and FNA above the base code, we are recommending a work value of 6.78; i.e., $3.69 + 3.09 = 6.78$. We think this method of valuation keeps these procedures in proper rank order.

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) 45341, 45378, or 45999

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

Specialty Gastroenterology How often? Rarely

Specialty Gastrointestinal/Endoscopic Surgeons How often? Rarely

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? 300

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

Specialty Gastroenterology Frequency 230 Percentage 76.66 %

Specialty Gastrointestinal/Endoscopic Surgeons Frequency 70 Percentage 23.33 %

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. 43237

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:45392 Tracking Number: AD2 Global Period: 000 Specialty Society RVU: **6.78** RUC RVU: **6.54**

CPT Descriptor: Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year old man presents with left flank pain. He underwent gastrectomy for gastric cancer two years earlier. An abdominal CT demonstrates a 2 cm mass adjacent to the sigmoid colon. Colonoscopy with endoscopic ultrasound and possible transendoscopic ultrasound guided biopsy was requested.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: 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: A standard colonoscope is inserted into the rectum and advanced through the colon to the cecum. The colonoscope is withdrawn and the mucosa carefully examined. In the sigmoid colon, there is a smooth, extrinsic appearing compression of the colonic lumen without obvious mucosal abnormalities. The remainder of the procedure is unremarkable. A dedicated echoendoscope is prepared with a balloon placed over the transducer housing. The echoendoscope is inserted into the rectum and advanced through the colon under direct visualization. In the area of the suspected lesion, the acoustic coupling balloon is filled with water. Continuous imaging with ultrasound is performed and visualization of the lesion, the colonic wall layers and the peri-colonic structures is procured. An extracolonic mass is seen adjacent to the sigmoid colon. As the identified abnormality may represent recurrent disease, fine needle aspiration biopsy is undertaken. Intravenous antibiotics are administered to the patient. The first echoendoscope is withdrawn. A linear scanning echoendoscope is prepared for the exam. The linear scanning echoendoscope is introduced into the rectum and advanced to the sigmoid colon under direct visualization. A needle biopsy catheter is advanced through the linear scanning echo endoscope and directed under ultrasound guidance into the lesion of interest. Multiple biopsies are taken until an adequate sample is procured. The echoendoscope is withdrawn.

Description of Post-Service Work: The patient is transferred to the recovery suite. Post procedure vital signs are assessed. The radiographs generated during the exam are reviewed. A procedure report is dictated. When stable for discharge, the findings are reviewed with patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Drs. Michael Levy (ASGE) and Joel Brill (AGA)				
Specialty(s):	Gastroenterology				
CPT Code:	45392				
Sample Size:	60	Resp n:	35	Response: 58.33 %	
Sample Type:	Convenience				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	7.00	7.30	7.50	8.90	18.00
Pre-Service Evaluation Time:			30.0		
Pre-Service Positioning Time:			5.0		
Pre-Service Scrub, Dress, Wait Time:			10.0		
Intra-Service Time:	30.00	60.00	75.00	90.00	150.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	<u>20.00</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>
43242	000	7.30

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) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
43264	000	8.89

CPT Descriptor Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts

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

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

Number of respondents who choose Key Reference Code: 19 % of respondents: 54.2 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 45392	Key Reference CPT Code: 43242
Median Pre-Service Time	45.00	0.00
Median Intra-Service Time	75.00	0.00
Median Immediate Post-service Time	20.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	140.00	0.00

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

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

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	5.00
--------------------------	------	------

Physical effort required	5.00	4.00
--------------------------	------	------

Psychological Stress (Mean)

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

Outcome depends on the skill and judgment of physician	5.00	5.00
--	------	------

Estimated risk of malpractice suit with poor outcome	5.00	4.00
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	4.00
----------------------------------	------	------

Intra-Service intensity/complexity	5.00	5.00
------------------------------------	------	------

Post-Service intensity/complexity	4.00	4.00
-----------------------------------	------	------

ADDITIONAL RATIONALE

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

Our societies conducted a survey and received an appropriate number of responses and the data were tightly distributed around the median. Despite doing so we felt that the resulting recommended work values were inappropriately high and inconsistent with the values of similar procedures in the family of codes even if adjusted to the 25th percentile work value of the survey data. Instead, we are recommending a work value of 5.33 for code 45391 and a work value of 6.78 for code 45392. The recommended work values were derived by taking the work value for the base colonoscopy code and adding to this value the incremental work values assigned to the sigmoidoscopy EUS codes (codes 45341 and 45342). The base colonoscopy code, 45378 has a work value of 3.69. The base sigmoidoscopy code, 45330, has a work value of 0.96. Code 45341, sigmoidoscopy with EUS, has a work value of 2.60 or an incremental value of 1.64 RVUs above the base sigmoidoscopy. Thus, we are recommending a work value of 5.33 RVUs for code 45341; i.e., $3.69 + 1.64 = 5.33$ RVUs. The work value assigned to code 45342, EUS with biopsy or fine needle aspiration, is 4.05 RVUs or 3.09 RVUs above the base code. Using this amount as the incremental work value for performing a colonoscopy with EUS and FNA above the base code, we are recommending a work value of 6.78; i.e., $3.69 + 3.09 = 6.78$. We think this method of valuation keeps these procedures in proper rank order.

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) 45342, 45378, or 45999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty Gastrointestinal/Endoscopic Surgeons How often? Rarely

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? 30

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

Specialty Gastroenterology Frequency 24 Percentage 80.00 %

Specialty Gastrointestinal/Endoscopic Surgeons Frequency 6 Percentage 20.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. The PLI for this code is in the same category as code 45383.

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

	A	B	C	D	E	F	G
1		staff, supply, equip		45391		45392	
	Meeting Date: April 2004 Specialties: ASGE, AGA			Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination		Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	
2		CODE	DESC				
3	LOCATION			Office	Facility	Office	Facility
4	GLOBAL PERIOD				0		0
5	TOTAL TIME	L037D	RN/LPN/MTA		22		22
6	PRE-service time	L037D	RN/LPN/MTA		19		19
7	SERVICE time	L037D	RN/LPN/MTA		0		0
8	POST-service time	L037D	RN/LPN/MTA		3		3
9	PRE-SERVICE - BEFORE ADMISSION						
10	Start: Following decision for surgery visit						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
15	Phone calls & prescriptions	L037D	RN/LPN/MTA		3		3
16	End: When pt enters site for service						
17	SERVICE PERIOD - ADMISSION TO DISCHARGE						
18	Start: When pt enters site for procedure						
19	Pre-service services						
20	Review charts	L037D	RN/LPN/MTA				
23	Complete diag forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
24	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
25	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA				
26	Dischg day mgmt outpt=6" 99238=12" 99239=15"	L037D	RN/LPN/MTA				
27	Other Clinical Activity: Clean equipment	L037D	RN/LPN/MTA				
28	End: Patient leaves office/facility						
29	POST-SERVICE Period - AFTER DISCHARGE						
30	Start: Patient leaves office/facility						
31	Follow-up phone call	L037D	RN/LPN/MTA		3		3
40	Total Office Visit Time	L037D	RN/LPN/MTA				
41	Other Activity: Download data from recorder to workstation, print report, and prepare file for MD review						
42	End: last office visit - end of global period						
43	MEDICAL SUPPLIES						
44	Procedure Scrub, Dress						
45							
46							
47							
48	Equipment						
49							
50							
51							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Liver Transplantation

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes 47133 *Donor hepatectomy (including cold preservation), ~~with preparation and maintenance of allograft, from cadaver donor~~*; 47143 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment*; 47144 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into two partial liver grafts (ie, left lateral segment (segments II and III) and right trisegment (segments I and IV through VIII))*; and 47145 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into two partial liver grafts (ie, left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII))* are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at this time **the RUC does not submit any recommendations for codes 47133, 47143, 47144, and 47145.**

Backbench Reconstruction Codes (47146 and 47147)

The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts, including CPT codes 47146 *Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each* and 47147 *Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each*. These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

The RUC understands that there were no existing codes to describe reconstructive backbench work. The extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers is unknown. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore,

the specialty has indicated that these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team.

The specialty discussed the significant intensity and complexity of the backbench reconstruction. The RUC understands that the three-dimensional visualization is difficult and the surgeon must guess as to what it is going to look like when it is placed in the recipient. The impact of complications of these anastomoses will affect the mortality rate for the patient and the surgeon who is performing the anastomoses is aware at that time the importance of making certain that the organ is perfect. In addition, the specialty clarified that although venous anastomoses are often viewed as more work than arterial anastomoses, the opposite is true for this backbench reconstruction. The veins are typically easier than the artery as these anastomoses are in the arterial branches and are smaller than the vein.

The RUC reviewed survey data from more than forty transplant surgeons for these two services. The RUC understands that these are essentially add-on codes and only include intra-service work. These services should be modifier -51 exempt. CPT code 47146 requires 60 minutes of intra-service time and 47147 requires 65 minutes of intra-service time. The RUC agreed that the survey medians of 6.00 for 47146 and 7.00 for 47147 were appropriate based on comparison with the reference services 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (work relative value = 4.04 and 45 minutes intra-service time) and 35682 *Bypass graft; autogenous composite, two segments of veins from two locations* (work relative value = 7.19 and 78 minutes intra-service time). The RUC agreed that these new codes were more intense than the reference services, as indicated by the survey results. **The RUC recommends 6.00 for CPT code 47146 and 7.00 for CPT code 47147.**

Practice Expense

Codes 47146 and 47147 are essentially add-on services performed in the facility. Therefore, there are no additional direct practice expense inputs.

Liver allotransplantation involves three distinct components of physician work:

1) Cadaver donor hepatectomy includes harvesting the graft and cold preservation of the graft (perfusing with cold preservation solution and cold maintenance) (see 47133). A living donor hepatectomy includes harvesting the graft, cold preservation of the graft (perfusing with cold preservation solution and cold maintenance), and care of the donor (See 47140-47142).

2) Backbench work

Backbench standard preparation of the whole liver graft will include one of the following:

Preparation of a whole liver graft (including cholecystectomy, if necessary and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation) (see 47143)

Preparation as described for a whole liver graft, plus a trisegment split into two partial grafts (see 47144)

Preparation as described for a whole liver graft, plus a lobe split into two partial grafts (see 47145)

Backbench additional reconstruction of the liver graft may include venous and/or arterial anastomosis(es) (see 47146,47147).

3) Recipient liver allotransplantation includes recipient hepatectomy (partial or whole), transplantation of the allograft (partial or whole), and care of the recipient (see 47135, 47136).

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲47133	AE1	Donor hepatectomy <u>(including cold preservation)</u> , with preparation and maintenance of allograft , from cadaver donor (47134 has been deleted. To report, use 47140)	XXX	Currently not on the MFS, No RUC Recommendation at this time
47135		Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age	090	81.40 (No Change)
47136		heterotopic, partial or whole, from cadaver or living donor, any age	090	68.50 (No Change)
▲47140	AE2	Donor hepatectomy <u>(including cold preservation)</u> , with preparation and maintenance of allograft , from living donor; left lateral segment only (segments II and III)	090	54.92 (No Change)
▲47141	AE3	total left lobectomy (segments II, III and IV)	090	67.40 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 47142	AE4	total right lobectomy (segments V, VI, VII and VIII)	090	74.89 (No Change)
● 47143	AE5	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment	XXX	Currently not on the MFS, No RUC Recommendation at this time
● 47144	AE6	with trisegment split of whole liver graft into two partial liver grafts (ie, left lateral segment (segments II and III) and right trisegment (segments I and IV through VIII))	090	Currently not on the MFS, No RUC Recommendation at this time
● 47145	AE7	with lobe split of whole liver graft into two partial liver grafts (ie, left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII)	090	Currently not on the MFS, No RUC Recommendation at this time
● 47146	AE8	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each	XXX	6.00
● 47147	AE9	arterial anastomosis, each (Do not report 47142-47147 in conjunction with 47120-47125, 47600, 47610)	XXX	7.00



American Society of Transplant Surgeons
1020 North Fairfax Street, #200, Alexandria, VA 22314
Telephone: (703) 684-5990
Fax: (703) 684-6303

April 1, 2004

William L. Rich III, MD, FACS
Chair, AMA/Relative Value Update Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Re: Organ Transplantation Codes

Dear Dr. Rich:

At its February 2004 meeting, the AMA's CPT Editorial Panel approved the American Society of Transplant Surgeons' (ASTS) proposal for organ transplantation coding changes in CPT.

Specifically, the Panel approved:

- New explanatory text for each of the six transplantation sections in CPT (Lung, Heart/Lung, Liver, Pancreas, Intestine, and Kidney);
- Editorial revisions to a number of current code descriptors;
- Eleven new codes describing standard backbench work for organ grafts;
- Eight new codes describing reconstructive backbench work for organ grafts; and
- One new code describing complete removal of a transplanted intestinal allograft.

ASTS has completed the AMA/RUC survey for physician relative work for the eight new codes describing reconstructive backbench work. The AMA/RUC Summary of Recommendation Forms are attached. Practice expense recommendations are also attached. The discussion that follows presents the ASTS' rationale for surveying only these eight new codes.

1. Donor Excision Codes

(RUC Tracking numbers: X1, X2, X3, AC1, AC2, AE1, AE3, AE4, AE5, AE6, AE7, AF1, AG1, AG2, AG8)

The CPT Panel approved editorial revisions to both cadaver and living donor excision codes. For 12 codes, the phrase *including cold preservation* replaced the phrase *with preparation and maintenance of allograft*. For one code, the editorial revision removes the language *excluding preparation and maintenance of allograft*.

Cadaver donor excision services are not paid under the Medicare physician fee schedule (MFS). Instead, these services are considered organ acquisition costs to the hospital and are reimbursed under Part A of Medicare through a payment to the hospital. Medicare regulation at 42 CFR, Section 412.100 provides that certain costs related to inpatient hospital services including, specifically, *organ acquisition costs incurred by hospitals with approved organ transplantation centers . . .* are made on a reasonable

cost basis. *Organ acquisition costs* are defined at 42 CFR, Section 412.100 to include, among other things, the surgeon's fee for excising cadaver organs. Although this regulation refers to kidney excision, CMS has stated elsewhere that this regulation applies to all organs, not just kidney. The Medicare Provider Reimbursement Manual, Part III §3625.3 specifically instructs hospitals to include *surgeon's (sic) fees for excising cadaveric organs* in reporting organ acquisition costs on the hospital cost report.

Additionally, we note that in 1994, ASTS attempted to perform RUC surveys for the extremely variable work of cadaver donor excision services. The values that the RUC recommended to CMS were not based on the survey results, but on facilitation, in an attempt to standardize a non-standard service. The following text, taken from the *Federal Register* (December 8, 1994, p. 63453), presents the CMS decision regarding the RUC recommendations:

We reviewed the RUC recommendation for these cadaver donor codes as a group with representatives of the RUC, our CMDs, and representatives of the specialty societies involved with transplant surgery. We have concluded that the assignment of RVUs to these codes could lead to inequitable payment to some physicians because of the marked variations in time associated with organ acquisitions. Therefore, payment for these services will not be made under the physician fee schedule. Rather, the services furnished by a surgeon who retrieves a cadaveric donor organ that is intended for a Medicare-covered transplant will continue to be paid outside the hospital prospective payment system at 100 percent of the reasonable cost under Part A on a retrospective basis, as set forth at 42 CFR 412.100. These costs are included in the organ acquisition charge of the Certified Transplant Center or the Independent Organ Procurement Organization. (emphasis added)

ASTS did not conduct a RUC survey for the cadaver donor excision codes, which were assigned AMA tracking numbers, for two reasons. First, the revisions to nomenclature were editorial in nature. Second, the RUC survey is designed for work-RVU recommendations for new and revised codes for payment under the MFS. Since excision of cadaveric organs may not be reimbursed under the MFS, by law, and since these services still involve *marked variations in time*, it is not appropriate for these codes to be reviewed through the RUC survey process.

Living donor excision services are reimbursed under the MFS. However, ASTS did not survey these codes because the changes were editorial and did not alter the underlying work. For transplant surgeons, the phrase *preparation and maintenance of allograft*, as it relates to the donor procedures, refers to *perfusion with cold preservation solution and cold maintenance*. For the transplant surgeon, in no instance, would *preparation and maintenance* have included backbench standard graft preparation or additional reconstructive work. The revised descriptors are meant to more clearly describe the work related to the donor procedure and not to change the work. We articulated this to the CPT Panel and the RUC just last year, when the new living liver donor codes were created and reviewed. At that time, CPT (and the RUC) indicated that we should pursue revising the language for all donor codes to make this consistent and clear to everyone. The CPT proposals, reviewed and accepted in February 2004, presented these editorial revisions.

2. Standard Backbench Codes

(RUC Tracking numbers: X2, X3, Y2, Y4, AC3, AE2, AF2, AG3, AG4)

The CPT Panel approved eleven new codes describing standard backbench work. ASTS did not survey these codes at this time because CMS and ASTS are in discussions regarding whether standard backbench

work should be considered an organ acquisition cost which is reimbursed under Part A, or whether these services should be treated as a Part B service paid under the MFS. Current Medicare regulations and guidance do not specifically address this issue.

ASTS has written to CMS stating its views that backbench work should be treated as a hospital organ acquisition cost because of the nature of the work. Briefly, the standard backbench codes describe work that is always necessary to prepare a graft for implantation. However, this work is extremely variable in its execution, as shown by the following examples: 1) The standard backbench graft preparation can be performed at either the donor or recipient site of service; 2) The recipient may die and the prepared graft will need to be sent to a different site for a different recipient; or 3) The grafts may be “split” and then transplanted in one or more recipients at one or more locations. Because of the marked variability in this work, similar to cadaver organ acquisition, it makes most sense to consider this work as a hospital organ acquisition cost. The ASTS has asked CMS to issue definitive guidance on this subject. If CMS determines that backbench work is part of hospital organ acquisition costs reimbursed under Part A, it would not be appropriate for these codes to be reviewed through the RUC survey process. However, if CMS determines that these new codes are new Part B services to be paid under the MFS, then ASTS will conduct AMA/RUC surveys.

3. Backbench Reconstruction Codes

(RUC Tracking numbers: AC4, AC5, AE8, AE9, AF3, AG5, AG6, AG7)

The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts. These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

ASTS has conducted RUC surveys for these codes. As we stated in our CPT proposal, there were no existing codes to describe reconstructive backbench work. We do not know the extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, ASTS believes these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team. It is appropriate that these new backbench reconstruction codes be reviewed by the RUC for MFS RVW recommendations to CMS.

4. Removal of Intestinal Allograft

(RUC Tracking number: AC6)

The CPT Panel approved one new code to describe removal of a transplanted intestinal allograft. ASTS attempted to survey this code, but only received a few responses. This service is infrequently performed (approximately 10 times annually), and is performed by a limited number of transplant surgeons in the country. Our discussions with these surgeons revealed the fact that total postoperative patient care is extensive. These patients will be hospitalized for 21 or more days, followed by two to three office visits weekly. Although there are codes in the MFS that have extensive hospital care (e.g. 39503 with LOS=30 days) or that have extensive outpatient care (e.g. 66172 with 12 office visits), there are no codes in the MFS that have the combination of significant hospital and office work through a 90-day global period.

Dr. William Rich

April 1, 2004

Page 4

Valuing a code with this extensive total work using a survey of magnitude estimation is not possible because there are no good references for "total work."

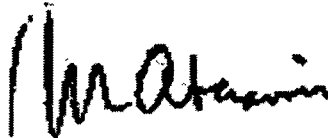
Additionally, the surgeons who perform this service correctly point out that the intestinal transplantation codes (44135 and 44136) are restricted services under Part B and do not have assigned work-RVUs. Restricted status means that special coverage instructions apply. If a restrictive service is covered and no RVUs are shown, the service is carrier-priced. ASTS recommends that new code 441X4 for removal of intestinal allograft be listed as carrier priced. We also suggest that the global period assignment be 000 instead of 090, since there is so much variability in the post-service work for these patients.

5. Direct Practice Expense

For the eight backbench donor organ reconstruction codes (441X2, 441X3, 471X4, 471X5, 485X2, 503X3, 503X4, and 503X5), ASTS recommends zero direct practice expense inputs. Any necessary clinical staff labor is already included with the primary procedure. There would be no office supplies or office equipment utilized for these facility-only codes.

ASTS appreciates the opportunity to submit this information to the RUC, along with our physician work recommendations for the eight new reconstructive backbench codes. If you have any questions prior to the RUC meeting, please contact me at 312-695-0254 or Ms. Gail Durant, ASTS Executive Director, at 703-684-5990

Sincerely,



Michael M. Abecassis, MD, FACS
RUC Advisor, ASTS

cc: Abraham Shaked, MD, PhD, FACS
President, ASTS

Attachments

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

Recommended Work Relative Value

CPT Code:47146 Tracking Number: AE8 Global Period: XXX Specialty Society RVU: **6.00** RUC RVU: **6.00**

CPT Descriptor: Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The liver graft recipient portal vein is thrombosed (non-usable) and a venous extension is necessary on the donor liver allograft portal vein. Under loupe magnification, an anastomosis between a conduit (either the common or external iliac arteries) and the portal vein is performed on the donor allograft.

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: In the case of portal vein thrombosis in the recipient, a venous extension may be needed on the donor portal vein. On ice, with continuous bathing in cold preservation solution, a segment of donor iliac vein with matching diameter to the portal vein (either common or external iliac vein) is anastomosed end-to-end to the portal vein. This anastomosis is performed with fine (5-0) monofilament suture. The liver graft is kept cold in anticipation of transplantation. If necessary, the liver graft is repackaged in a sterile fashion and maintained cold prior to transplantation.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Michael Abecassis, MD, FACS				
Specialty(s):	American Society of Transplant Surgeons				
CPT Code:	47146				
Sample Size:	250	Resp n:	42	Response: 16.80 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	2.57	4.50	6.00	7.19	13.00
Pre-Service Evaluation Time:			0.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	20.00	45.00	60.00	75.00	135.00
Post-Service	Total Min**	CPT code / # of visits			
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>
35685	ZZZ	4.04

CPT Descriptor Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
35682	ZZZ	7.19

CPT Descriptor Bypass graft; autogenous composite, two segments of veins from two locations

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

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

Number of respondents who choose Key Reference Code: 22 % of respondents: 52.3 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 47146	Key Reference CPT Code: <u>35685</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	60.00	45.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	60.00	45.00

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

The number of possible diagnosis and/or the number of management options that must be considered	3.71	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.32	3.32
Urgency of medical decision making	3.55	2.65

Technical Skill/Physical Effort (Mean)

Technical skill required	3.86	2.73
Physical effort required	3.67	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.27	3.50
Outcome depends on the skill and judgment of physician	4.45	3.50
Estimated risk of malpractice suit with poor outcome	3.23	2.68

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.68	3.27
Intra-Service intensity/complexity	4.68	3.50
Post-Service intensity/complexity	4.00	3.36

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.*

In order to maximize the use of organs from deceased donors, organs that in previous decades would not have been considered optimal, are currently being utilized. These include organs with anomalous vascular anatomy (multiple arteries and veins in kidneys, aberrant arteries in livers and pancreas, etc.). In addition, with increasing technology such as microvascular suture techniques, and with better surgical skills, transplant surgeons have been able to utilize previously discarded organs and partial organs from living donors. These developments have resulted in more complex backbench procedures required to render these organs usable.

Transplant surgeons have rated the complexity and intensity of the physician work for the surveyed backbench donor organ reconstructive procedures greater than the reference codes 35685 or 35682. These reconstructions are essential to the successful completion of the transplantation procedure and carry the same significant intensity/complexity of the primary transplantation procedure. In the case of vascular anastomoses necessary for either vascular anomalies or other circumstances, the risk to a less than perfect procedure is graft thrombosis, which will either require graft removal or retransplantation. With respect to the liver, retransplantation carries a 50% mortality rate. In the case of ureteral anastomoses, the risk of a less than perfect procedure is a significant urinary leak that can lead to significant post-transplant morbidity and possible mortality.

Attached is a table that presents the work, time, and intensity/complexity comparison for all surveyed reconstructive backbench codes and reference codes. The codes on this table are listed in descending intensity/complexity families, with the liver backbench reconstructive codes at the highest level, followed by intestine, pancreas, and finally kidney. The table also shows the comparative reference code information (35685, 35682, and 35686). For each of these eight new codes, the survey median RVW is recommended. This results in correct relativity between the codes and compared with similar references.

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. If necessary, AE8 would be reported as an add-on procedure to 47135 or 47136 (liver allotransplantation).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There is no existing code which describes backbench reconstructive work on donor organs. We do not know the extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers.

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

Specialty transplant surgery How often? Rarely

Specialty How often?

Specialty How often?

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

Specialty ASTS Estimate: <5% of total national liver transplantations. UNOS data: 59,449 liver transplants for the period 1988 – June 30, 2003. 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?

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

Specialty ASTS Estimate: < 1% of total national liver transplantations. UNOS data: 59,449 liver transplants for the period 1988 – June 30, 2003.

Frequency 0

Percentage

%

Specialty

Frequency 0

Percentage

%

Specialty

Frequency 0

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. Surgical

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

Recommended Work Relative Value

CPT Code:47147 Tracking Number: AE9 Global Period: XXX Specialty Society RVU: 7.00 RUC RVU: 7.00

CPT Descriptor: Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The right hepatic artery of a liver allograft is aberrant or injured (lacerated) and continuity between the celiac axis and the vessel is necessary. Under loupe magnification, an arterial anastomosis is performed to reconstruct the right hepatic artery on the donor allograft.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: On ice, with continuous bathing in cold preservation solution, an end-to-end or end-to-side arterial anastomoses between the right hepatic artery and the celiac axis is performed using either running or interrupted fine (7-0) monofilament suture under loupe magnification between either the superior mesenteric artery or the replaced (or injured) right hepatic artery, and either the splenic artery stump, or the gastroduodenal artery stump. Depending on the anatomy of the donor, other techniques for arterial reconstruction may be applied. The liver graft is kept cold in anticipation of transplantation. If necessary, the liver graft is repackaged in a sterile fashion and maintained cold prior to transplantation.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	Michael Abecassis, MD, FACS					
Specialty(s):	American Society of Transplant Surgeons					
CPT Code:	47147					
Sample Size:	250	Resp n:	43	Response:	%	
Sample Type:	Random					
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:		3.20	4.84	7.00	8.00	14.00
Pre-Service Evaluation Time:				0.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		25.00	45.00	65.00	75.00	180.00
Post-Service	Total Min**	<u>CPT code / # of visits</u>				
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>
35682	ZZZ	7.19

CPT Descriptor Bypass graft; autogenous composite, two segments of veins from two locations

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
35685	ZZZ	4.04

CPT Descriptor Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 37.2 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 47147	Key Reference CPT Code: 35682
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	65.00	78.00
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	65.00	78.00

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	4.50	2.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	3.25
Urgency of medical decision making	4.45	2.83

Technical Skill/Physical Effort (Mean)

Technical skill required	4.27	2.73
Physical effort required	4.07	2.57

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.73	3.40
Outcome depends on the skill and judgment of physician	4.75	3.63
Estimated risk of malpractice suit with poor outcome	3.63	2.63

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.81	3.38
Intra-Service intensity/complexity	4.93	3.53
Post-Service intensity/complexity	4.25	3.50

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.*

In order to maximize the use of organs from deceased donors, organs that in previous decades would not have been considered optimal, are currently being utilized. These include organs with anomalous vascular anatomy (multiple arteries and veins in kidneys, aberrant arteries in livers and pancreas, etc.). In addition, with increasing technology such as microvascular suture techniques, and with better surgical skills, transplant surgeons have been able to utilize previously discarded organs and partial organs from living donors. These developments have resulted in more complex backbench procedures required to render these organs usable.

Transplant surgeons have rated the complexity and intensity of the physician work for the surveyed backbench donor organ reconstructive procedures greater than the reference codes 35685 or 35682. These reconstructions are essential to the successful completion of the transplantation procedure and carry the same significant intensity/complexity of the primary transplantation procedure. In the case of vascular anastomoses necessary for either vascular anomalies or other circumstances, the risk to a less than perfect procedure is graft thrombosis, which will either require graft removal or retransplantation. With respect to the liver, retransplantation carries a 50% mortality rate. In the case of ureteral anastomoses, the risk of a less than perfect procedure is a significant urinary leak that can lead to significant post-transplant morbidity and possible mortality.

Attached is a table that presents the work, time, and intensity/complexity comparison for all surveyed reconstructive backbench codes and reference codes. The codes on this table are listed in descending intensity/complexity families, with the liver backbench reconstructive codes at the highest level, followed by intestine, pancreas, and finally kidney. The table also shows the comparative reference code information (35685, 35682, and 35686). For each of these eight new codes, the survey median RVW is recommended. This results in correct relativity between the codes and compared with similar references.

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. If necessary, AE9 would be reported as an add-on procedure to 47135 or 47136 (liver allotransplantation).
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There is no existing code which describes backbench reconstructive work on donor organs. We do not know the extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers.

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

Specialty transplant surgery How often? Rarely

Specialty How often?

Specialty How often?

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

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty ASTS Estimate: <30% of total national liver transplantations. UNOS data: 59,449 liver transplants for the period 1988 – June 30, 2003. 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?

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

Specialty ASTS Estimate: <6% of total national liver transplantations. UNOS data: 59,449 liver transplants for the period 1988 – June 30, 2003.

Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Specialty Frequency 0 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. Surgical

Svy N	DESC	STAT	RVW	IWPUT	INTRA
47146 42	Liver vein	MIN	2.57		20
		25th	4.50		45
		MED	6.00	0.100	60
		75th	7.19		75
		MAX	13.00		135
47149 43	Liver artery	MIN	3.20		25
		25th	4.84		45
		MED	7.00	0.108	65
		75th	8.00		75
		MAX	14.00		180
44720 22	Intestine vein	MIN	4.00		22
		25th	4.56		45
		MED	5.00	0.100	50
		75th	6.88		60
		MAX	9.00		90
44721 21	Intestine artery	MIN	4.00		22
		25th	6.00		60
		MED	7.00	0.100	70
		75th	8.00		75
		MAX	11.00		90
48552 31	Pancreas vein	MIN	1.75		20
		25th	3.34		42
		MED	4.17	0.083	50
		75th	5.38		73
		MAX	7.50		95
50327 36	Kidney vein	MIN	2.56		20
		25th	4.00		44
		MED	4.04	0.070	58
		75th	4.83		65
		MAX	7.20		90
50328 41	Kidney artery	MIN	1.75		20
		25th	3.50		45
		MED	4.50	0.075	60
		75th	7.00		80
		MAX	7.50		95
50329 37	Kidney ureter	MIN	2.40		20
		25th	3.34		45
		MED	4.30	0.078	55
		75th	5.00		70
		MAX	6.50		90

References	RVW	IWPUT	INTRA
------------	-----	-------	-------

35685	1st	4.04	0.090	45
35682	2nd	7.19	0.092	78
35686	3rd	3.34	0.095	35

Svy / Ref	N	COMPLEXITY			INTENSITY								
		Pre	Intra	Post	ME1	ME2	ME3	TS1	TS2	PS1	PS2	PS3	
47146 35685	22	3.71	4.32	3.55	3.86	3.67	4.27	4.45	3.23	4.68	4.68	4.00	
	22	2.67	3.32	2.65	2.73	2.67	3.50	3.50	2.68	3.27	3.50	3.36	
47149 35682	16	4.50	4.60	4.45	4.27	4.07	4.73	4.75	3.63	4.81	4.93	4.25	
	16	2.77	3.25	2.83	2.73	2.57	3.40	3.63	2.63	3.38	3.53	3.50	
44720 35685	15	3.71	4.47	3.79	4.13	4.07	4.53	4.53	3.87	4.67	4.80	4.33	
	15	2.79	3.27	2.71	2.73	2.53	3.27	3.47	2.60	3.33	3.53	3.27	
44721 35685	10	4.44	4.90	4.22	4.50	4.60	4.80	5.00	3.80	4.80	4.80	4.50	
	10	3.11	3.30	3.00	2.90	2.70	3.40	3.70	2.60	3.40	3.50	3.40	
48552 35685	20	3.21	4.14	3.22	3.23	2.47	3.82	4.02	2.73	4.27	4.23	3.59	
	20	2.79	3.50	2.67	2.64	2.47	3.32	3.66	2.41	3.45	3.68	3.45	
50327 35685	20	2.63	3.75	2.65	2.90	2.44	4.00	4.00	2.75	3.90	4.25	3.40	
	20	2.47	3.45	2.61	2.95	2.44	4.00	3.90	2.70	3.85	4.00	3.55	
50328 35685	15	3.46	4.33	3.58	4.13	3.29	4.47	4.40	2.87	4.47	4.33	3.93	
	15	3.08	3.67	3.17	3.07	2.79	4.07	4.03	2.47	3.73	3.73	3.40	
50329 35685	14	3.46	4.36	3.31	3.57	2.85	4.21	4.36	2.57	4.43	4.43	3.79	
	14	3.15	3.79	3.31	3.07	2.85	3.93	4.07	2.50	3.64	3.86	3.43	

Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit
Bypass graft; autogenous composite, two segments of veins from two locations
Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
February 2004
Stapling Hemorrhoidopexy

CPT created a new code 46947 *Hemorrhoidopexy, (e.g. for prolapsing internal hemorrhoids by stapling)* to describe the repair of hemorrhoidal prolapse utilizing a stapling technique because current CPT nomenclature does not accurately describe this procedure. This procedure is different than other internal hemorrhoidectomy codes, which involve either excision and suture ligation or rubber band ligation.

Although the survey responses met the minimum RUC standards, the presenters stated that the survey respondents estimated a relative value that was too high and would have created a rank order anomaly. The presenters argued that a value that was below the survey minimum value was necessary. The survey respondents chose code 46260 *Hemorrhoidectomy, internal and external, complex or extensive* (work RVU= 6.36) as the reference service but the specialty society consensus committee felt that the new code should be valued less than the reference code. The specialty society consensus committee reviewing the current survey agreed that new code 46947 is more complex and requires additional technical skill, compared with the treatment options such as 46221 *Hemorrhoidectomy, by simple ligature (e.g., rubber band)* (work RVU= 2.04) or 46255 *Hemorrhoidectomy, internal and external, simple* (work RVU = 4.59). In terms of total work, 46947 fits well above 46221 and 46255, but below 46260. Although the survey's lowest value of 6.00 fit this rank order, the presenters stated that the specialty consensus committee believes that the resulting IWPUT of 0.086 would be inconsistent with other comparable codes. The specialty then calculated a relative value that would place the new code in proper rank order.

The intra-service work/intensity of the new code was believed to be .060 which was similar to intensities calculated for 45150 *Division of stricture of rectum (work RVU 5.66)*, 38305 *Drainage of lymph node abscess or lymphadenitis; extensive* (work RVU = 5.99), and 49585 *Repair umbilical hernia, age 5 years or over; reducible* (work RVU = 6.22). Utilizing an IWPUT of 0.060 which is similar to these three codes, an RVW of 5.20 was calculated based on a total time of 168 minutes. Other CPT codes with similar total time and/or intra-service time/work were reviewed such as 43244 *Upper GI endoscopy w-esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices* (work RVU = 5.04 and total time = 147 minutes) also code 58600 *Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral* (work RVU = 5.57, total time = 164). The RUC agreed that a value of 5.20 would place 46947 in a correct "total work" relative position to 46221, 46255, and 46260. This value also correlates well to the intra-service intensity of 45150, 38305, and 49585.

The RUC recommends a work RVU of 5.20 for code 46947.

Practice Expense

The inputs approved by the RUC are the standard inputs for a 90 day global period code performed only in the facility setting. The RUC also approved some additional supplies for the post operative office visits.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
46262		<i>Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy</i> <u>(For injection of hemorrhoids, see 46500; for destruction, see 46934-46936; for ligation, see 46945, 46946; for hemorrhoidopexy, 46947)</u>	090	7.49 (No Change)
46500		<i>Injection of sclerosing solution, hemorrhoids</i> <u>(For excision of hemorrhoids, see 46250-46262; destruction, 46934-46936; ligation, see 46945-46946; hemorrhoidopexy, 46947)</u>	010	1.61 (No Change)
46936		<i>Destruction of hemorrhoids, any method; internal and external</i> <u>(For excision of hemorrhoids, see 46250-46262; injection, see 46500; ligation, see 46945-46946; hemorrhoidopexy, 46947)</u>		3.68 (No Change)
•46947	D1	Hemorrhoidopexy, (eg, for prolapsing internal hemorrhoids) by stapling <u>(For excision of hemorrhoids, see 46250-46262; for injection, see 46500; for destruction, see 46934-46936)</u>	090	5.20

New CPT Code: 46947 (D1) Global: 090 Recommended RVW: 5.20
CPT Descriptor: Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids by stapling)

Survey Vignette (Typical Patient)

A 36-year-old female presents with grade III prolapsing internal hemorrhoids that have failed non-operative management. After the decision is made to operate, the surgeon reviews all the previous laboratory and endoscopic studies, and informed consent is obtained. At operation, she undergoes a stapled hemorrhoidopexy. Postoperative visits are conducted as necessary during the 90-day global period to assure normal recovery and the absence of any complications.

Percentage of Survey Respondents who found Vignette to be Typical: 94% agreed, other respondents indicated typical patient would be older.

Clinical Description Of Service:

Pre-operative work:

- Write orders for pre-operative medications and enemas
- Review pre-operative work-up
- Review the planned procedure
- Counsel the patient and obtain informed consent
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome with patient and family
- Review length and type of anesthesia with anesthesiologist
- Verify that all necessary surgical instruments and supplies are available in the operative suite
- After induction of spinal anesthesia, monitor patient positioning, prepping and draping, and assist with positioning as needed
- Scrub and gown

Intra-operative Work:

A progressive anal dilation is performed, and a circular anoscope is inserted into the anus. A purse-string suture anoscope is inserted through the circular anoscope. A circumferential purse-string suture is placed into the mucosa and submucosa only. A digital vaginal examination is performed in order to confirm that the posterior vaginal wall is not incorporated into the purse-string suture. Once the vaginal exam is completed, the purse-string suture is gently tightened in order to draw the redundant rectal mucosa into the lumen of the rectum. An opened stapler is inserted through the circular anoscope, and the anvil is passed through the purse-string suture. The purse-string suture is tied around the shaft of the stapler. The suture threader is used to pull the free ends of the suture through lateral channels of the stapler housing. The stapler is tightened. The vagina is once again examined to confirm that the posterior vaginal wall is not incorporated into the stapler. The stapler is fired and held closed for one minute to assist hemostasis. The head of the stapler is opened, and the stapler and circular anoscope are removed together. The specimen is removed from the stapler and inspected by the surgeon to verify that a complete circumferential excision of tissue was obtained. A digital examination confirms that the staple line is circumferential. The purse-string anoscope or a retractor is then inserted into the anus to inspect for bleeding at the staple line. Local anesthetic may be injected for post-op analgesia.

Postoperative work:

- Prior to discharge from facility: Apply dry dressings; write orders for post-op medication, diet and patient activity; discuss the procedure outcome with patient; dictate a post-op report; dictate procedure outcome and expected recovery letter for referring physician and/or insurance company.
- At each office visit: Examine the patient, checking for inflammation/delayed healing, partial impaction and patient functional progress; answer patient questions; discuss patient progress with referring physician (verbal/written); and dictate patient progress notes for medical chart.

SURVEY DATA

Presenter(s):	David Margolin, MD				
Specialty(s):	American Society of Colon and Rectal Surgeons				
CPT Code:	46947				
Sample Size:	70	Resp n:	31	Resp %:	44%
Sample Type:	Random – mailed to geographically distributed random selection of physicians who indicated that they perform PPH (as found on the website: http://www.pphinfo.com/find.jsp)				
		Low	25th pctl	Median	75th pctl
Survey RVW:		6.00	6.37	7.00	8.00
Pre-Service Evaluation Time:				40	
Pre-Service Positioning Time:				10	
Pre-Service Scrub, Dress, Wait Time:				10	
Intra-Service Time:		15	20	30	30
Post-Service	Total Min*	CPT code / # of visits			
Immed. Post-time:	22				
Critical Care time/visit(s):					
Other Hospital time/visit(s):					
Discharge Day Mgmt:	18	99238 x 0.5			
Office time/visit(s):	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).

KEY REFERENCE SERVICE(S):

CPT	Descriptor	new '04 RVW	Glob
46260	Hemorrhoidectomy, internal and external, complex or extensive;	6.36	90

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

TIME ESTIMATES (MEDIAN)	Svy CPT 46947	Ref CPT 46260
Pre-service	60	60
Intra-service	30	60
Same Day Immediate Post-service	22	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	38	38
TOTAL TIME	168	206

INTENSITY/COMPLEXITY MEASURES (MEAN)

Respondents who chose key reference code	19	19
--	----	----

TIME SEGMENTS

Pre-service	3.05	3.06
Intra-service	3.54	3.19
Post-service	2.79	2.75

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.26	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.69	2.69
Urgency of medical decision making	2.58	2.56

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.68	3.38
Physical effort required	2.95	3.13

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.47	3.19
Outcome depends on the skill and judgment of physician	3.68	3.19
Estimated risk of malpractice suit with poor outcome	3.58	3.25

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

Internal hemorrhoids usually are not painful, but may bleed and may stretch until they bulge outside the anus (i.e., prolapsed hemorrhoid). Common treatment options include:

- 46221 *Rubber band ligation* where the hemorrhoidal tissue is pulled into a double-sleeved cylinder to allow the placement of latex/rubber bands around the tissue. Over time, the tissue below the bands dies off and is eliminated during a bowel movement. Often, however, there is the need for more than one procedure to resolve the condition. [46221: 10-day global; RVW=2.03; office-based]
- 46255 or 46260 *Hemorrhoidectomy* where the tissue that causes bleeding or protrusion is surgically removed. [4625.: 90-day global; RVW=4.57; facility based] or [46260: 90-day global; RVW=6.33; facility based]

Other methods of hemorrhoid treatment include infrared coagulation, bicap coagulation, injection sclerotherapy, laser hemorrhoidectomy, and doppler ultrasound guided hemorrhoidal artery ligation. New code 46947 describes the repair of hemorrhoidal prolapse utilizing a stapling technique.

The consensus committee reviewing the current survey (including ASCRS, ACS, and ASGS representation) agree that new code 46947 is more complex and requires additional technical skill, compared with the treatment options - 46221, 46255, or 46260. In terms of total work, 46947 fits well above 46221 and 46255, but below 46260. Although the survey's lowest value of 6.00 fit this rank order, the consensus committee believes that the resulting IWPUT of 0.086 (Table 2a.) may be slightly inconsistent with other comparable codes.

Other CPT codes with similar total time and/or intraservice time/work were reviewed (Table 1). The intraservice work/intensity was believed to be most similar to 45150, 38305, and 49585. Utilizing an IWPUT of 0.060 which is similar to these three codes, an RVW of 5.20 is calculated (Table 2b.).

An RVW of 5.20 is recommended for 46947. This value places 46947 in a correct "total work" relative position to 46221, 46255, and 46260. This value also correlates well to the intraservice intensity of 45150, 38305, and 49585.

Table 1.

	CPT	Descriptor	GLOB	2004 RVW	IWPUT	TOT min	PRE min	INTRA min	SD min	HV -31	HV -38	OV -13	OV -12
RUC	46221	Hemorrhoidectomy, by simple ligature (eg, rubber band)	010	2.03	0.047	68	15	15	15			1	
Hvd	15822	Blepharoplasty, upper eyelid;	090	4.42	0.053	136	41	33	21				3 5
RUC	46255	Hemorrhoidectomy, internal and external, simple;	090	4.57	0.019	191	60	45	30		0.5	1	1
RUC	43244	Upper GI endoscopy w- esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices	000	5.02	0.054	147	57	54	36				
NEW	46947	Hemorrhoidopexy	090	5.20	0.060	168	60	30	22		0.5	1	1
RUC	58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	090	5.57	0.059	164	50	35	20		1.0	1	
Hvd	45150	Division of stricture of rectum	090	5.64	0.061	136	47	30	19	0.5	1.0		2.5
RUC	38305	Drainage of lymph node abscess or lymphadenitis; extensive	090	5.97	0.064	184	45	30	30		0.5	2	1
RUC	49585	Repair umbilical hernia, age 5 years or over, reducible	090	6.19	0.062	176	45	45	30		0.5	1	1
RUC	46260	Hemorrhoidectomy, internal and external, complex or extensive;	090	6.33	0.043	206	60	60	30		0.5	1	1
RUC	46262	Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy	090	7.46	0.088	176	40	45	20		0.5	1	2

Table 2a.

<u>Building Block Analysis</u>		<u>Minimum Survey</u> RVW = 6.00	
	Svy Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)
eval & positioning	50	0.0224	1.12
scrub, dress, wait	10	0.0081	0.08
Pre-service total			1.20
<u>Post-service:</u>	Time	Intensity	(=time x intensity)
Immediate post	22	0.0224	0.49
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
Discharge 99238	0.5	1.28	0.64
99213	1	0.65	0.65
99212	1	0.43	0.43
Post-service total			2.21
	Time	IWPUT	INTRA-RVW
<u>Intra-service:</u>	30	0.086	2.59

Table 2b.

<u>Building Block Analysis</u>		<u>Recommended RVW</u> 5.20	
	Svy Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)
eval & positioning	50	0.0224	1.12
scrub, dress, wait	10	0.0081	0.08
Pre-service total			1.20
<u>Post-service:</u>	Time	Intensity	(=time x intensity)
Immediate post	22	0.0224	0.49
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
Discharge 99238	0.5	1.28	0.64
99213	1	0.65	0.65
99212	1	0.43	0.43
Post-service total			2.21
	Time	IWPUT	INTRA-RVW
<u>Intra-service:</u>	30	0.060	1.79

Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? **NO**
 2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. **N/A**
-

FREQUENCY INFORMATION**How was this service previously reported**

46999 Unlisted procedure, anus

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

Specialty: colon & rectal 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: colon & rectal surgery/general surgery

Frequency: This procedure was initiated in Europe in 1988 and described in US literature in 1998. In 2001 approximately 1500 procedures were performed (based on manufacture's data).

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: colon & rectal surgery/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? Yes

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

CPT	DESCRIPTION	GLOBAL
46947 D1	Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids by stapling)	90

CLINICAL STAFF TIME:

Pre-service period clinical staff time: Sixty minutes has been established by a PEAC workgroup as the typical total time it takes on average across all specialties and for all categories of pre-service work to get a patient into a facility for a procedure. This time has been applied.

Service period clinical staff time: The assignment of 6 minutes (as supported by the PEAC) relative to coding of 99238 for discharge management for outpatient services has been applied.

Post-service period clinical staff time: Standard EM postop visit times for clinical staff have been applied as appropriate.

SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:

Standard PEAC minimum multispecialty office visit supplies and supplies for anoscopy at one visit have been applied.

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D
1		staff, supply, equip		46947
2		CODE	DESC	Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids by stapling)
3	LOCATION			Fac-Only
4	GLOBAL PERIOD			90
5	TOTAL TIME	L037D	RN/LPN/MTA	129
6	PRE-service time	L037D	RN/LPN/MTA	60
7	SERVICE time	L037D	RN/LPN/MTA	6
8	POST-service time	L037D	RN/LPN/MTA	63
9	PRE-SERVICE - BEFORE ADMISSION			
10	Start: Following decision for surgery visit			
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA	8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	7
17	End: When pt enters site for service			
18	SERVICE PERIOD - ADMISSION TO DISCHARGE			
19	Start: When pt enters site for procedure			
39	Dischg day mgmt outpt=6" 99238=12" 99239=15"	L037D	RN/LPN/MTA	6
41	End: Patient leaves office/facility			
42	POST-SERVICE Period - AFTER DISCHARGE			
43	Start: Patient leaves office/facility			
47	99211 16 minutes		16	
48	99212 27 minutes		27	1.0
49	99213 36 minutes		36	1.0
50	99214 53 minutes		53	
51	99215 63 minutes		63	
53	Total Office Visit Time	L037D	RN/LPN/MTA	63
55	End: last office visit - end of global period			
56	MEDICAL SUPPLIES			
57	pack, minimum multi-specialty visit	SA048	pack	2
58	anoscope	SD003	item	1
59	lubricating jelly (K-Y) (5gm uou)	SJ032	item	4
60	swab, procto 16in	SJ052	item	3
61	Equipment			
62	exam lamp	E30006		X
63	power table	E11003		X

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Pancreas Transplantation

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes *48550 Donor pancreatectomy (including cold preservation), ~~with preparation and maintenance of allograft from cadaver donor~~, with or without duodenal segment for transplantation* and *48551 Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from the iliac artery to the superior mesenteric artery and to the splenic artery* are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at this time **the RUC does not submit any recommendations for codes 48550 and 48551.**

Backbench Reconstruction Codes 48552

The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts, including CPT code 48552 *Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation; venous anastomosis, each*. This code describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient. The specialty has indicated that typically only one anastomosis is performed

The RUC understands that there were no existing codes to describe reconstructive backbench work. The extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers is unknown. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, the specialty has indicated that these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team.

The specialty discussed the significant intensity and complexity of the backbench reconstruction. The RUC understands that the three-dimensional visualization is difficult and the surgeon must guess as to what it is going to look like when it is placed in the recipient. The impact of complications of these anastomoses will affect the mortality rate for the patient and the surgeon who is performing the anastomoses is aware at that time the importance of making certain that the organ is perfect.

The RUC reviewed survey data from more than thirty transplant surgeons for this service. The RUC understands that this is essentially an add-on codes and only includes intra-service work. This service should be modifier -51 exempt. CPT code 48552 requires 40 minutes of intra-service time. The RUC agreed that the survey median of 4.30 is appropriate based on comparison with the reference services 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (work relative value = 4.04 and 45 minutes intra-service time) and 35682 *Bypass graft; autogenous composite, two segments of veins from two locations* (work relative value = 7.19 and 78 minutes intra-service time). The RUC agreed that this new service is more intense than the reference services, as indicated by the survey results. **The RUC recommends 4.30 for CPT code 48552..**

Practice Expense

CPT Code 48552 is essentially add-on services performed in the facility. Therefore, there are no additional direct practice expense inputs.

Pancreas allotransplantation involves three distinct components of physician work:

1) Cadaver donor pancreatectomy including harvesting the pancreas graft, with or without duodenal segment, and cold preservation of the graft (perfusing with cold preservation solution and cold maintenance) (see 48550).

2) Backbench work

Backbench standard preparation of a cadaver donor pancreas allograft prior to transplantation includes dissection of the allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from the iliac artery to the superior mesenteric artery and to the splenic artery (see 48551).

Backbench additional reconstruction of a cadaver donor pancreas allograft prior to transplantation may include venous anastomosis(-es) (see 48552).

3) Allotransplantation. Recipient pancreas allotransplantation includes transplantation of allograft, and care of the recipient (see 48554).

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲48550	AF1	Donor pancreatectomy (including cold preservation), with preparation and maintenance of allograft from cadaver donor, with or without duodenal segment for transplantation	XXX	Currently not on the MFS. No RUC Recommendation at this time.
●48551	AF2	Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of the allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from the iliac artery to the superior mesenteric artery and to the splenic artery	XXX	Currently not on the MFS. No RUC Recommendation at this time.
●48552	AF3	Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation; venous anastomosis, each (Do not report 48551 and 48552 in conjunction with 35531, 35563, 35685, 38100, 38101, 38102, 44010, 44820, 44850, 47460, 47505 - 47525, 47550 - 47556, 48100 - 48120, 48545))	XXX	4.30
48554		<i>Transplantation of pancreatic allograft</i>	090	34.12 (No Change)
48556		<i>Removal of transplanted pancreatic allograft</i>	090	15.69 (No Change)



American Society of Transplant Surgeons
1020 North Fairfax Street, #200, Alexandria, VA 22314
Telephone: (703) 684-5990
Fax: (703) 684-6303

April 1, 2004

William L. Rich III, MD, FACS
Chair, AMA/Relative Value Update Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Re: Organ Transplantation Codes

Dear Dr. Rich:

At its February 2004 meeting, the AMA's CPT Editorial Panel approved the American Society of Transplant Surgeons' (ASTS) proposal for organ transplantation coding changes in CPT.

Specifically, the Panel approved:

- New explanatory text for each of the six transplantation sections in CPT (Lung, Heart/Lung, Liver, Pancreas, Intestine, and Kidney);
- Editorial revisions to a number of current code descriptors;
- Eleven new codes describing standard backbench work for organ grafts;
- Eight new codes describing reconstructive backbench work for organ grafts; and
- One new code describing complete removal of a transplanted intestinal allograft.

ASTS has completed the AMA/RUC survey for physician relative work for the eight new codes describing reconstructive backbench work. The AMA/RUC Summary of Recommendation Forms are attached. Practice expense recommendations are also attached. The discussion that follows presents the ASTS' rationale for surveying only these eight new codes.

1. Donor Excision Codes

(RUC Tracking numbers: X1, X2, X3, AC1, AC2, AE1, AE3, AE4, AE5, AE6, AE7, AF1, AG1, AG2, AG8)

The CPT Panel approved editorial revisions to both cadaver and living donor excision codes. For 12 codes, the phrase *including cold preservation* replaced the phrase *with preparation and maintenance of allograft*. For one code, the editorial revision removes the language *excluding preparation and maintenance of allograft*.

Cadaver donor excision services are not paid under the Medicare physician fee schedule (MFS). Instead, these services are considered organ acquisition costs to the hospital and are reimbursed under Part A of Medicare through a payment to the hospital. Medicare regulation at 42 CFR, Section 412.100 provides that certain costs related to inpatient hospital services including, specifically, *organ acquisition costs incurred by hospitals with approved organ transplantation centers . . .* are made on a reasonable

cost basis. *Organ acquisition costs* are defined at 42 CFR, Section 412.100 to include, among other things, the surgeon's fee for excising cadaver organs. Although this regulation refers to kidney excision, CMS has stated elsewhere that this regulation applies to all organs, not just kidney. The Medicare Provider Reimbursement Manual, Part III §3625.3 specifically instructs hospitals to include *surgeon's (sic) fees for excising cadaveric organs* in reporting organ acquisition costs on the hospital cost report.

Additionally, we note that in 1994, ASTS attempted to perform RUC surveys for the extremely variable work of cadaver donor excision services. The values that the RUC recommended to CMS were not based on the survey results, but on facilitation, in an attempt to standardize a non-standard service. The following text, taken from the *Federal Register* (December 8, 1994, p. 63453), presents the CMS decision regarding the RUC recommendations:

We reviewed the RUC recommendation for these cadaver donor codes as a group with representatives of the RUC, our CMDs, and representatives of the specialty societies involved with transplant surgery. We have concluded that the assignment of RVUs to these codes could lead to inequitable payment to some physicians because of the marked variations in time associated with organ acquisitions. Therefore, payment for these services will not be made under the physician fee schedule. Rather, the services furnished by a surgeon who retrieves a cadaveric donor organ that is intended for a Medicare-covered transplant will continue to be paid outside the hospital prospective payment system at 100 percent of the reasonable cost under Part A on a retrospective basis, as set forth at 42 CFR 412.100. These costs are included in the organ acquisition charge of the Certified Transplant Center or the Independent Organ Procurement Organization. (emphasis added)

ASTS did not conduct a RUC survey for the cadaver donor excision codes, which were assigned AMA tracking numbers, for two reasons. First, the revisions to nomenclature were editorial in nature. Second, the RUC survey is designed for work-RVU recommendations for new and revised codes for payment under the MFS. Since excision of cadaveric organs may not be reimbursed under the MFS, by law, and since these services still involve *marked variations in time*, it is not appropriate for these codes to be reviewed through the RUC survey process.

Living donor excision services are reimbursed under the MFS. However, ASTS did not survey these codes because the changes were editorial and did not alter the underlying work. For transplant surgeons, the phrase *preparation and maintenance of allograft*, as it relates to the donor procedures, refers to *perfusion with cold preservation solution and cold maintenance*. For the transplant surgeon, in no instance, would *preparation and maintenance* have included backbench standard graft preparation or additional reconstructive work. The revised descriptors are meant to more clearly describe the work related to the donor procedure and not to change the work. We articulated this to the CPT Panel and the RUC just last year, when the new living liver donor codes were created and reviewed. At that time, CPT (and the RUC) indicated that we should pursue revising the language for all donor codes to make this consistent and clear to everyone. The CPT proposals, reviewed and accepted in February 2004, presented these editorial revisions.

2. Standard Backbench Codes

(RUC Tracking numbers: X2, X3, Y2, Y4, AC3, AE2, AF2, AG3, AG4)

The CPT Panel approved eleven new codes describing standard backbench work. ASTS did not survey these codes at this time because CMS and ASTS are in discussions regarding whether standard backbench

work should be considered an organ acquisition cost which is reimbursed under Part A, or whether these services should be treated as a Part B service paid under the MFS. Current Medicare regulations and guidance do not specifically address this issue.

ASTS has written to CMS stating its views that backbench work should be treated as a hospital organ acquisition cost because of the nature of the work. Briefly, the standard backbench codes describe work that is always necessary to prepare a graft for implantation. However, this work is extremely variable in its execution, as shown by the following examples: 1) The standard backbench graft preparation can be performed at either the donor or recipient site of service; 2) The recipient may die and the prepared graft will need to be sent to a different site for a different recipient; or 3) The grafts may be “split” and then transplanted in one or more recipients at one or more locations. Because of the marked variability in this work, similar to cadaver organ acquisition, it makes most sense to consider this work as a hospital organ acquisition cost. The ASTS has asked CMS to issue definitive guidance on this subject. If CMS determines that backbench work is part of hospital organ acquisition costs reimbursed under Part A, it would not be appropriate for these codes to be reviewed through the RUC survey process. However, if CMS determines that these new codes are new Part B services to be paid under the MFS, then ASTS will conduct AMA/RUC surveys.

3. Backbench Reconstruction Codes

(RUC Tracking numbers: AC4, AC5, AE8, AE9, AF3, AG5, AG6, AG7)

The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts. These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

ASTS has conducted RUC surveys for these codes. As we stated in our CPT proposal, there were no existing codes to describe reconstructive backbench work. We do not know the extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, ASTS believes these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team. It is appropriate that these new backbench reconstruction codes be reviewed by the RUC for MFS RVW recommendations to CMS.

4. Removal of Intestinal Allograft

(RUC Tracking number: AC6)

The CPT Panel approved one new code to describe removal of a transplanted intestinal allograft. ASTS attempted to survey this code, but only received a few responses. This service is infrequently performed (approximately 10 times annually), and is performed by a limited number of transplant surgeons in the country. Our discussions with these surgeons revealed the fact that total postoperative patient care is extensive. These patients will be hospitalized for 21 or more days, followed by two to three office visits weekly. Although there are codes in the MFS that have extensive hospital care (e.g. 39503 with LOS=30 days) or that have extensive outpatient care (e.g. 66172 with 12 office visits), there are no codes in the MFS that have the combination of significant hospital and office work through a 90-day global period.

Dr. William Rich

April 1, 2004

Page 4

Valuing a code with this extensive total work using a survey of magnitude estimation is not possible because there are no good references for "total work."

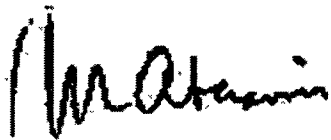
Additionally, the surgeons who perform this service correctly point out that the intestinal transplantation codes (44135 and 44136) are restricted services under Part B and do not have assigned work-RVUs. Restricted status means that special coverage instructions apply. If a restrictive service is covered and no RVUs are shown, the service is carrier-priced. ASTS recommends that new code 441X4 for removal of intestinal allograft be listed as carrier priced. We also suggest that the global period assignment be 000 instead of 090, since there is so much variability in the post-service work for these patients.

5. Direct Practice Expense

For the eight backbench donor organ reconstruction codes (441X2, 441X3, 471X4, 471X5, 485X2, 503X3, 503X4, and 503X5), ASTS recommends zero direct practice expense inputs. Any necessary clinical staff labor is already included with the primary procedure. There would be no office supplies or office equipment utilized for these facility-only codes.

ASTS appreciates the opportunity to submit this information to the RUC, along with our physician work recommendations for the eight new reconstructive backbench codes. If you have any questions prior to the RUC meeting, please contact me at 312-695-0254 or Ms. Gail Durant, ASTS Executive Director, at 703-684-5990

Sincerely,



Michael M. Abecassis, MD, FACS
RUC Advisor, ASTS

cc: Abraham Shaked, MD, PhD, FACS
President, ASTS

Attachments

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

Recommended Work Relative Value

CPT Code:48552 Tracking Number: AF3 Global Period: XXX Specialty Society RVU: **4.30** RUC RVU: **4.30**

CPT Descriptor: Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation; venous anastomosis, each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The portal vein on the pancreas allograft is short and requires an extension graft prior to transplantation. Under loupe magnification, an anastomosis between a conduit (either the common or external iliac vein) and the portal vein is performed on the allograft.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: On ice, with continuous bathing in cold preservation solution, a segment of donor iliac vein with matching diameter to the portal vein (either common or external iliac vein) is anastomosed end-to-end to the portal vein. The anastomosis is performed with fine (5-0) monofilament suture under loupe magnification.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):		Michael Abecassis, MD, FACS				
Specialty(s):		American Society of Transplant Surgeons				
CPT Code:		48552				
Sample Size: 250		Resp n: 31		Response: 12.40 %		
Sample Type: Random						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		1.75	3.42	4.30	5.75	7.50
Pre-Service Evaluation Time:				0.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		20.00	44.00	50.00	75.00	95.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		0.00				
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):	<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>
35685	ZZZ	4.04

CPT Descriptor Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
35682	ZZZ	7.19

CPT Descriptor Bypass graft; autogenous composite, two segments of veins from two locations

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

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

Number of respondents who choose Key Reference Code: 20 % of respondents: 64.5 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 48552	Key Reference CPT Code: 35685
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	50.00	45.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	50.00	45.00

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

The number of possible diagnosis and/or the number of management options that must be considered	3.21	2.79
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	3.50
--	------	------

Urgency of medical decision making	3.22	2.67
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.23	2.64
--------------------------	------	------

Physical effort required	2.47	2.47
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.82	3.32
Outcome depends on the skill and judgment of physician	4.02	3.66
Estimated risk of malpractice suit with poor outcome	2.73	2.41

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.27	3.45
Intra-Service intensity/complexity	4.23	3.68
Post-Service intensity/complexity	3.59	3.45

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.*

In order to maximize the use of organs from deceased donors, organs that in previous decades would not have been considered optimal, are currently being utilized. These include organs with anomalous vascular anatomy (multiple arteries and veins in kidneys, aberrant arteries in livers and pancreas, etc.). In addition, with increasing technology such as microvascular suture techniques, and with better surgical skills, transplant surgeons have been able to utilize previously discarded organs and partial organs from living donors. These developments have resulted in more complex backbench procedures required to render these organs usable.

Transplant surgeons have rated the complexity and intensity of the physician work for the surveyed backbench donor organ reconstructive procedures greater than the reference codes 35685 or 35682. These reconstructions are essential to the successful completion of the transplantation procedure and carry the same significant intensity/complexity of the primary transplantation procedure. In the case of vascular anastomoses necessary for either vascular anomalies or other circumstances, the risk to a less than perfect procedure is graft thrombosis, which will either require graft removal or retransplantation. With respect to the liver, retransplantation carries a 50% mortality rate. In the case of ureteral anastomoses, the risk of a less than perfect procedure is a significant urinary leak that can lead to significant post-transplant morbidity and possible mortality.

Attached is a table that presents the work, time, and intensity/complexity comparison for all surveyed reconstructive backbench codes and reference codes. The codes on this table are listed in descending intensity/complexity families, with the liver backbench reconstructive codes at the highest level, followed by intestine, pancreas, and finally kidney. The table also shows the comparative reference code information (35685, 35682, and 35686). For each of these eight new codes, the survey median RVW is recommended. This results in correct relativity between the codes and compared with similar references.

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

Specialty ASTS Estimate: <15% of total national pancreas transplantations. [UNOS data: 3,395 pancreatic transplantations for the period 1998 - April 2003.]

Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Specialty Frequency 0 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. Surgical

Svy N	DESC	STAT	RVW	IWPUT	INTRA
47146 42	Liver vein	MIN	2.57		20
		25th	4.50		45
		MED	6.00	0.100	60
		75th	7.19		75
		MAX	13.00		135
47149 43	Liver artery	MIN	3.20		25
		25th	4.84		45
		MED	7.00	0.108	65
		75th	8.00		75
		MAX	14.00		180
44720 22	Intestine vein	MIN	4.00		22
		25th	4.56		45
		MED	5.00	0.100	50
		75th	6.88		60
		MAX	9.00		90
44721 21	Intestine artery	MIN	4.00		22
		25th	6.00		60
		MED	7.00	0.100	70
		75th	8.00		75
		MAX	11.00		90
48552 31	Pancreas vein	MIN	1.75		20
		25th	3.34		42
		MED	4.17	0.083	50
		75th	5.38		73
		MAX	7.50		95
50327 36	Kidney vein	MIN	2.56		20
		25th	4.00		44
		MED	4.04	0.070	58
		75th	4.83		65
		MAX	7.20		90
50328 41	Kidney artery	MIN	1.75		20
		25th	3.50		45
		MED	4.50	0.075	60
		75th	7.00		80
		MAX	7.50		95
50329 37	Kidney ureter	MIN	2.40		20
		25th	3.34		45
		MED	4.30	0.078	55
		75th	5.00		70
		MAX	6.50		90

References		RVW	IWPUT	INTRA
35685	1st	4.04	0.090	45
35682	2nd	7.19	0.092	78
35686	3rd	3.34	0.095	35

Svy / Ref	N	COMPLEXITY			INTENSITY								
		Pre	Intra	Post	ME1	ME2	ME3	TS1	TS2	PS1	PS2	PS3	
47146 35685	22	3.71	4.32	3.55	3.86	3.67	4.27	4.45	3.23	4.68	4.68	4.00	
	22	2.67	3.32	2.65	2.73	2.67	3.50	3.50	2.68	3.27	3.50	3.36	
47149 35682	16	4.50	4.60	4.45	4.27	4.07	4.73	4.75	3.63	4.81	4.93	4.25	
	16	2.77	3.25	2.83	2.73	2.57	3.40	3.63	2.63	3.38	3.53	3.50	
44720 35685	15	3.71	4.47	3.79	4.13	4.07	4.53	4.53	3.87	4.67	4.80	4.33	
	15	2.79	3.27	2.71	2.73	2.53	3.27	3.47	2.60	3.33	3.53	3.27	
44721 35685	10	4.44	4.90	4.22	4.50	4.60	4.80	5.00	3.80	4.80	4.80	4.50	
	10	3.11	3.30	3.00	2.90	2.70	3.40	3.70	2.60	3.40	3.50	3.40	
48552 35685	20	3.21	4.14	3.22	3.23	2.47	3.82	4.02	2.73	4.27	4.23	3.59	
	20	2.79	3.50	2.67	2.64	2.47	3.32	3.66	2.41	3.45	3.68	3.45	
50327 35685	20	2.63	3.75	2.65	2.90	2.44	4.00	4.00	2.75	3.90	4.25	3.40	
	20	2.47	3.45	2.61	2.95	2.44	4.00	3.90	2.70	3.85	4.00	3.55	
50328 35685	15	3.46	4.33	3.58	4.13	3.29	4.47	4.40	2.87	4.47	4.33	3.93	
	15	3.08	3.67	3.17	3.07	2.79	4.07	4.03	2.47	3.73	3.73	3.40	
50329 35685	14	3.46	4.36	3.31	3.57	2.85	4.21	4.36	2.57	4.43	4.43	3.79	
	14	3.15	3.79	3.31	3.07	2.85	3.93	4.07	2.50	3.64	3.86	3.43	

Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit
Bypass graft; autogenous composite, two segments of veins from two locations
Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Kidney Transplantation

The RUC understands that CMS is currently conducting a comprehensive review of payment for all transplantation services. At this time, CPT codes 50300 *Donor nephrectomy (including cold preservation); with preparation and maintenance of allograft, from cadaver donor, unilateral or bilateral*; 50323 *Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic, and retroperitoneal attachments, excision of adrenal gland, and preparation of renal vein(s), renal artery(-ies), and ureter(s), ligating branches, as necessary*; and 50325 *Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of renal vein(s), renal artery(-ies), and ureter(s), ligating branches, as necessary* are not paid on the Medicare Physician Payment Schedule. CMS will contact the RUC if this policy changes and provide the RUC with the opportunity to review these services. Accordingly, at this time **the RUC does not submit any recommendations for codes 50300, 50323, and 50325.**

Backbench Reconstruction Codes (50327, 50328, and 50329)

The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts, including CPT codes 50327 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each*; 50328 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each*; and 50329 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each*. These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

The RUC understands that there were no existing codes to describe reconstructive backbench work. The extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers is unknown. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, the specialty has indicated that these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who

performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team.

The specialty discussed the significant intensity and complexity of the backbench reconstruction. The RUC understands that the three-dimensional visualization is difficult and the surgeon must guess as to what it is going to look like when it is placed in the recipient. The impact of complications of these anastomoses will affect the mortality rate for the patient and the surgeon who is performing the anastomoses is aware at that time the importance of making certain that the organ is perfect.

The RUC reviewed survey data from more than thirty-five transplant surgeons for these two services. The RUC understands that these are essentially add-on codes and only include intra-service work. These services should be modifier -51 exempt. CPT code The RUC expressed concern regarding the median survey time of 60 minutes for these codes as the vessels are larger than in the organs discussed in the other backbench reconstruction work (intestine, liver, and pancreas). After extensive discussion, the RUC agreed to modify the physician time. Accordingly, 50327, 50328, and 50329 will be modified to be approximately 45 minutes of intra-service time. The RUC agreed that the survey 25th percentile of 4.00 for 50327, 3.50 for 50328, and 3.34 for 50329 were appropriate based on comparison with the reference services 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (work relative value = 4.04 and 45 minutes intra-service time) and 35682 *Bypass graft; autogenous composite, two segments of veins from two locations* (work relative value = 7.19 and 78 minutes intra-service time). The RUC agreed that these services differ slightly in intensity, but are very similar in intensity and time as 35686. **The RUC recommends 4.00 for CPT code 50327, 3.50 for CPT code 50328, and 3.34 for CPT code 50329.**

Practice Expense

CPT codes 50327, 50328, and 50329 are essentially add-on services performed in the facility. Therefore, there are no additional direct practice expense inputs.

Renal autotransplantation includes reimplantation of the autograft as the primary procedure, along with secondary extra-corporeal procedure(s) (eg, partial nephrectomy, nephrolithotomy) reported with modifier 51 (see 50380 and applicable secondary procedure(s))

Renal allotransplantation involves three distinct components of physician work:

1) Cadaver donor nephrectomy, unilateral or bilateral, includes harvesting the graft(s) and cold preservation of the graft(s) (perfusing with cold preservation solution and cold maintenance) (see 50300). A living donor nephrectomy includes harvesting the graft, cold preservation of the graft (perfusing with cold preservation solution and cold maintenance), and care of the donor (see 50320 or 50547).

2) Backbench work

Backbench standard preparation of a cadaver donor renal allograft prior to transplantation includes: dissection and removal of perinephric fat, diaphragmatic, and retroperitoneal attachments; excision of adrenal gland; and preparation of renal vein(s), renal artery(-ies), and ureter(s), ligating branches, as necessary (see 50323).

Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of renal vein(s), renal artery(-ies), and ureter(s), ligating branches, as necessary (see 50325).

Backbench additional reconstruction of a cadaver or living donor renal allograft prior to transplantation may include venous, arterial, and/or ureteral anastomosis(-es) necessary for implantation (see 50327-50329).

3) Recipient renal allotransplantation includes transplantation of the allograft (with or without recipient nephrectomy) and care of the recipient (see 50360, 50365).

(For dialysis, see 90935-90999)

(For laparoscopic donor nephrectomy, use 50547)

(For laparoscopic drainage of lymphocele to peritoneal cavity, use 49323)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 50300	AG1	Donor nephrectomy <u>(including cold preservation)</u> ; with preparation and maintenance of allograft , from cadaver donor, unilateral or bilateral	XXX	Currently not on the MFS. No RUC recommendation at this time.
▲ 50320	AG2	open, from living donor (excluding preparation and maintenance of allograft)	090	22.18 (No Change)
● 50323	AG3	Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic, and retroperitoneal attachments, excision of adrenal gland, and preparation of	XXX	Currently not on the MFS. No RUC recommendation at this time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		renal vein(s), renal artery(-ies), and ureter(s), ligating branches, as necessary (Do not report 50323 in conjunction with 60540)		
● 50325	AG4	Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of renal vein(s), renal artery(-ies), and ureter(s), ligating branches, as necessary	XXX	Currently not on the MFS. No RUC recommendation at this time.
● 50327	AG5	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each	XXX	4.00
● 50328	AG6	arterial anastomosis, each	XXX	3.50
● 50329	AG7	ureteral anastomosis, each	XXX	3.34
▲ 50360		Renal allotransplantation, implantation of graft; excluding donor and <u>without</u> recipient nephrectomy	090	31.48 (No Change)
50365		<i>with recipient nephrectomy</i>	090	36.75 (No Change)
50380		<i>Renal autotransplantation, reimplantation of kidney (For renal autotransplantation extra-corporeal "(bench)" surgery, use autotransplantation as the primary procedure and add the secondary procedure(s) (eg, partial nephrectomy, nephrolithotomy), and use with the modifier 51)</i>	090	20.73 (No Change)

▲50547	AG8	Laparoscopy, surgical; donor nephrectomy (<u>including cold preservation</u>), from living donor (excluding preparation and maintenance of allograft) <i>(For open procedure, use 50320)</i> <u>(For backbench renal allograft standard preparation prior to transplantation, see 50325)</u> <u>(For backbench renal allograft reconstruction prior to transplantation, see 50327-50329)</u>	090	25.46 (No Change)
60540		<i>Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);</i>	090	17.00 (No Change)
60545		<i>with excision of adjacent retroperitoneal tumor</i> <u>(Do not report 60545 in conjunction with 50325)</u>	090	19.85 (No Change)



American Society of Transplant Surgeons
1020 North Fairfax Street, #200, Alexandria, VA 22314
Telephone: (703) 684-5990
Fax: (703) 684-6303

April 1, 2004

William L. Rich III, MD, FACS
Chair, AMA/Relative Value Update Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Re: Organ Transplantation Codes

Dear Dr. Rich:

At its February 2004 meeting, the AMA's CPT Editorial Panel approved the American Society of Transplant Surgeons' (ASTS) proposal for organ transplantation coding changes in CPT.

Specifically, the Panel approved:

- New explanatory text for each of the six transplantation sections in CPT (Lung, Heart/Lung, Liver, Pancreas, Intestine, and Kidney);
- Editorial revisions to a number of current code descriptors;
- Eleven new codes describing standard backbench work for organ grafts;
- Eight new codes describing reconstructive backbench work for organ grafts; and
- One new code describing complete removal of a transplanted intestinal allograft.

ASTS has completed the AMA/RUC survey for physician relative work for the eight new codes describing reconstructive backbench work. The AMA/RUC Summary of Recommendation Forms are attached. Practice expense recommendations are also attached. The discussion that follows presents the ASTS' rationale for surveying only these eight new codes.

1. Donor Excision Codes

(RUC Tracking numbers: X1, X2, X3, AC1, AC2, AE1, AE3, AE4, AE5, AE6, AE7, AF1, AG1, AG2, AG8)

The CPT Panel approved editorial revisions to both cadaver and living donor excision codes. For 12 codes, the phrase *including cold preservation* replaced the phrase *with preparation and maintenance of allograft*. For one code, the editorial revision removes the language *excluding preparation and maintenance of allograft*.

Cadaver donor excision services are not paid under the Medicare physician fee schedule (MFS). Instead, these services are considered organ acquisition costs to the hospital and are reimbursed under Part A of Medicare through a payment to the hospital. Medicare regulation at 42 CFR, Section 412.100 provides that certain costs related to inpatient hospital services including, specifically, *organ acquisition costs incurred by hospitals with approved organ transplantation centers . . .* are made on a reasonable

cost basis. *Organ acquisition costs* are defined at 42 CFR, Section 412.100 to include, among other things, the surgeon's fee for excising cadaver organs. Although this regulation refers to kidney excision, CMS has stated elsewhere that this regulation applies to all organs, not just kidney. The Medicare Provider Reimbursement Manual, Part III §3625.3 specifically instructs hospitals to include *surgeon's (sic) fees for excising cadaveric organs* in reporting organ acquisition costs on the hospital cost report.

Additionally, we note that in 1994, ASTS attempted to perform RUC surveys for the extremely variable work of cadaver donor excision services. The values that the RUC recommended to CMS were not based on the survey results, but on facilitation, in an attempt to standardize a non-standard service. The following text, taken from the *Federal Register* (December 8, 1994, p. 63453), presents the CMS decision regarding the RUC recommendations:

We reviewed the RUC recommendation for these cadaver donor codes as a group with representatives of the RUC, our CMDs, and representatives of the specialty societies involved with transplant surgery. We have concluded that the assignment of RVUs to these codes could lead to inequitable payment to some physicians because of the marked variations in time associated with organ acquisitions. Therefore, payment for these services will not be made under the physician fee schedule. Rather, the services furnished by a surgeon who retrieves a cadaveric donor organ that is intended for a Medicare-covered transplant will continue to be paid outside the hospital prospective payment system at 100 percent of the reasonable cost under Part A on a retrospective basis, as set forth at 42 CFR 412.100. These costs are included in the organ acquisition charge of the Certified Transplant Center or the Independent Organ Procurement Organization. (emphasis added)

ASTS did not conduct a RUC survey for the cadaver donor excision codes, which were assigned AMA tracking numbers, for two reasons. First, the revisions to nomenclature were editorial in nature. Second, the RUC survey is designed for work-RVU recommendations for new and revised codes for payment under the MFS. Since excision of cadaveric organs may not be reimbursed under the MFS, by law, and since these services still involve *marked variations in time*, it is not appropriate for these codes to be reviewed through the RUC survey process.

Living donor excision services are reimbursed under the MFS. However, ASTS did not survey these codes because the changes were editorial and did not alter the underlying work. For transplant surgeons, the phrase *preparation and maintenance of allograft*, as it relates to the donor procedures, refers to *perfusion with cold preservation solution and cold maintenance*. For the transplant surgeon, in no instance, would *preparation and maintenance* have included backbench standard graft preparation or additional reconstructive work. The revised descriptors are meant to more clearly describe the work related to the donor procedure and not to change the work. We articulated this to the CPT Panel and the RUC just last year, when the new living liver donor codes were created and reviewed. At that time, CPT (and the RUC) indicated that we should pursue revising the language for all donor codes to make this consistent and clear to everyone. The CPT proposals, reviewed and accepted in February 2004, presented these editorial revisions.

2. Standard Backbench Codes

(RUC Tracking numbers: X2, X3, Y2, Y4, AC3, AE2, AF2, AG3, AG4)

The CPT Panel approved eleven new codes describing standard backbench work. ASTS did not survey these codes at this time because CMS and ASTS are in discussions regarding whether standard backbench

work should be considered an organ acquisition cost which is reimbursed under Part A, or whether these services should be treated as a Part B service paid under the MFS. Current Medicare regulations and guidance do not specifically address this issue.

ASTS has written to CMS stating its views that backbench work should be treated as a hospital organ acquisition cost because of the nature of the work. Briefly, the standard backbench codes describe work that is always necessary to prepare a graft for implantation. However, this work is extremely variable in its execution, as shown by the following examples: 1) The standard backbench graft preparation can be performed at either the donor or recipient site of service; 2) The recipient may die and the prepared graft will need to be sent to a different site for a different recipient; or 3) The grafts may be "split" and then transplanted in one or more recipients at one or more locations. Because of the marked variability in this work, similar to cadaver organ acquisition, it makes most sense to consider this work as a hospital organ acquisition cost. The ASTS has asked CMS to issue definitive guidance on this subject. If CMS determines that backbench work is part of hospital organ acquisition costs reimbursed under Part A, it would not be appropriate for these codes to be reviewed through the RUC survey process. However, if CMS determines that these new codes are new Part B services to be paid under the MFS, then ASTS will conduct AMA/RUC surveys.

3. Backbench Reconstruction Codes

(RUC Tracking numbers: AC4, AC5, AE8, AE9, AF3, AG5, AG6, AG7)

The CPT Panel approved eight new codes describing reconstructive backbench work for organ grafts. These codes describe work (primarily anastomoses), which are not typical, but may be necessary to prepare the organ for transplantation into a specific recipient.

ASTS has conducted RUC surveys for these codes. As we stated in our CPT proposal, there were no existing codes to describe reconstructive backbench work. We do not know the extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers. However, reconstructive services are performed in conjunction with the needs of the recipient transplant procedure, when necessary. Therefore, ASTS believes these services would not be considered part of a hospital's organ acquisition cost and should be reimbursed as Part B services under the MFS. These new codes describe this atypical additional work and permit the surgeon who performs the service to properly report the procedure. This is an important point because the surgeon who performs this work is generally not part of the recipient transplant team. It is appropriate that these new backbench reconstruction codes be reviewed by the RUC for MFS RVW recommendations to CMS.

4. Removal of Intestinal Allograft

(RUC Tracking number: AC6)

The CPT Panel approved one new code to describe removal of a transplanted intestinal allograft. ASTS attempted to survey this code, but only received a few responses. This service is infrequently performed (approximately 10 times annually), and is performed by a limited number of transplant surgeons in the country. Our discussions with these surgeons revealed the fact that total postoperative patient care is extensive. These patients will be hospitalized for 21 or more days, followed by two to three office visits weekly. Although there are codes in the MFS that have extensive hospital care (e.g. 39503 with LOS=30 days) or that have extensive outpatient care (e.g. 66172 with 12 office visits), there are no codes in the MFS that have the combination of significant hospital and office work through a 90-day global period.

Valuing a code with this extensive total work using a survey of magnitude estimation is not possible because there are no good references for "total work."

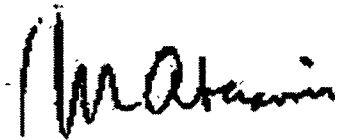
Additionally, the surgeons who perform this service correctly point out that the intestinal transplantation codes (44135 and 44136) are restricted services under Part B and do not have assigned work-RVUs. Restricted status means that special coverage instructions apply. If a restrictive service is covered and no RVUs are shown, the service is carrier-priced. ASTS recommends that new code 441X4 for removal of intestinal allograft be listed as carrier priced. We also suggest that the global period assignment be 000 instead of 090, since there is so much variability in the post-service work for these patients.

5. Direct Practice Expense

For the eight backbench donor organ reconstruction codes (441X2, 441X3, 471X4, 471X5, 485X2, 503X3, 503X4, and 503X5), ASTS recommends zero direct practice expense inputs. Any necessary clinical staff labor is already included with the primary procedure. There would be no office supplies or office equipment utilized for these facility-only codes.

ASTS appreciates the opportunity to submit this information to the RUC, along with our physician work recommendations for the eight new reconstructive backbench codes. If you have any questions prior to the RUC meeting, please contact me at 312-695-0254 or Ms. Gail Durant, ASTS Executive Director, at 703-684-5990

Sincerely,



Michael M. Abecassis, MD, FACS
RUC Advisor, ASTS

cc: Abraham Shaked, MD, PhD, FACS
President, ASTS

Attachments

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

Recommended Work Relative Value

CPT Code:50327 Tracking Number: AG5 Global Period: XXX Specialty Society RVU: **4.04** RUC RVU: **4.00**

CPT Descriptor: Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The renal vein of a right renal allograft from a deceased donor is short and thin, and requires elongation prior to transplantation. A backbench vena cava extension graft or vein patch (venoplasty) is performed on the allograft.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: On ice, with continuous bathing in cold preservation solution, the renal vein extension graft is constructed in continuity with the renal vein by using a vascular stapler across the vena cava both above and below the renal vein(s), so that a "tube" of cava can serve as the extension graft. This requires two applications of the stapler and oversewing of the staple lines for reinforcement, as necessary. If the superior aspect of the cava is short and cannot accommodate a staple line without compromising the lumen of the renal vein(s), a venoplasty is required; a triangulated vein patch is used to cover the deficit by using two suture lines of fine monofilament suture in the superior aspect of the extension.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Michael Abecassis, MD, FACS				
Specialty(s):	American Society of Transplant Surgeons				
CPT Code:	50327				
Sample Size:	250	Resp n:	36	Response:	%
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	2.56	4.00	4.04	4.83	7.20
Pre-Service Evaluation Time:			0.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	20.00	44.00	44.00	65.00	90.00
Post-Service	Total Min**	CPT code / # of visits			

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:Key CPT Code
35685Global
ZZZWork RVU
4.04CPT Descriptor Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduitOther Reference CPT Code
35682Global
ZZZWork RVU
7.19CPT Descriptor Bypass graft; autogenous composite, two segments of veins from two locations**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

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

Number of respondents who choose Key Reference Code: 20 % of respondents: 55.5 %

TIME ESTIMATES (Median)

New/Revised
CPT Code:
50327

Key
Reference
CPT Code:
35685

Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	44.00	45.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	44.00	45.00

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

The number of possible diagnosis and/or the number of management options that must be considered	2.63	2.47
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.45
--	------	------

Urgency of medical decision making	2.65	2.61
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	2.90	2.95
--------------------------	------	------

Physical effort required	2.44	2.44
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	4.00
Outcome depends on the skill and judgment of physician	4.00	3.90
Estimated risk of malpractice suit with poor outcome	2.75	2.70

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.90	3.85
Intra-Service intensity/complexity	4.25	4.00
Post-Service intensity/complexity	3.40	3.55

ADDITIONAL RATIONALE

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

In order to maximize the use of organs from deceased donors, organs that in previous decades would not have been considered optimal, are currently being utilized. These include organs with anomalous vascular anatomy (multiple arteries and veins in kidneys, aberrant arteries in livers and pancreas, etc.). In addition, with increasing technology such as microvascular suture techniques, and with better surgical skills, transplant surgeons have been able to utilize previously discarded organs and partial organs from living donors. These developments have resulted in more complex backbench procedures required to render these organs usable.

Transplant surgeons have rated the complexity and intensity of the physician work for the surveyed backbench donor organ reconstructive procedures greater than the reference codes 35685 or 35682. These reconstructions are essential to the successful completion of the transplantation procedure and carry the same significant intensity/complexity of the primary transplantation procedure. In the case of vascular anastomoses necessary for either vascular anomalies or other circumstances, the risk to a less than perfect procedure is graft thrombosis, which will either require graft removal or retransplantation. With respect to the liver, retransplantation carries a 50% mortality rate. In the case of ureteral anastomoses, the risk of a less than perfect procedure is a significant urinary leak that can lead to significant post-transplant morbidity and possible mortality.

Attached is a table that presents the work, time, and intensity/complexity comparison for all surveyed reconstructive backbench codes and reference codes. The codes on this table are listed in descending intensity/complexity families, with the liver backbench reconstructive codes at the highest level, followed by intestine, pancreas, and finally kidney. The table also shows the comparative reference code information (35685, 35682, and 35686). For each of these eight new codes, the survey median RVW is recommended. This results in correct relativity between the codes and compared with similar references.

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. If necessary, AG5 would be reported as an add-on procedure to 50360 or 50365 (kidney transplantation).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There is no existing code which describes backbench reconstructive work on donor organs. We do not know the extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty transplant surgery How often? Rarely

Specialty How often?

Specialty How often?

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

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty ASTS Estimate: < 40% of total national kidney transplantations. [There are approximately 9,000 kidney transplantations performed annually].

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?

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

Specialty ASTS Estimate: <20% of total national kidney transplantations. [There are approximately 9,000 kidney transplantations performed annually].

Frequency 50

Percentage

%

Specialty

Frequency 0

Percentage

%

Specialty

Frequency 0

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. Surgical

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

Recommended Work Relative Value

CPT Code:50328 Tracking Number: AG6 Global Period: XXX Specialty Society RVU: **4.50** RUC RVU: **3.50**

CPT Descriptor: Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Two renal "end" arteries are present on a renal allograft. Backbench arterial anastomosis, either end-to-end or side-to-side, is performed on the allograft to create a single arterial lumen for transplantation.

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Work is performed on ice, with continuous bathing in cold preservation solution. The main renal artery is kept attached to the aortic patch of the donor, and if the ostia of the aberrant artery is greater than 1.0 cm apart, the aortic patch is shortened by cutting out a redundant portion of aortic patch and reconstituting continuity with a single layer of fine (6-0) monofilament suture. Alternatively, the aberrant artery is reimplanted onto the main renal artery either end-to-side or side-to-side forming a single arterial lumen for transplantation.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):		Michael Abecassis, MD, FACS			
Specialty(s):		American Society of Transplant Surgeons			
CPT Code:		50328			
Sample Size: 250		Resp n: 41		Response: %	
Sample Type: Random					
		Low	25 th pctl	Median*	75 th pctl
Survey RVW:		1.75	3.50	4.50	7.00
Pre-Service Evaluation Time:				0.0	
Pre-Service Positioning Time:				0.0	
Pre-Service Scrub, Dress, Wait Time:				0.0	
Intra-Service Time:		20.00	45.00	45.00	80.00
Post-Service		Total Min**	CPT code / # of visits		
Immed. Post-time:		0.00			
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:	<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:Key CPT Code
35685Global
ZZZWork RVU
4.04CPT Descriptor Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduitOther Reference CPT Code
35682Global
ZZZWork RVU
7.19CPT Descriptor Bypass graft; autogenous composite, two segments of veins from two locations**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 36.5 %

TIME ESTIMATES (Median)

New/Revised
CPT Code:
50328

Key
Reference
CPT Code:
35685

Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	45.00	45.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	45.00	45.00

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

The number of possible diagnosis and/or the number of management options that must be considered	3.46	3.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	3.67
Urgency of medical decision making	3.58	3.17

Technical Skill/Physical Effort (Mean)

Technical skill required	4.13	3.07
Physical effort required	3.29	2.79

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.47	4.07
Outcome depends on the skill and judgment of physician	4.40	4.03
Estimated risk of malpractice suit with poor outcome	2.87	2.47

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.47	3.73
Intra-Service intensity/complexity	4.33	3.73
Post-Service intensity/complexity	3.93	3.40

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.*

In order to maximize the use of organs from deceased donors, organs that in previous decades would not have been considered optimal, are currently being utilized. These include organs with anomalous vascular anatomy (multiple arteries and veins in kidneys, aberrant arteries in livers and pancreas, etc.). In addition, with increasing technology such as microvascular suture techniques, and with better surgical skills, transplant surgeons have been able to utilize previously discarded organs and partial organs from living donors. These developments have resulted in more complex backbench procedures required to render these organs usable.

Transplant surgeons have rated the complexity and intensity of the physician work for the surveyed backbench donor organ reconstructive procedures greater than the reference codes 35685 or 35682. These reconstructions are essential to the successful completion of the transplantation procedure and carry the same significant intensity/complexity of the primary transplantation procedure. In the case of vascular anastomoses necessary for either vascular anomalies or other circumstances, the risk to a less than perfect procedure is graft thrombosis, which will either require graft removal or retransplantation. With respect to the liver, retransplantation carries a 50% mortality rate. In the case of ureteral anastomoses, the risk of a less than perfect procedure is a significant urinary leak that can lead to significant post-transplant morbidity and possible mortality.

Attached is a table that presents the work, time, and intensity/complexity comparison for all surveyed reconstructive backbench codes and reference codes. The codes on this table are listed in descending intensity/complexity families, with the liver backbench reconstructive codes at the highest level, followed by intestine, pancreas, and finally kidney. The table also shows the comparative reference code information (35685, 35682, and 35686). For each of these eight new codes, the survey median RVW is recommended. This results in correct relativity between the codes and compared with similar references.

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. If necessary, AG6 would be reported as an add-on procedure to 50360 or 50365 (kidney transplantation).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There is no existing code which describes backbench reconstructive work on donor organs. We do not know the extent to which this work was reported under organ acquisition, unlisted service codes, or other CPT codes, using modifiers.

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

Specialty transplant surgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty ASTS Estimate: < 20% of total national kidney transplantations. [There are approximately 9,000 kidney transplantations performed annually]. 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 ASTS Estimate: < 8 % of total national kidney transplantations. [There are approximately 9,000 kidney transplantations performed annually]. Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

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

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

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

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

Recommended Work Relative Value

CPT Code:50329 Tracking Number: AG7 Global Period: XXX Specialty Society RVU: **4.30** RUC RVU: **3.34**

CPT Descriptor: Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Double ureters are present on a renal allograft. Backbench ureteral anastomosis is performed on the allograft creating an ureteroureterostomy, so that there will be one ureteral orifice for the transplantation ureteroneocystostomy anastomosis (transplantation work is reported separately).

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: On ice, with continuous bathing in cold preservation solution, the ureters are joined distally by a side-to-side ureteral anastomosis with running (6-0) absorbable monofilament.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):		Michael Abecassis, MD, FACS				
Specialty(s):		American Society of Transplant Surgeons				
CPT Code:		50329				
Sample Size: 250		Resp n: 37		Response: %		
Sample Type: Random						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		2.40	3.34	4.30	5.00	6.50
Pre-Service Evaluation Time:				0.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		20.00	45.00	45.00	70.00	90.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		0.00				
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):	<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
35685Global
ZZZWork RVU
4.04CPT Descriptor Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduitOther Reference CPT Code
35682Global
ZZZWork RVU
7.19CPT Descriptor Bypass graft; autogenous composite, two segments of veins from two locations**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

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

Number of respondents who choose Key Reference Code: 14 % of respondents: 37.8 %

TIME ESTIMATES (Median)

New/Revised
CPT Code:
50329 Key
Reference
CPT Code:
35685

Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	45.00	45.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	45.00	45.00

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

The number of possible diagnosis and/or the number of management options that must be considered	3.46	3.15
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.36	3.79
--	------	------

Urgency of medical decision making	3.31	3.31
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.57	3.07
--------------------------	------	------

Physical effort required	2.85	2.85
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.21	3.93
Outcome depends on the skill and judgment of physician	4.36	4.07
Estimated risk of malpractice suit with poor outcome	2.57	2.50

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.43	3.64
Intra-Service intensity/complexity	4.43	3.86
Post-Service intensity/complexity	3.79	3.43

ADDITIONAL RATIONALE

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

In order to maximize the use of organs from deceased donors, organs that in previous decades would not have been considered optimal, are currently being utilized. These include organs with anomalous vascular anatomy (multiple arteries and veins in kidneys, aberrant arteries in livers and pancreas, etc.). In addition, with increasing technology such as microvascular suture techniques, and with better surgical skills, transplant surgeons have been able to utilize previously discarded organs and partial organs from living donors. These developments have resulted in more complex backbench procedures required to render these organs usable.

Transplant surgeons have rated the complexity and intensity of the physician work for the surveyed backbench donor organ reconstructive procedures greater than the reference codes 35685 or 35682. These reconstructions are essential to the successful completion of the transplantation procedure and carry the same significant intensity/complexity of the primary transplantation procedure. In the case of vascular anastomoses necessary for either vascular anomalies or other circumstances, the risk to a less than perfect procedure is graft thrombosis, which will either require graft removal or retransplantation. With respect to the liver, retransplantation carries a 50% mortality rate. In the case of ureteral anastomoses, the risk of a less than perfect procedure is a significant urinary leak that can lead to significant post-transplant morbidity and possible mortality.

Attached is a table that presents the work, time, and intensity/complexity comparison for all surveyed reconstructive backbench codes and reference codes. The codes on this table are listed in descending intensity/complexity families, with the liver backbench reconstructive codes at the highest level, followed by intestine, pancreas, and finally kidney. The table also shows the comparative reference code information (35685, 35682, and 35686). For each of these eight new codes, the survey median RVW is recommended. This results in correct relativity between the codes and compared with similar references.

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 ASTS Estimate: < 1 % of total national kidney transplantations. [There are approximately 9,000 kidney transplantations performed annually].

Frequency 0

Percentage

%

Specialty

Frequency 0

Percentage

%

Specialty

Frequency 0

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. Surgical

Svy N	DESC	STAT	RVW	IWPUT	INTRA
47146 42	Liver vein	MIN	2.57		20
		25th	4.50		45
		MED	6.00	0.100	60
		75th	7.19		75
		MAX	13.00		135
47149 43	Liver artery	MIN	3.20		25
		25th	4.84		45
		MED	7.00	0.108	65
		75th	8.00		75
		MAX	14.00		180
44720 22	Intestine vein	MIN	4.00		22
		25th	4.56		45
		MED	5.00	0.100	50
		75th	6.88		60
		MAX	9.00		90
44721 21	Intestine artery	MIN	4.00		22
		25th	6.00		60
		MED	7.00	0.100	70
		75th	8.00		75
		MAX	11.00		90
48552 31	Pancreas vein	MIN	1.75		20
		25th	3.34		42
		MED	4.17	0.083	50
		75th	5.38		73
		MAX	7.50		95
50327 36	Kidney vein	MIN	2.56		20
		25th	4.00		44
		MED	4.04	0.070	58
		75th	4.83		65
		MAX	7.20		90
50328 41	Kidney artery	MIN	1.75		20
		25th	3.50		45
		MED	4.50	0.075	60
		75th	7.00		80
		MAX	7.50		95
50329 37	Kidney ureter	MIN	2.40		20
		25th	3.34		45
		MED	4.30	0.078	55
		75th	5.00		70
		MAX	6.50		90

References		RVW	IWPUT	INTRA
35685	1st	4.04	0.090	45
35682	2nd	7.19	0.092	78
35686	3rd	3.34	0.095	35

Svy / Ref	N	COMPLEXITY			INTENSITY								
		Pre	Intra	Post	ME1	ME2	ME3	TS1	TS2	PS1	PS2	PS3	
47146 35685	22	3.71	4.32	3.55	3.86	3.67	4.27	4.45	3.23	4.68	4.68	4.00	
	22	2.67	3.32	2.65	2.73	2.67	3.50	3.50	2.68	3.27	3.50	3.36	
47149 35682	16	4.50	4.60	4.45	4.27	4.07	4.73	4.75	3.63	4.81	4.93	4.25	
	16	2.77	3.25	2.83	2.73	2.57	3.40	3.63	2.63	3.38	3.53	3.50	
44720 35685	15	3.71	4.47	3.79	4.13	4.07	4.53	4.53	3.87	4.67	4.80	4.33	
	15	2.79	3.27	2.71	2.73	2.53	3.27	3.47	2.60	3.33	3.53	3.27	
44721 35685	10	4.44	4.90	4.22	4.50	4.60	4.80	5.00	3.80	4.80	4.80	4.50	
	10	3.11	3.30	3.00	2.90	2.70	3.40	3.70	2.60	3.40	3.50	3.40	
48552 35685	20	3.21	4.14	3.22	3.23	2.47	3.82	4.02	2.73	4.27	4.23	3.59	
	20	2.79	3.50	2.67	2.64	2.47	3.32	3.66	2.41	3.45	3.68	3.45	
50327 35685	20	2.63	3.75	2.65	2.90	2.44	4.00	4.00	2.75	3.90	4.25	3.40	
	20	2.47	3.45	2.61	2.95	2.44	4.00	3.90	2.70	3.85	4.00	3.55	
50328 35685	15	3.46	4.33	3.58	4.13	3.29	4.47	4.40	2.87	4.47	4.33	3.93	
	15	3.08	3.67	3.17	3.07	2.79	4.07	4.03	2.47	3.73	3.73	3.40	
50329 35685	14	3.46	4.36	3.31	3.57	2.85	4.21	4.36	2.57	4.43	4.43	3.79	
	14	3.15	3.79	3.31	3.07	2.85	3.93	4.07	2.50	3.64	3.86	3.43	

Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit
Bypass graft; autogenous composite, two segments of veins from two locations
Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Renal Pelvic – Ureter Therapeutic Agents Instillation

The CPT Editorial Panel in February 2004 created a new code for the service of instillation of therapeutic agents into the renal pelvis or ureter to treat either an urothelial tumor or fungal infections of the upper tracts. No other code had previously described this service.

The RUC reviewed the specialty societies' initial recommendations and determined that the pre-service time for this code was inappropriate. The society agreed and explained that the pre-service time should be reduced by 10 minutes to 20.5 minutes, as the physician does not need to scrub prior to performing this procedure, only sterile gloves are necessary. The RUC then reviewed the intra-service time and due to the hazardous material being handled, recommends that the intra-service time should be increased to 30 minutes to reflect the physician constant attention to ensure the safety of the patient and staff. In addition, this 30 minutes is necessary to comply with the recommended infusion time. The society agreed with this recommendation and explained that in a similar CPT code 51720 *Bladder instillation of anticarcinogenic agent (including detention time)* (Work RVU=1.96), which has 27 minutes of intra-service time and an IWPOT of 0.058, the physician does monitor the patient for the entire intra-service period. The RUC was comfortable with this intra-service time comparison and recommended 30 minutes of intra-service time for 50391 *Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)*. The RUC believed that the work value of 51720 could be applied to new code 50391 with adjustments in physician time. **The RUC recommendations for code 50391 are summarized below.:**

CPT Code	Pre-Service Time	Intra-Service Time	Post-Service Time	Work RVU
50391	20.5	30	10	1.96

. The RUC also used a building block methodology to establish the 1.96 Work RVUs for 50391, as shown below.

50391			RVW
Global = 000		Rec RVW	1.96
	Survey Data	RUC Std.	RVW
<u>Pre-service:</u>	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	20.5	0.0224	0.459
Pre-service scrub, dress, wait		0.0081	0
Pre-service total			0.459
<u>Post-service:</u>	Time	Intensity	(=time x intensity)
Immediate post	10	0.0224	0.224
Post-service total			0.224
	Time	IWPUT	INTRA-RVW
<u>Intra-service:</u>	30	0.043	1.28

Practice Expense Inputs for 50391

The RUC then reviewed the practice expense inputs for 50391. The society proposed, and the RUC agreed, that the pre-service time for the facility-setting should have zero time because all of the clinical labor time is being provided by the hospital staff for this typically inpatient stay patient. In addition, the society recommended, and the RUC agreed, that in the non-facility setting, the pre-service time should be cross-walked to PEAC reviewed code 51720 resulting in 8 minutes of total pre-service time. In addition, the RUC recommended, and the specialty agreed, that the assist physician time should go to zero minutes because the physician is monitoring the patient for the entire service and therefore does not require additional staff to assist him/her. It was also recommended that the time for preparing and positioning the patient should go to zero because in the description of the intra-service time, the physician is positioning the patient. The supplies and equipment were then reviewed and modified to ensure no duplication. **The modified practice expense inputs for 50391 were approved by the Facilitation Committee.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 50391	AH1	Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, antineoplastic or antifungal agent)	000	1.96

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

Recommended Work Relative Value

CPT Code:50391 Tracking Number: Global Period: 000 Specialty Society RVU: **2.50** RUC RVU: **1.96**

CPT Descriptor: Instillation (s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58 - year old male with solitary kidney has known 0.5 cm papillary tumor involving the medical aspect of the renal pelvis with associated hydronephrosis. A prior nephrostomy tube had been placed two weeks ago for renal drainage. After a lengthy discussion of options, a decision is made to utilize infusion of BCG into the right renal pelvis to destroy the cancer and prevent tumor reoccurrence. BCG is instilled into the renal pelvis via the established nephrostomy tube. One amp of BCG is mixed with 50 ml of normal saline.

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?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Review procedure, post-procedure instructions with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Position patient on operating table

Description of Intra-Service Work:

- The patient is positioned in the flank position
- The field is sterilized, prepped and draped
- Under fluoroscopic guidance the position of the previously placed nephrostomy tube is confirmed
- The anti-neoplastic agent (e.g. BCG) is prepared per protocol
- Approximately 50 ml of the irrigant is poured into an Asepto syringe connected to the nephrostomy tube
- The patient is kept in this position for an appropriate amount of time
- The fluid is allowed to drain from the kidney and disposed of according to OSHA protocol
- The nephrostomy tube is reconnected to the drainage system

Description of Post-Service Work:

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from table
- Meet with family and discuss the procedure and expected outcome and possible problems after discharge home
- Post-op Same day work after discharge from recovery
- Dictate detailed operative narrative

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):		Jeffery A. Dann, M.D.				
Specialty(s):		American Urological Association				
CPT Code:		50391				
Sample Size:	985	Resp n:	42	Response:	%	
Sample Type: Random						
		Low	25th pctl	Median*	75th pctl	High
Survey RVW:		0.67	2.30	2.50	6.53	14.00
Pre-Service Evaluation Time:				13.0		
Pre-Service Positioning Time:				7.5		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		5.00	10.00	30.00	30.00	120.00
Post-Service	Total Min**	CPT code / # of visits				
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>
50555	000	6.52

CPT Descriptor Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
52000	000	2.01

CPT Descriptor Cystourethroscopy (separate procedure)

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

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

Number of respondents who choose Key Reference Code: 8 % of respondents: 19.0 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 50391	Key Reference CPT Code: 50555
Median Pre-Service Time	20.50	24.00
Median Intra-Service Time	30.00	65.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	60.50	89.00

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	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.50
Physical effort required	4.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.00
Outcome depends on the skill and judgment of physician	4.00	3.00
Estimated risk of malpractice suit with poor outcome	2.00	2.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.00	2.00
Intra-Service intensity/complexity	3.00	2.00
Post-Service intensity/complexity	3.00	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.*

IWP/UT for new/revised CPT code 5039X - 0.084

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) Miscellaneous code section of the CPT book

How often do physicians 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? 3000
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?
1,500 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. 51720 is better because of the higher risk of the patients becoming septic rather quickly.

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

	A	B	C	D
1				
2				50391
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal)	
4	LOCATION		Non Facility	Facility
5	GLOBAL PERIOD			
6	TOTAL CLINICAL LABOR TIME	L037D	26.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	8.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	18.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	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		4	
13	Coordinate pre-surgery services			
14	Schedule space and equipment in facility			
15	Provide pre-service education/obtain consent		4	
16	Follow-up phone calls & prescriptions			
17	Other Clinical Activity (please specify)			
18	End: When patient enters office/facility for surgery/procedure			
19	SERVICE PERIOD			
20	Start: When patient enters office/facility for surgery/procedure			
21	Pre-service services			
22	Review charts		3	
23	Greet patient and provide gowning		3	
24	Obtain vital signs		3	
25	Provide pre-service education/obtain consent			
26	Prepare room, equipment, supplies		2	
27	Setup scope (non facility setting only)			
28	Prepare and position patient/ monitor patient/ set up IV			
29	Sedate/apply anesthesia			
30	Intra-service			
31	Assist physician in performing procedure			
32	Post-Service			
33	Monitor pt following service/check tubes, monitors, drains		2	
34	Clean room/equipment by physician staff		3	
35	Clean Scope			
36	Clean Surgical Instrument Package			
37	Complete diagnostic forms, lab & X-ray requisitions			
38	Review/read X-ray, lab, and pathology reports			
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		2	
40	Discharge day management 99238 --12 minutes 99239 --15 minutes			
41	Other Clinical Activity (please specify)			
42	End: Patient leaves office			
43	POST-SERVICE PERIOD			
44	Start: Patient leaves office/facility			
45	Conduct phone calls/call in prescriptions			
46	Office Visits			
47	List Number and Level of Office Visits			
48	99211 16 minutes	16		
49	99212 27 minutes	27		
50	99213 36 minutes	36		
51	99214 53 minutes	53		
52	99215 63 minutes	63		
53	Other			
54				
55	Total Office Visit Time		0	0
56	Other Activity (please specify)			
57	End: with last office visit before end of global period			
58	MEDICAL SUPPLIES			
59	PEAC multispecialty supply package	SA048	1	
60	Gown, surgical	SB028	1	
61	Drape, sterile barrier (16x29)	SB011	1	
62	Mask, surgical with face shield	SB034	1	
63	Needle, 18-27 gauge	SC029	1	
64	Shoe covers, surgical	SB039	1	
65	Swab pad, alcohol	SJ053	2	
66	Syringe 10-12 ml	SC051	1	
67	Gloves, sterile	SB024	1	
68	Underpad (2ftx3ft) Chux	SB004	3	
69	Biohazard bag	SM004	1	
70	Asepto bulb syringe	SJ001	1	
71				
72	EQUIPMENT			
73	Ventilator hood and blower	E91003	1	
74	Power Table	E11003	1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Pelvic Floor Defect Repair

The CPT Editorial Panel created a new code to describe a new improvement in female reconstructive surgery i.e. the insertion of mesh or other prosthesis for the repair of a pelvic floor defect via the vaginal approach.

The RUC reviewed the specialty society's recommendations for 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach* and agreed that because the survey respondents may have been confused by the concept of an add-on code and that as a result physician time and work recommendations were inflated, information gathered by the consensus panel regarding physician time and work RVU recommendations would be more appropriate to review. The RUC reviewed the consensus panel's recommendation of physician pre-service time, 5 minutes, and felt that this was inappropriate because this time is accounted for within the base code for vaginal repair and therefore removed this time resulting in a physician time recommendation of only 45 minutes of intra-service time. To construct a relative value recommendation the society made a comparison to CPT code 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, Intra-Service Time=52 minutes). The RUC agreed that the physician work of the reference service and the surveyed code was similar in physician time and intensity was able to make a good cross-reference. The specialty clarified that this service is typically provided using a single approach and reporting this code once in response to questions on whether the code could be reported for both the posterior and anterior approach. **The RUC recommends a work RVU value of 4.88 for 57267.**

Practice Expense

There are no practice expense inputs associated with this procedure since it is an add-on code performed in the facility setting only.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
+ • 57267	AI1	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior,	ZZZ	N/A	4.88

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
		<p>posterior compartment), vaginal approach (List separately in addition to code for primary procedure)</p> <p><u>(Report code 57267 in addition to 45560, 57240-57265)</u></p>			

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

Recommended Work Relative Value

CPT Code:57267 Tracking Number: AI1 Global Period: ZZZ Specialty Society RVU: **4.88** RUC RVU: **4.88**

CPT Descriptor: Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure) (Report code 572XX in addition to code for vaginal repair)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 y/o G4 P4 female patient presents complaining of vaginal pressure, discomfort, and bulging exacerbated by lifting and straining. She has had a previous attempt at repair of rectocele and has no history of urinary incontinence. Her past medical history is negative. Her pertinent physical examination reveals a significant loss of support of the rectum to 2 cm beyond the hymen. Vaginal apical support is adequate but the intervening native endopelvic fascial supportive tissues are very poor. The surgeon considers them inadequate to provide future support alone. He/she performs rectocele repair. Because of the lack of reasonable tissue strength, the surgeon inserts a prosthetic graft over the native tissues to buttress the weak endopelvic fascia between the vagina and rectum.

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:

- * Identification of appropriate material for insertion
- * Supervision of OR staff when opening material

Description of Intra-Service Work:

- * Examine vaginal defect
- * Prepare surgical graft material
- * Cut graft material to correct size
- * Dissect deep in pelvis and identify ischial spines and surrounding ligamentous tissues for attachment
- * Place sutures deep into pelvis beyond vaginal apex for initial attachment
- * Attach graft to stay sutures and tie to suspend deep in pelvis
- * Place several subsequent sutures in levator muscles, lateral vagina and graft to attach graft along full length of vagina bilaterally
- * Place sutures through distal perineal muscles and graft to attach to distal vagina
- * Resect excess vaginal epithelium
- * Irrigate copiously
- * Close remaining vaginal epithelium with running suture
- * Pack the vagina with gauze

Description of Post-Service Work:**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	04/2004
Presenter(s):	Robert Harris, MD, FACOG; George Hill, MD, FACOG; Sandra Reed, MD, FACOG
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG); American Urogynecological Society (AUGS)
CPT Code:	57267

Sample Size: 60		Resp n: 31		Response: %		
Sample Type: Convenience						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		0.67	8.26	11.00	11.32	14.00
Pre-Service Evaluation Time:				0.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		20.00	37.50	45.00	97.50	180.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		0.00				
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>
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)

<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: 19.3 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 57267	Key Reference CPT Code: 49568
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	45.00	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
Median Total Time	45.00	52.00

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	3.94	3.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.52	3.37
Urgency of medical decision making	3.10	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.26	3.68
Physical effort required	3.94	3.48

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.77	3.47
Outcome depends on the skill and judgment of physician	4.29	3.81
Estimated risk of malpractice suit with poor outcome	4.00	3.65

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.45	3.13
Intra-Service intensity/complexity	4.19	3.48
Post-Service intensity/complexity	3.19	3.10

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.*

SEE ATTACHMENT A

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. See attachment B

FREQUENCY INFORMATION

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

* CPT code 15350 Application of allograft, skin; 100 sq cm or less

* CPT code 15400 Application of xenograft, skin; 100 sq cm or less

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urogynecologists How often? Commonly

Specialty Gynecologists How often? Sometimes

Specialty Urologists How often? Sometimes

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 Urogynecologists	Frequency 1000	Percentage	%
Specialty Gynecologists	Frequency 500	Percentage	%
Specialty Urologists	Frequency 500	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,625 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Urogynecologists	Frequency 812	Percentage	%
Specialty Gynecologists	Frequency 406	Percentage	%
Specialty Urologists	Frequency 407	Percentage	%

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

Professional Liability Insurance Information (PLI)

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

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

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

ADDITIONAL RATIONALE

The American College of Obstetricians and Gynecologists (ACOG) convened their RUC panel to review survey data for CPT code +57267. In addition, a representative from the American Urogynecological Society (AUGS) was invited to participate.

After reviewing the survey data, the panel concluded that survey respondents may have been confused by the concept of an add-on code and that as a result physician time and work recommendations were inflated. The group agreed to use a consensus panel format to revise physician time and develop work RVU recommendations.

CONSENSUS PANEL RECOMEMNDATIONS

Work RVU recommendation

After a discussion the group recommended a value of 4.88RVW for +57267. The panel cross-walked this value from the reference service (CPT code 49568).

SURVEY RVW VALUES

Low	.67
25 th percentile	8.26
Median	11.00
75 th percentile	11.32
High	14.00

Physician time recommendations

After a discussion the group recommended the following revisions to physician time.

CONSENSUS PANEL PHYSICIAN TIME REVISIONS

TIME PERIOD	SURVEY	CONSENSUS PANEL RECOMMENDATION
Pre-Service	30	5
Intra-Service	60	45
Post-Service	30	0
Total Time	120	50

DISCUSSION

During their discussion the consensus panel

- made revisions to physician time
- compared the surveyed code to the reference service
- compared IWPOT values of the surveyed code to other add-on codes

Revisions to Physician Time

The consensus panel reviewed the survey data for physician time. In general they felt it was slightly inflated. They concluded that this was due not to unfamiliarity with the service but confusion regarding what physician work is included in an add-on code.

The panel did not think 30 minutes for pre-service or post-service periods was necessary. Although they did agree that a few minutes needed to be allocated in the pre-service

period because the physician will need to supervise the identification and opening of the mesh material by OR staff. The procedure is uncommon enough and the material very expensive that typically a physician will need to be involved in this task. ***The panel agreed to allocate five minutes to the pre-service period. They did not think any time needed to be allocated in the post service period.***

The panel also agreed that 60 minutes for the intra-service period was too high. The panel discussed challenges the physician faces during the intra-service period. The placement of mesh to support pelvic floor structures risks erosion of the mesh into the urethra, bladder, rectum and vagina with serious sequelae. In addition, the physician faces difficulty in locating the tissue beneath the pubic symphysis and in the retroperitoneal space for anchoring of the mesh material. After considering these issues, 45 minutes seemed to be a fair estimate of the time. ***The AUGS representative, representing the sub-specialty that most commonly performs this procedure, agreed that in his experience, 45 minutes was a reasonable estimate for the intra-service period.***

Comparison to Reference Service CPT code 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))

The group compared the surveyed code to the reference code. The group identified CPT code 49568, as the reference service. The group agreed that while the reference service was performed by general surgeons and urogynecologists tended to perform the surveyed code, the physician work of the two codes was similar enough to make a reasonable reference service. ***The group concluded that a work RVU value of 4.88 (same work value as the reference service) was appropriate for the surveyed code.***

IWPUT Comparisons

Understanding that there are limitations to interpreting IWPUT values for add-on codes, the group decided to compare the IWPUT values of the surveyed code to existing add-on codes. They agreed that it was merely a method to test the reasonableness of their recommendations. A summary of these values is below. ***After reviewing these values, the panel felt that the recommendation of 4.88 RVU and 50 minutes total physician time was reasonable and appropriate.***

ADD-ON CODE IWPUT COMPARISONS

CODE #	DESCRIPTOR	DATA	IWPUT
+57267	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site	RUC	.106
44015	Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (List separately in addition to primary procedure)	HARVARD	.110
44121	Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	HARVARD	.074

ACOG Attachment A +57267 Work Summary Recommendation Form

44128	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	RUC	.111
44139	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	RUC	.074
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)	RUC	.094
64901	Nerve graft, each additional nerve; single strand (List separately in addition to code for primary procedure)	HARVARD	.062
64902	Nerve graft, each additional nerve; multiple strands (cable) (List separately in addition to code for primary procedure)	HARVARD	.064

SERVICES REPORTED WITH MULTIPLE CODES

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

+57267 is an add-on code so it is always reported with another code. Since it is an add-on code multiple procedure reduction policies do not apply.

CODES TYPICALLY REPORTED WITH +57267

Code#	Descriptor	Global	Work RVU	Pre Time	Intra Time	Immed Post Time	*Total Time
45560	Repair of rectocele (separate procedure)	90	10.56	90	90	30	352
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	90	6.06	52	45	20	182
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	90	5.52	48	37	21	166
57260	Combined anteroposterior colporrhaphy	90	8.26	55	61	28	240
57265	Combined anteroposterior colporrhaphy; with enterocele repair	90	11.32	55	71	25	225

* Total time includes discharge, hospital and office visits.

CODING SCENARIOS

Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
(1) 45560 – 10.56 RVU	(1) 57240 – 6.06 RVU	(1) 57250 – 5.52RVU	(1) 57260 – 8.26 RVU	(1) 57265 – 11.32 RVU
(2) +57267 – 4.88RVU	(2) +57267 – 4.88RVU	(2) +57267 – 4.88RVU	(2) +57267 – 4.88RVU	(2) +57267 – 4.88RVU
Total – 15.44 RVU	Total – 10.94 RVU	Total – 10.4 RVU	Total – 13.14 RVU	Total – 16.2 RVU

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2004

Vaginal Extra and Intraperitoneal Colpopexy

The CPT Editorial Panel revised an existing code and created a new code to describe vaginal extra and intraperitoneal colpopexies, procedures that describe the suspension of the apex of the vagina in women with prolapse of the vaginal vault apex via an extraperitoneal approach (outside the peritoneum) or an intraperitoneal approach (inside or within the peritoneum).

57282

The RUC considered changes made to 57282 *Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)* (Work RVU=8.85), and considered these changes to be editorial since this revision intended to more accurately describe the physician work involved in code 57282. **The RUC recommended maintaining the current work relative value of 8.85 for 57282.**

57283

The RUC reviewed the survey results for 57283 *intra-peritoneal approach (uterosacral, levator myorrhaphy)*. The survey respondents indicated that this procedure is more complex, requires more mental effort, technical skill and psychological stress than its reference service code, 57282 *Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)* (Work RVU=8.85). In addition, 57283 requires more time to complete (335 minutes total time) than its reference code 57282 which has a total time of 240 minutes. The RUC noted that 57283 requires 25 more minutes of intra-service work. In addition, the pre-service work for 57283 is more work as it includes an examination of the vaginal defect. The RUC agreed that the median RVU was appropriate and reflected the differences in work with the reference service. **Therefore, the RUC recommends the median 14.00 work RVU for 57283.**

Practice Expense

The RUC reviewed the practice expense inputs for 57283. These inputs were assessed and the RUC agreed that they met PEAC accepted standards of clinical labor time, supplies and equipment. The RUC recommends the practice expense inputs as defined in the attached spreadsheets.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲57282		Sacrospinous ligament fixation for prolapse of vagina Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)	090	8.85 (No Change)
●57283	E1	intra-peritoneal approach (uterosacral, levator myorrhaphy) <u>(Do not report 58263 in addition to 57283)</u>	090	14.00

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

CPT Code:57283 Tracking Number: E1 Global Period:090 **Recommended RVW: 14.00**

CPT Descriptor: Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old G3P3 female patient presents complaining of vaginal pressure, discomfort, and heaviness as well as vaginal bulging exacerbated by lifting and prolonged standing. There is no history of incontinence but she has some bladder pressure and urinary frequency. Her past medical history is negative. Her pertinent physical examination reveals significant inversion of the vaginal apex 2 cm beyond the level of the hymen. In addition, an enterocele is demonstrated at the vault of the apex. The physician is trained in pelvic reconstructive surgery and performs transvaginal colpopexy with entrance into peritoneal cavity through the enterocele sac and bilateral attachment of the vaginal apex (anterior and posterior endopelvic fascia) to the uterosacral ligaments or levator musculature with enterocele repair.

Percentage of Survey Respondents who found Vignette to be Typical: 97.60%

Description of Pre-Service Work:

- Paperwork for hospital admission
- Perform interval history and physical exam
- 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:

- Examine vaginal defect
- Open vaginal mucosa at apex of vagina
- Dissect anterior and posterior endopelvic fascia away from mucosa exposing enterocele
- Identify peritoneum and enter sharply under direct visualization
- Retract bowel away and pack with laparotomy towel
- Identify and palpate ureters bilaterally
- Identify uterosacral ligaments on each side
- Grasp uterosacral ligaments high in the pelvis with clamps and place on traction
- Place series of interrupted sutures through uterosacral ligaments on both sides
- Perform culdeplasty to obliterate culdesac
- Bring sutures through exposed anterior (pubocervical) and posterior (rectovaginal) endopelvic fascia
- Tie sutures to suspend vagina deep in the pelvis

- Close the vaginal vault with interrupted sutures
- A foley catheter is placed and left in for bladder drainage
- Pack the vagina with gauze

Description of Post-Service Work:

- Accompany patient to recovery room
- Write post-operative orders
- Speak with family
- Dictate operative note
- Observe patient in recovery until stable
- See and evaluate patient in hospital for two visits plus discharge
- Office evaluation and management for two post-operative visits

SURVEY DATA

CORRECT DATA

RUC Meeting Date (mm/yyyy)		01/2004			
Presenter(s):		Robert Harris, MD, FACOG/George Hill, MD, FACOG/Sandra Reed, MD, FACOG			
Specialty(s):		American College of Obstetricians and Gynecologists (ACOG)/American Urogynecological Association (AUGS)			
CPT Code:		57283			
Sample Size: 100		Resp n: 42		Resp %: 42.0%	
Sample Type:		Convenience			
		Low	25 th pctl	Median*	75th pctl
Survey RVW:		7.00	11.75	14.00	14.95
Pre-Service Evaluation Time:				60.00	
Pre-Service Positioning Time:				12.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		30.00	86.25	95.00	120.00
Post-Service		Total Min**	CPT code / # of visits		
Immed. Post-time:		30.00			
Critical Care time/visit(s):		0.00	99291x 0 99292x 0		
Other Hospital time/visit(s):		49.00	99231x 1 99232x 1 99233x 0		
Discharge Day Mgmt:		36.00	99238x 1.00 99239x 0.0		
Office time/visit(s):		38.00	99211x 0.0 12x 1.00 13x 1.00 14x 0.00 15x 0.0		

To calculate above and below time recommendations, tab here

**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>
57282	090	8.85

CPT Descriptor Sacrospinous ligament fixation for prolapse of vagina

<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: 24

TIME ESTIMATES (Median)

New/Revised
CPT Code:
57283

Key Reference
CPT Code:
57282

Median Pre-Service Time	87.00	52.00
Median Intra-Service Time	95.00	70.00
Median Immediate Post-service Time	30.00	27.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	49.00	51.00
Median Discharge Day Management Time	36.00	0.00
Median Office Visit Time	38.00	40.00
Median Total Time	335.00	240.00

Calculate total
reference time
tab here

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

The number of possible diagnosis and/or the number of management options that must be considered	4.31	4.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.76
Urgency of medical decision making	3.17	3.15

Technical Skill/Physical Effort (Mean)

Technical skill required	4.83	4.52
Physical effort required	4.52	4.29

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.50	4.29
Outcome depends on the skill and judgement of physician	4.76	4.45
Estimated risk of malpractice suit with poor outcome	4.00	3.95

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.78	3.71
Intra-Service intensity/complexity	4.56	4.34
Post-Service intensity/complexity	3.59	3.54

ADDITIONAL RATIONALE

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

RUC Advisors from the American College of Obstetricians and Gynecologists (ACOG) and a representative from the American Urogynecological Society (AUGS) reviewed the survey data. The physicians utilized two methods to assess the adequacy of the survey median:

- Comparison to reference CPT code 57282
- Calculation of IWPUT

COMPARISON TO REFERENCE CPT CODE 57282

57282, Sacrospinous ligament fixation for prolapse of vagina, 8.85 RVW.

24/42 survey respondents identified 57282 as a reference code. The median survey value of 14.00 RVW for 572XX is higher than the current value of CPT code 57282, which is 8.85 RVW. The committee felt that the overall survey results supported this higher value because:

- significantly higher physician time for surveyed code 57283 (355 min) than reference code 57282 (240 min)
- higher intensity/complexity measures for surveyed code (57283) than the reference code (57282)

The representative from AUGS agreed that these higher measures were appropriate and a higher value for the surveyed code was justified. He identified elements that make the surveyed procedure more complex and intensive than the reference code:

- the typical patient for the surveyed code is elderly and more complex; if the patient were a good surgical candidate this procedure would have been performed abdominally
- the surveyed code describes a procedure that puts both ureters and the bowel at risk.

CALCULATION OF IWPUT

The committee then calculated the IWPUT of the surveyed code using the RUC approved method. The calculation of an IWPUT for 57283 resulted in a value of .079. The committee felt that this value was consistent with other intensive vaginal procedures. The reference code had a value of .041. It was agreed that this lower IWPUT for the reference code was appropriate since it was not intraperitoneal and this procedure does not have as much risk to the ureters or the bowel.

After considering all of these elements the committee concluded that a value of 14.00 RVW was a fair and appropriate 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: 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.

The typical patient presents with multiple defects. The patient may have defect of the anterior, posterior or both.

Code#	Decsriptor	Global	Work RVU	Pre Time	Intra Time	Post Time	Total
57240	ANT COLPORRHAPHY REPR CYSTOCELE	90	6.06	52	45	85	182
57250	POST COLPORRHAPHY REPR RECTOCELE	90	5.52	48	37	81	166
57260	COMBINED AP COLPORRHAPHY;	90	8.26	55	61	124	240

CODING SCENARIOS

Coding Scenario - 1	Coding Scenario -2	Coding Scenario - 3
57283 - 14.00 RVU	57283 - 14.00 RVU	57283 - 14.00 RVU
57240 - 3.03 RVU	57250 - 2.76 RVU	57260 - 4.13 RVU
TOTAL - 17.03	TOTAL - 16.76	TOTAL - 18.13 RVU

FREQUENCY INFORMATION

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

57282, Sacrospinous ligament fixation for prolapse of vagina

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

Specialty - Urogynecology How often? commonly

Specialty - Gynecology How often? sometimes

Specialty - Urology How often? sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 15000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty - Urogynecology	Frequency	9750	Percentage	65%
Specialty - Gynecology	Frequency	2625	Percentage	17.5%
Specialty - Urology	Frequency	2625	Percentage	17.5%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
7500

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

Specialty - Urogynecology	Frequency	4875	Percentage	65%
Specialty - Gynecology	Frequency	1312.5	Percentage	17.5%
Specialty - Urology	Frequency	1312.5	Percentage	17.5%

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

	A	B	C ACOG 99239	D
1			FAMILY 1	
2			CPT Code -57283	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Colpopexy, vaginal, intra-pelvic approach (uterosacral, levator myorrhaphy)	
4	LOCATION		In Office	Out Office
5	GLOBAL PERIOD			90
6	TOTAL CLINICAL LABOR TIME		0.0	135.0
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	63.0
10	PRE-SERVICE			
11	Start: Following visit when decision for surgery or procedure made			
12	Complete pre-service diagnostic & referral forms	1130		5
13	Coordinate pre-surgery services	1130		20
14	Schedule space and equipment in facility	1130		8
15	Office visit before surgery/procedure Review test and exam results			
16	Provide pre-service education/obtain consent	1130		20
17	Follow-up phone calls & prescriptions	1130		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	1130		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		27
49	99213 36 minutes	36		36
50	99214 53 minutes	53		
51	99215 63 minutes	63		
52	Other			
53				
54	Total Office Visit Time		0	63
55	Other Activity (please specify)			
56	End: with last office visit before end of global period			

	A	B	C ACOG CANN	D
2			CPT Code -57283	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Colpopexy, vaginal, intra-peritoneal approach (uterosacral, levator myorrhaphy)	
4	LOCATION		In Office	Out Office
57	MEDICAL SUPPLIES			
58	drape sheet	1106		2
59	Minimum supply package			2
60	pelvic exam package			2
61				
62				
63				
64				
65	Equipment			
66	power table	E11003		63
67	fiberoptic exam light	E11006		63
68				
69				
70				
71				

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
April 2004

Endometrial Cryoablation Therapy

The specialty society did not present survey data for CPT code 58356 *Endometrial cryoablation with ultrasonic guidance, including endometrial curettage when performed* at the April 2004 RUC meeting as it was first necessary to seek clarification on the code descriptor at the May CPT Editorial Panel meeting. The RUC recommends that this infrequently performed service be carrier priced in 2005. The RUC anticipates that it will review survey data for this code at the September 2004 meeting. **The RUC recommends that CPT code 58356 be carrier priced in 2005.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
58340		<i>Catheterization and introduction of saline or contrast material for hysterosonography or hysterosalpingography</i> <i>(For radiological supervision and interpretation of hysterosonography, see 76831)(For radiological supervision and interpretation of hysterosalpingography, see 74740)</i> <i>(For endometrial cryoablation with ultrasonic guidance, use Category III code 0009T)</i>	000	0.88 (No Change)
58353		<i>Endometrial ablation, thermal, without hysteroscopic guidance</i> <i>(For hysteroscopic procedure, use 58563)</i>	010	3.55 (No Change)
•58356	AJ1	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage when performed <u>(Do not report 5835X in conjunction with 58100, 58120 58340, 76700, 76856)</u>	010	Carrier Price (To be reviewed at the Sept 2004 RUC Meeting)
0009T		Endometrial cryoablation with ultrasonic guidance <u>(0009T has been deleted. To report, use 5835X)</u>	XXX	N/A

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Hysteroscopic Fallopian Tube Cannulation and Placement of Permanent Implants

The CPT Editorial Panel has created a new code to report female sterilization via hysteroscopy that avoids abdominal incisions for access to the fallopian tubes.

The RUC reviewed the recommendations for 58565 *Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants* forwarded by the specialty society. The society felt that the survey times and hospital/office visits associated with the new code were incorrect due to the inexperience of the survey respondents and therefore, the specialty society, using a consensus panel assigned the following times:

60 minutes	Pre-service time
50 minutes	Intra-service time
30 minutes	Post-service time
18 minutes	Half a discharge day management visit (99238)
30 minutes	2 –level two office visits (99212)

Using these newly assigned times, the RUC used a building block approach to determine the work RVU recommendation for 58565. The RUC agreed that the recommended work RVU for the new code should be constructed by adding the work RVUs of 58559 *Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)* (Work RVU=6.16) and two-level two office visits 99212 *Office/outpatient visit est.* (Work RVU=0.43) resulting in 7.02 work RVUs. The RUC felt comfortable using 58559 as a reference code because there was similar time and intensity in comparison to the new code. **The RUC recommends 7.02 work RVUs for 58565.**

Practice Expense:

There was significant discussion regarding the clinical labor time of 58565. The society recommends that there are two staff members assisting the physician while performing the service. The society explained that one scrubbed staff member, an RN/LPN/MTA, is assisting the physician manipulate the catheter used in coordination with the hysteroscope while the other staff member, an RN, is assisting the physician with the actual procedure. The RUC agreed with this rationale and made further modifications to staff times to be consistent with PEAC accepted standards. The supplies were modified to include a cleaning scope pack and the removal of one gown.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
58558		<i>Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C</i>	000	4.74 (No Change)
●58565	AK1	<p>with bilateral fallopian tube cannulation <u>to induce occlusion</u> by placement <u>of permanent implants</u></p> <p><u>(Do not report 58565 in conjunction with 58555 or 57800)</u></p> <p><u>(For unilateral procedure, use modifier 52)</u></p>	090	7.02

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

CPT Code:58565 Tracking Number: AK1 Global Period: 090	Recommended Work Relative Value Specialty Society RVU: 9.99 RUC RVU: 7.02
---	--

CPT Descriptor: Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants

(Do not report 5856X in conjunction with 58555 or 57800)

(For unilateral procedure, use modifier 52)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 37-year-old multiparous woman desires permanent sterilization. She is a poor candidate for laparoscopy in that she is obese and has had several previous abdominal surgical procedures. She has been counseled regarding the various options available to her and her partner including vasectomy, minilaparotomy, open laparoscopy as well as hysteroscopic techniques and has opted for the hysteroscopic approach.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 40%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made and continues until the time of the procedure. This activity includes reviewing the previous work-up, including consulting with the referring physician, if necessary, taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communicating with the patient (and/or her family) to explain the indications for the procedure, as well as the operative risks and benefits, and to obtain informed consent. The physician admits the patient to the surgery center, prepares the hospital records and chart in accordance with hospital policy. Other pre-operative services include scheduling the procedure, dressing, scrubbing, and waiting to begin the procedure. The physician must personally assure that all necessary equipment and supplies are available and compatible. The physician must also confirm proper positioning of the patient.

Description of Intra-Service Work: Following induction of appropriate anesthesia, a pelvic exam is performed. A perineal/vaginal prep is performed. Sterile drapes are placed. A speculum is inserted into the vagina and a single-toothed tenaculum is placed on the anterior lip of the cervix. A paracervical block is performed. The cervix is serially dilated. The operative hysteroscope is introduced through the dilated cervix. A complete diagnostic survey of the uterine cavity is performed. Access to both fallopian tube ostia is assessed for adequacy. Each tube is cannulated, then microinserts are placed bilaterally. The hysteroscope is removed from the uterus. The tenaculum is removed and bleeding from the site controlled, if necessary. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family and other health care professionals (including written and oral reports and orders). Discharge management includes the physician's final examination of the patient, instructions for continuing care, and preparation of the discharge records. In addition, two office visits are included in the global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2004
Presenter(s):	George Hill, MD, FACOG and Craig Sobolewski, MD, FACOG
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)

CPT Code: 58565						
Sample Size: 70		Resp n: 30		Response: 42.85 %		
Sample Type: Convenience						
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:		4.65	8.25	9.99	9.99	13.00
Pre-Service Evaluation Time:				35.0		
Pre-Service Positioning Time:				10.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		15.00	26.25	50.00	30.00	60.00
<u>Post-Service</u>		<u>Total Min**</u>	<u>CPT code / # of visits</u>			
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>18.0</u>	99238x 0.50 99239x 0.00			
Office time/visit(s):		<u>30.0</u>	99211x 0.0 12x 2.0 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>
58561	000	9.99

CPT Descriptor Hysteroscopy, surgical; with removal of leiomyomata

<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: 33.3 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 58565	Key Reference CPT Code: 58561
Median Pre-Service Time	60.00	40.00
Median Intra-Service Time	50.00	75.00
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	0.00
Median Office Visit Time	30.0	0.00
Median Total Time	188.00	145.00

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	3.33	3.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.30
Urgency of medical decision making	2.30	2.80

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	4.20
Physical effort required	3.33	3.23

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.27	2.83
Outcome depends on the skill and judgment of physician	4.23	3.87
Estimated risk of malpractice suit with poor outcome	4.50	4.20

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.20	3.00
Intra-Service intensity/complexity	3.97	3.73
Post-Service intensity/complexity	2.70	2.73

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.*

SEE ATTACHMENT A

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) CPT code 58579 Unlisted hysteroscopy procedure, uterus

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

Specialty Gynecology 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? 6500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Gynecology	Frequency 6500	Percentage 100.00 %
----------------------	----------------	---------------------

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

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

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

Specialty	Frequency	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. Surgical

ADDITIONAL RATIONALE

The American College of Obstetricians and Gynecologists (ACOG) convened their RUC panel to review survey data for CPT code 58565.

The panel identified CPT code 58561 as the appropriate reference code and they concluded that the survey RVU median of 9.99 was a fair and reasonable value.

PANEL DISCUSSION

The panel discussion focused on the following issues:

- general comments on the data
- comparison of the surveyed code to the reference service and other hysteroscopic codes
- IWPUT comparisons

General Comments on the Data

The panel felt that the survey respondents under-estimated their intra-service (30min) and post service (15min) time. The panel concluded that these underestimations were the result of unfamiliarity of the survey instrument and a lack of a precise understanding of the different service periods and did not accurately reflect the true typical physician time it takes to perform this procedure.

In terms of the RVU values, the panel felt that these were fairly tight and thus could be trusted as good estimates for valuing the physician work value of the code.

Comparison to Reference Service

The panel compared the surveyed code to CPT code 58561, Hysteroscopy, surgical; with removal of leiomyomata and other hysteroscopic codes. The panel agreed that 58565 was unique in that it was a hysteroscopic procedure but it had been assigned a 90-day global period. While the 90-day global was necessary to accommodate the two office visits that typically followed this procedure, it did create difficulties in making comparisons to other hysteroscopic codes which are 0 day globals.

DATA FOR OTHER HYSTEROSCOPIC CODES

Code #	Descriptor	Global	Work RVU	Pre Time	Intra Time	Post Time	Total Time
58561	Hysteroscopy, surgical; with removal of leiomyomata	0	9.99	40	75	30	145
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	0	6.16	40	60	30	130
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	0	4.74	30	40	20	90

The panel reviewed data for the different hysteroscopic codes and discussed the physician work involved in the different procedures. The panel agreed that the physician work for the surveyed code was greater than 58558. When considering the reference services, 58561, the panel agreed that it was fair to consider the intra-service physician time valued slightly less for the surveyed code, 58565, but when office visits are added to the surveyed code the value should be similar to the reference service, 58561

IWPUT Comparisons

The panel then compared IWPUT values to test the reasonableness of their recommendation. The results are below. While the IWPUT value of the surveyed code was slightly higher, the panel concluded that this was the result of the underestimation in physician time for the intra and post service periods.

IWPUT Comparisons

<u>Code #</u>	<u>Descriptor</u>	<u>DATA</u>	<u>IWPUT</u>
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation and microinsert placement	RUC	.209
58561	Hysteroscopy, surgical; with removal of leiomyomata	RUC	.112
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	RUC	.077
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	RUC	.119

CPT Code: 58565
Specialty Society('s) ACOG

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

CPT Long Descriptor:

58565, Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants

(Do not report 58565 in conjunction with 58555 or 57800)

(For unilateral procedure, use modifier 52)

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

Geographic Practice Setting %: Rural _____ Suburban _____ Urban _____

Type of Practice %: _____ Solo Practice
_____ Single Specialty Group
_____ Multispecialty Group
_____ Medical School Faculty Practice Plan

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

The ACOG RUC panel in addition to a representative from the American Association of Gynecological Laparoscopists (AAGL) developed practice expense recommendations for 58565 using a consensus panel format.

Initial review of the CPEP clinical staff time data was conducted in December 1997 by a panel of 11 ACOG Fellows (representing all ob-gyn specialties), a practice administrator and a nurse. In December 1999, a consensus panel of six ACOG Fellows representing the range of ob-gyn practice met to review the previous panel's recommendations and revised them in accordance with the requested RUC/PEAC format.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The staff assists with all pre-service activities related to the procedure. Typically these activities include:

- completing pre-service diagnostic and referral forms
- providing pre-service education and obtaining consent and
- conducting follow-up phone calls.

Intra-Service Clinical Labor Activities:

The staff also assists with intra-service activities related to the procedure. Typically these activities include:

- greeting patient and providing gowning
- obtaining vital signs
- confirming consent
- preparing room for the procedure
- setting up hysterscope
- preparing and positioning patient
- assisting with sedating patient
- assisting with procedure
- cleaning up room after procedure
- cleaning hysterscope and other equipment
- checking status of patient
- coordinating instructions for home and other discharge day activities
- scheduling office visits.

Post-Service Clinical Labor Activities:

Staff assists with office visits.

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

CPT Long Descriptor: 58565, Hysteroscopy, surgical; with with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants

(Do not report 58565 in conjunction with 58555 or 57800)

(For unilateral procedure, use modifier 52)

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

Geographic Practice Setting %: Rural _____ Suburban _____ Urban _____

Type of Practice %: _____ Solo Practice
_____ Single Specialty Group
_____ Multispecialty Group
_____ Medical School Faculty Practice Plan

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

The ACOG RUC panel in addition to a representative from the American Association of Gynecological Laparoscopists (AAGL) developed practice expense recommendations for 58565 using a consensus panel format.

Initial review of the CPEP clinical staff time data was conducted in December 1997 by a panel of 11 ACOG Fellows (representing all ob-gyn specialties), a practice administrator and a nurse. In December 1999, a consensus panel of six ACOG Fellows representing the range of ob-gyn practice met to review the previous panel's recommendations and revised them in accordance with the requested RUC/PEAC format.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The staff assists with all pre-service activities related to the procedure. Typically these activities include:

- completing pre-service diagnostic and referral forms
- providing pre-service education and obtaining consent

CPT Code: 58565
Specialty Society('s) ACOG

- scheduling space
- conducting follow-up phone calls.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

Staff assists with office visits.

	A	B	C	D	E	F	G	H
1								
2			58565					
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	cannulation to induce occlusion by placement of permanent implants					
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		90	90	N/A	0		
6	TOTAL CLINICAL LABOR TIME		207.0	120.0	0.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		35.0	60.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		118.0	6.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		54.0	54.0	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	1130	5	5				
13	Coordinate pre-surgery services	1130	10	20				
14	Schedule space and equipment in facility	1130	0	8				
15	Provide pre-service education/obtain consent	1130	10	20				
16	Follow-up phone calls & prescriptions	1130	10	7				
17	Other Clinical Activity (please specify)							
18	End: When patient enters office/facility for surgery/procedure							
19	SERVICE PERIOD							
20	Start: When patient enters office/facility for surgery/procedure							
21	Pre-service services							
22	Review charts							
23	Greet patient and provide gowning	1130	3					
24	Obtain vital signs	1130	5					
25	Provide pre-service education/obtain consent	1130						
26	Prepare room, equipment, supplies	1130	2					
27	Setup scope (non facility setting only)	1130	5					
28	Prepare and position patient/ monitor patient/ set up IV	1130	2					
29	Sedate/apply anesthesia	1130	2					
30	Intra-service							
31	Assist physician in performing procedure	1130	50					
32	Assist physician in performing procedure	7129	33					
33	Post-Service							
34	Monitor pt following service/check tubes, monitors, drains							
35	Clean room/equipment by physician staff	1130	3					
36	Clean Scope	1130	10					
37	Clean Surgical Instrument Package							
38	Complete diagnostic forms, lab & X-ray requisitions							
39	Review/read X-ray, lab, and pathology reports							
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	1130	3					
41	Discharge day management 99238 -12 minutes 99239 -15 minutes	1130		6				
42	Other Clinical Activity (please specify)							
43	End: Patient leaves office							
44	POST-SERVICE Period							
45	Start: Patient leaves office/facility							
46	Conduct phone calls/call in prescriptions							
47	Office visits							
48	List Number and Level of Office Visits							
49	99211 16 minutes	16						
50	99212 27 minutes	27	2	2				
51	99213 36 minutes	36						
52	99214 53 minutes	53						
53	99215 63 minutes	63						
54	Other							
55	Total Office Visit Time		54	54				
56	Other Activity (please specify)							
57	End: with last office visit before end of global period							
58								
59								

	A	B	C	D	E	F	G	H
2			58565					
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	cannulation to induce occlusion by placement of permanent implants					
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
60	MEDICAL SUPPLIES							
61	PEAC multispecialty supply package	SA048						
62	Gown, surgical	SB028	2					
63	Shoe covers, surgical	SB039	2					
64	mask, surgical	SB033	3					
65	Essure Coil (1 packet per procedure) (not in database, documentation provided)		1					
66	pack, pelvic exam	SA051	3	2				
67	pack, minimum multi-specialty visit	SA048	3	2				
68	pack, urology cystoscopy visit	SA058	1					
69	synnge, Toomey	SC062	1					
70	needle, 18-26g 1 5-3 5in, spinal	SC028	1					
71	sodium chloride 9%imgation (500-1000ml uou)	SH069	3					
72	gloves, non-sterile	SB022	1					
73	gloves, sterile	SB024	1					
74	gauze, sterile 4in x 4in (10 pack uou)	SG056	1					
75	lidocaine - inj (Xylocaine)	SH047	20					
76	pack, cleaning and disinfecting, endoscope	SA041	1					
77	Equipment							
78	Ventilator hood and blower	E91003						
79	Power Table	E11003	104	54				
80	fiberoptic exam light	E11006	79	54				
81	endoscope, rigid hysteroscope	E13402	45					
82	video system, endoscopy (processor, digital capture, monitor, printer, cart)		45					
83	light source	E13122	45					
84	obturator and sheath (not in database, documentation will be provided)		45					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2004

BSO Total Omentectomy with TAH for Malignancy

The CPT Editorial Panel created a new code to describe a bilateral salpingo-oophorectomy with total omentectomy with total abdominal hysterectomy for malignancy, a procedure for women who do not need to have lymph node dissection for staging because the disease has already spread intra-abdominally.

58956

It was determined by the RUC that the work associated with the new code 58956 *Bilateral salpingo-oophorectomy with total omentectomy with total abdominal hysterectomy for malignancy* is less intense than that of the work associated with the reference code 58953 *Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking* (Work RVU=31.95). The survey median value of 25.00 RVU was not consistent with the values of other related codes. By using a building block approach, the RUC approved the specialty society recommendation of 20.78 for 58956. This recommendation was formulated by adding the work of two previously RUC reviewed codes, 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)* (Work RVU=15.22) and half of the work associated with 49255 *Omentectomy, epiploectomy, resection of omentum (separate procedure)* (Work RVU=11.12). The office time/visits were modified to include three 99213 visits. **The RUC recommends a work relative value of 20.78 for 58956.**

When the RUC decided the work RVU for 58956 it took into consideration that this included only *bilateral salpingo-oophorectomy with total omentectomy with total abdominal hysterectomy for malignancy*. The CPT Editorial Panel Executive Committee voted to accept this recommended revision to the new code 58956, to preclude reporting this code for those procedures in which partial omentectomy procedures are performed.

Practice Expense

The RUC reviewed and modified the practice expense inputs for 58956. The post-op visits were changed to three, 99213 visits and a post-op incision care kit was added. The RUC recommends the practice expense inputs as defined in the attached spreadsheets, for this facility-based service. No practice expense inputs were recommended in the non-facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 58956	M1	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy (Do not report 58956 in conjunction with <u>49255, 58150, 58180, 58262, 58263, 58550, 58661, 58700, 58720, 58900, 58925, 58940</u>)	090	20.78
58953		Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;	090	31.95 (No Change)

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

CPT Code:58956 Tracking Number: Global Period:090 Recommended RVW: 20.78

CPT Descriptor: Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year-old woman presented with postmenopausal bleeding for 18 months duration biopsy reveals a FIGO grade 3 endometrial carcinoma. Patient is taken for exploratory laparotomy. At the time of surgery there are several 2cm implants found in the omentum. There is no adenopathy and no peritoneal implants. Patient undergoes TAH BSO and complete omentectomy to remove all gross disease. The patient receives usual follow-up care in the hospital and office during the 90-day global period.

Percentage of Survey Respondents who found Vignette to be Typical: 90.00%

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

Description of Intra-Service Work: The patient is positioned on the table and an exam under anesthesia is performed. The patient is prepped and draped and an abdominal incision is made. A thorough exam of the abdomen and pelvis is done which reveals multiple omental metastasis that involve the greater and lesser omentum. There does not appear to be other intraperitoneal disease and there is no retroperitoneal lymphadenopathy. A retractor is placed and a complete TAH/BSO is performed. The lymph nodes and retroperitoneal spaces are carefully inspected. After completion of the TAH/BSO a complete omentectomy is performed. The omentum is freed from the transverse colon and the omentum is taken off the greater curvature of the stomach up to the splenic hilum. All of the metastatic disease is resected with the omentectomy. Hemostasis is ensured and the abdomen is irrigated, and closed.

Description of Post-Service Work: Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. The physician visits the patient in the hospital for 5-6 days. The physician reviews the pathology with the patient. The patient is discharged on post op day 6-7 with instructions for follow-up care. The patient will be evaluated in 1-2 weeks to determine when adjuvant therapy should begin and evaluated at 6-8 weeks for a post operative check. The patient has 2-3 visits during the post operative period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2004
Presenter(s):	Barbara Goff, MD; George Hill, MD; Sandra Reed, MD

Specialty(s):	American College of Obstetricians & Gynecologists (ACOG) & Society of Gynecologic Oncologists (SGO)				
CPT Code:	58956				
Sample Size:	75	Resp n:	30	Resp %:	40.0%
Sample Type:	Convenience				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	18.00	24.00	25.00	27.38	32.00
Pre-Service Evaluation Time:			77.50		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	60.00	120.00	150.00	180.00	240.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	30.00				
Critical Care time/visit(s):	0.00	99291x 0 99292x 0			
Other Hospital time/visit(s):	109.00	99231x 2 99232x 1 99233x 1			
Discharge Day Mgmt:	36.00	99238x 1.00 99239x 0.00			
Office time/visit(s):	69.00	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00			

To calculate above and below time recommendations, tab here

**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>
58953	090	31.95

CPT Descriptor Bilateral salpingo-oophorectomy with ometectomy, total abdominal hysterectomy and radical dissection for debulking

<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

TIME ESTIMATES (Median)

	New/Revised CPT Code: 58956	Key Reference CPT Code: 58953
Median Pre-Service Time	113.00	90.00
Median Intra-Service Time	150.00	285.00
Median Immediate Post-service Time	30.00	45.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	109.00	139.00

Median Discharge Day Management Time	36.00	36.00
Median Office Visit Time	69.00	76.00
Median Total Time	507.00	671.00

Calculate total
reference time
tab here

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.46	4.69
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.44	4.63
Urgency of medical decision making	4.44	4.63

Technical Skill/Physical Effort (Mean)

Technical skill required	4.31	4.69
Physical effort required	4.31	4.69

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.25	4.63
Outcome depends on the skill and judgement of physician	4.44	4.69
Estimated risk of malpractice suit with poor outcome	4.13	4.13

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.23	4.62
Intra-Service intensity/complexity	4.15	4.62
Post-Service intensity/complexity	4.38	4.69

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.*

ACOG's RUC advisors and physician representatives from the Society of Gynecologic Oncologists (SGO) met by conference call to review the survey data. After reviewing the survey data, the panel of physicians concluded that 20.78 RVW was a fair and appropriate value. This value was obtained by using the building block method.

BUILDING BLOCK METHOD

The panel unanimously agreed that the survey median value of 25.00 RVW was not consistent with the values of other related codes. The building block approach was suggested as an alternative method for developing a recommended RVW value. The code seemed well suited to the building block approach and the panel agreed to use this method.

CPT code 58150, Total hysterectomy - 15.22 RVW

+

CPT code 49255, Omentectomy (50% of 11.12 RVW = 5.56 RVW) 5.56 RVW

TOTAL = 20.78 RVW

The panel was comfortable with this value.

PRE-SERVICE TIME DISCUSSED

The panel discussed the surveyed time of 113 minutes for CPT code 58956. The panel noted that in the RUC database for reference code 58953 the actual surveyed time for pre-service work was 150 minutes but the RUC adjusted it to 90 minutes (see RUC rationale tab in RUC database for CPT code 58953). The panel concluded that this indicated that the surveyed time of 113 minutes for pre-service work for 58956 was consistent with the reference code. The two gynecologic oncologists on the panel noted that in their personal experience 113 minutes was in the range for typical pre-service time for this procedure.

IWPUT

The panel tested the reasonableness of the recommendation of 20.78 RVW for 58956 by comparing the IWPUT value of the surveyed code to the reference code.

The committee calculated the IWPUT of the surveyed code using the RUC approved method. Calculation of an IWPUT for 58956 resulted in a value of .069. The calculation of an IWPUT for reference code 58953 was .072. The panel agreed that a slightly higher IWPUT for the reference code was appropriate because the reference code was more complex, required greater technical skill and presented a more significant risk of complications. The consistently higher survey intensity/complexity measures for the reference code supported this conclusion.

After considering all of these elements the committee agreed that a value of 20.78 RVW was a fair and appropriate 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? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 58953 with -52 modifier or 58150 with 49255

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

Specialty Gyn Oncologists 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? 3000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Gyn Oncologists Frequency 3000 Percentage 100.00%

Specialty Frequency 0 Percentage 0.00%

Specialty Frequency 0 Percentage 0.00%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Gyn Oncologists Frequency 1500 Percentage 100.00%

Specialty Frequency 0 Percentage 0.00%

Specialty Frequency 0 Percentage 0.00%

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

	A	B	C ACOG 58956	D
1			FAMILY 1	
2			CPT Code -58956	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy	
4	LOCATION		In Office	Out Office
5	GLOBAL PERIOD			90
6	TOTAL CLINICAL LABOR TIME		0.0	180.0
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	108.0
10	PRE-SERVICE			
11	Start: Following visit when decision for surgery or procedure made			
12	Complete pre-service diagnostic & referral forms	1130		5
13	Coordinate pre-surgery services	1130		20
14	Schedule space and equipment in facility	1130		8
15	Office visit before surgery/procedure Review test and exam results			
16	Provide pre-service education/obtain consent	1130		20
17	Follow-up phone calls & prescriptions	1130		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	1130		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		108
50	99214 53 minutes	53		
51	99215 63 minutes	63		
52	Other			
53				
54	Total Office Visit Time		0	108
55	Other Activity (please specify)			
56	End with last office visit before end of global period			

	A	B	C ACOG	D
2			CPT Code 58956	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy	
4	LOCATION		In Office	Out Office
57	MEDICAL SUPPLIES			
58	drape sheet	1106		1
59	Minimum supply package			3
60	pelvic exam package			1
61	suture removal kit			1
62	post-op incision kit			1
63				
64				
65	Equipment			
66	power table	E11003		125
67	fiberoptic exam light	E11006		125
68				
69				
70				
71				

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Cervical Laminoplasty

The CPT Editorial Panel created these two new codes to describe a different method of cervical laminoplasty which is an alternative approach for posterior decompression of the cervical spinal cord. The presenters recommended the survey 25th percentile value of 20.75 RVUs for 63050 *Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments*. The RUC reviewed the survey data and considered the similarities and differences between reference code 63015 *Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical* (work RVU = 19.32) and 63050 *Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments*. The presenters explained that the typical number of vertebral segments will be four or five. Code 63015 identifies a multisegmental cervical laminectomy for decompression of spinal stenosis without facetectomy, foraminotomy or discectomy. For 63015, the posterior elements of the spine are completely removed, as compared with 63050, where the posterior elements are left intact on one side to allow for expansion of the cross sectional area of the spinal canal. This is more difficult and the intensity is greater because of the degree of precision required to expand the spinal canal without removing the laminae, while avoiding putting pressure on the spinal cord. The presenters explained that the survey respondents overestimated the additional work involved in 63050 and recommended the 25th percentile to keep the code in proper rank order. The RUC reduced the pre-service time slightly, but maintained the median intra-service time of 150 minutes. The survey 25th percentile RVW of 20.75 is slightly higher than the reference code and reasonably accounts for the greater intensity/complexity of the intraoperative work for relative to 63015. **The RUC recommends a work RVU of 20.75 for code 63050.**

63051

Code 63051 adds reconstructive work to 63050. The discussion of work differences for 63050 compared to the reference service 63015 are the same for 63051. Therefore, the survey 25th percentile RVW of 24.25 would be appropriate to maintain proper rank order. This value is 3.50 RVUs greater than 63050 and reasonably accounts for the additional 40 minutes of intraservice work for reconstruction. In addition, the pre-service time was changed to match the pre-service time of 63050. **The RUC recommends a work RVU of 24.25 for code 63051.**

Practice Expense

The standard inputs for 90 day global period codes only performed in the facility were applied.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 63050	AL1	Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments;	090	20.75
● 63051	AL2	<p>with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)</p> <p><u>(Do not report 63050 or 63051 in conjunction with 22600, 22614, 22840-22842, 63001, 63015, 63045, 63048, 63295 for the same vertebral segment)</u></p>	090	24.25

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

CPT Code:63050 Tracking Number: AL1 Global Period: 090 **Recommended Work Relative Value**
Specialty Society RVU: **20.75** RUC RVU: **20.75**

CPT Descriptor: Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 46-year-old man has a six-month history of progressive hand weakness, paresthesias, and gait difficulty. He has hand intrinsic weakness and upper extremity sensory loss with lower extremity hyper-reflexia and positive Babinski signs. He undergoes a cervical laminoplasty from C3 to C7 for decompression of the spinal cord. Post operative hospital care and office visits are conducted as necessary through the 90-day global period.

Percentage of Survey Respondents who found Vignette to be Typical: 72%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Review pre-operative lab work-up; Write pre-operative orders for peri-operative medications; Locate, review, and place MRI and films on the view box in the operating room; Review planned incisions and procedure; Greet patient in holding area and review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family; Obtain informed consent; Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite; Review length and type of anesthesia with anesthesiologist; Monitor initial patient positioning for induction of general anesthesia; Following the induction of anesthesia, assist with repositioning of patient into the prone position on chest rolls; Apply a Mayfield pin head holder to the patient's head; verify/assist with padding of the patient to prevent pressure on neurovascular structures; Scrub and gown; Mark the incisions and supervise prepping/draping of the patient.

Description of Intra-Service Work:

A midline posterior cervical incision is made and the paraspinous muscles are reflected out to the facet joints, exposing the laminae, spinous processes and facet joints from C3 to C7. A high speed drill is used to create a multisegment osteotomy through the junction of the lamina and facet joints on the right side from C7 up through and including C3. The underlying ligamentum flavum is sectioned with micro Kerrison rongeurs. On the left side, the junction of the facet and lamina at each level is scored with the drill from C7 to C3 to create a stress riser in the bone. A small Key elevator is then placed into the right side osteotomy, between the lamina and facet joint, and the laminae are sequentially cracked back to expand the spinal canal. Hemostasis is achieved and the incision is closed in layers

Description of Post-Service Work:

Post-service Work – Hospital:

The patient's head is removed from three-point fixation and sterile dressings are applied; Return patient to supine position; 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; Order and review films to check alignment of cervical spine; Write orders daily, as necessary, for medications, diet, and patient activity; Examine patient daily, check wounds and patient progress; Review nursing/other 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, use and proper fit of collar, and activity limitations, including planned physical therapy; Answer patient/family questions, nursing/other staff questions; Write orders for post-discharge films, and medications; Chart patient discharge notes

Post-service Work – Office:

Write orders for medications and follow-up films; Review post-discharge films; Examine patient - perform periodic neurological exams; Monitor wounds and remove sutures/staples; Review use and proper fit of collar with patient; Review physical therapy progress and revise orders as needed; Dictate patient progress notes for medical chart; Answer patient/family questions, insurance staff questions; Discuss patient progress with referring physician (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	John Wilson, MD (AANS/CNS) Richard Boop, MD (AANS/CNS) Charles Mick, MD (NASS)					
Specialty(s):	AANS/CNS; NASS; AAOS					
CPT Code:	63050					
Sample Size:	290	Resp n:	29	Response: 10.00 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		12.56	20.75	24.00	30.00	45.00
Pre-Service Evaluation Time:				55.0		
Pre-Service Positioning Time:				25.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		60.00	120.00	150.00	180.00	270.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	30.00					
Critical Care time/visit(s):	0.0	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	68.0	99231x 2.0	99232x 1.0	99233x 0.0		
Discharge Day Mgmt:	36.0	99238x 1.00	99239x 0.00			
Office time/visit(s):	61.0	99211x 0.0	12x 1.0	13x 2.0	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>
63015	090	19.32

CPT Descriptor Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical

<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: 19 % of respondents: 65.5 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 63050	Key Reference CPT Code: 63015
Median Pre-Service Time	95.00	90.00
Median Intra-Service Time	150.00	150.00
Median Immediate Post-service Time	30.00	38.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	68.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	61.0	69.00
Median Total Time	440.00	451.00

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	3.88	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.18	3.53
Urgency of medical decision making	3.00	2.88

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	3.76
Physical effort required	4.00	3.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.59	3.59
Outcome depends on the skill and judgment of physician	4.35	3.71
Estimated risk of malpractice suit with poor outcome	3.94	3.53

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.41	4.18
Intra-Service intensity/complexity	4.35	4.12
Post-Service intensity/complexity	4.41	4.41

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 consensus committee reviewing the survey data above considered the similarities and differences between reference code 63015 and AL1-630X1. Code 63015 identifies a multisegmental cervical laminectomy for decompression of spinal stenosis without facetectomy, foraminotomy or discectomy. For 63015, the posterior elements of the spine are completely removed, as compared with AL1, where the posterior elements are left intact on one side to allow for expansion of the cross sectional area of the spinal canal permitting more normal reattachment of the cervical musculature and preservation of the posterior bony and ligamentous elements. This is more difficult and the intensity is greater because of the degree of precision required to expand the spinal canal without removing the laminae, while avoiding putting pressure on the spinal cord.

The survey 25th percentile RVW of 20.75 is recommended for AL1. This slightly higher RVU more reasonably accounts for the greater intensity/complexity of the intraoperative work for AL1 relative to 63015

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) 64999 Unlisted procedure, nervous system

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty NS How often? Sometimes

Specialty ORT How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100

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

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

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code:63051 Tracking Number: AL2 Global Period: 090	Recommended Work Relative Value Specialty Society RVU: 24.25 RUC RVU: 24.25
--	---

CPT Descriptor: Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32-year-old woman has episodic paresthesias radiating into all limbs with cervical extension. She has upper limb weakness and sensory loss with lower extremity hyperreflexia and positive Babinski signs. She undergoes a cervical laminoplasty from C3 to C7 for decompression of the spinal cord and reconstruction of the posterior spinal structures using an iliac crest allograft and non-segmental fixation. Post operative hospital care and office visits are conducted as necessary through the 90-day global period.

NOTE: When completing this survey, please consider only the physician work for the primary procedure. Obtaining the bone allograft or autograph would be reported separately.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Review pre-operative lab work-up; Write pre-operative orders for peri-operative medications; Locate, review, and place MRI and films on the view box in the operating room; Review planned incisions and procedure; Greet patient in holding area and review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family; Obtain informed consent; Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite; Review length and type of anesthesia with anesthesiologist; Monitor initial patient positioning for induction of general anesthesia; Following the induction of anesthesia, assist with repositioning of patient into the prone position on chest rolls; Apply a Mayfield pin head holder to the patient's head; verify/assist with padding of the patient to prevent pressure on neurovascular structures; Scrub and gown; Mark the incisions and supervise prepping/draping of the patient.

Description of Intra-Service Work:

A midline posterior cervical incision is made and the paraspinous muscles are reflected out to the facet joints, exposing the laminae, spinous processes and facet joints from C3 to C7. A high speed drill is used to create a multisegment osteotomy through the junction of the lamina and facet joints on the right side from C7 up through and including C3. The underlying ligamentum flavum is sectioned with micro Kerrison rongeurs. On the left side, the junction of the facet and lamina at each level is scored with the drill from C7 to C3 to create a stress riser in the bone. A Key elevator is then placed into the right side osteotomy, between the lamina and facet joint, and the laminae are sequentially cracked back to expand the spinal canal. An iliac crest allograft is shaped, fashioned (reported separately), and then fit into the right side osteotomy to keep the space open, posteriorly. Absorbable miniplates are then applied to each segment of the posterior cervical spine, with the plate spanning the osteotomy and iliac bone allograft. 3mm absorbable screws are then placed through the plate at each level into the facet and the lamina, securing the plate and maintaining the canal expansion. Hemostasis is achieved and the incision is closed in layers.

Description of Post-Service Work:

Post-service Work – Hospital:

The patient's head is removed from three-point fixation and sterile dressings are applied; Return patient to supine position; 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; Order and review films to check alignment of cervical spine; Write orders daily, as necessary, for medications, diet, and patient activity; Examine patient daily, check wounds and patient progress; Review nursing/other 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, use and proper fit of collar, and activity limitations, including planned physical therapy; Answer patient/family questions, nursing/other staff questions; Write orders for post-discharge films, and medications; Chart patient discharge notes

Post-service Work – Office:

Write orders for medications and follow-up films; Review post-discharge films; Examine patient - perform periodic neurological exams; Monitor wounds and remove sutures/staples; Review use and proper fit of collar with patient; Review physical therapy progress and revise orders as needed; Dictate patient progress notes for medical chart; Answer patient/family questions, insurance staff questions; Discuss patient progress with referring physician (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	John Wilson, MD (AANS/CNS) Richard Boop, MD (AANS/CNS) Charles Mick, MD (NASS)					
Specialty(s):	AANS/CNS; NASS; AAOS					
CPT Code:	63051					
Sample Size:	290	Resp n:	27	Response: 9.31 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		17.00	24.25	25.00	32.00	57.96
Pre-Service Evaluation Time:				55.0		
Pre-Service Positioning Time:				25.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		120.00	150.00	190.00	225.00	360.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	30.00					
Critical Care time/visit(s):	0.0	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	68.0	99231x 2.0	99232x 1.0	99233x 0.0		
Discharge Day Mgmt:	36.0	99238x 1.00	99239x 0.00			
Office time/visit(s):	61.0	99211x 0.0	12x 1.0	13x 2.0	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>
63015	090	19.32

CPT Descriptor Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical

<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: 77.7 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 63051	Key Reference CPT Code: 63015
Median Pre-Service Time	95.00	90.00
Median Intra-Service Time	190.00	150.00
Median Immediate Post-service Time	30.00	38.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	68.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	61.0	69.00
Median Total Time	480.00	451.00

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	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.63	3.72
Urgency of medical decision making	3.32	3.11

Technical Skill/Physical Effort (Mean)

Technical skill required	3.95	3.89
Physical effort required	4.05	3.94

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.79	3.67
Outcome depends on the skill and judgment of physician	4.74	3.72
Estimated risk of malpractice suit with poor outcome	4.26	3.61

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.53	4.22
Intra-Service intensity/complexity	4.47	4.06
Post-Service intensity/complexity	4.53	4.44

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.*

AL2-630X2 adds reconstructive work to AL1-630X1. The discussion of work differences for AL1 compared with 63015 are the same for AL2 (see summary recommendation form for AL1). The survey 25th percentile RVW of 24.25 is recommended for AL2. This value, which is 3.50 RVUs greater than AL1, reasonably accounts for the additional intraservice work for reconstruction

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: No

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

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility 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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64999 Unlisted procedure, nervous system

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

Specialty NS How often? Sometimes

Specialty ORT How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1800

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? 900

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. Surgical

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
090-DAY GLOBAL PERIOD - FACILITY DIRECT INPUTS**

CPT	DESCRIPTION	GLOB
63050 (AL1)	Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments;	090
63051 (AL2)	Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)	090

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

A Consensus Panel of representatives from AANS/CNS, NASS, and AAOS reviewed the details for reference code 63015 and approved the crosswalked details outlined below.

CLINICAL STAFF TIME:

Pre-service period clinical staff time (prior to admission): For AL1 and AL2, the standard 90-day global facility pre-service time of 60 minutes of clinical staff time is indicated.

Service period clinical staff time (admission to discharge): AL1 and AL2 are inpatient procedures. PEAC standard 12 minutes for discharge management activities is indicated

Post-service period clinical staff time (post discharge): For AL1 and AL2, PEAC standard times for each office visit are indicated.

SUPPLIES AND EQUIPMENT:

Supplies and equipment necessary at one or more POV are indicated.

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D	E	F	G
1	Meeting Date: RUC April 2004 Specialty: AANS/CNS, NASS, AAOS	CPT:		63050 (AL1)		63051 (AL2)	
2		DESCRIPTOR:		Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments,		Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments, with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)	
3							
4	Global Location	Code	Desc	NF	FAC	NF	FAC
5	TOTAL TIME	L037D	RN/LPN/MA	N/A	171	N/A	171
6	PRE-service time	L037D	RN/LPN/MA		60		60
7	SERVICE time	L037D	RN/LPN/MA		12		12
8	POST-service time	L037D	RN/LPN/MA		99		99
9	PRE-SERVICE - BEFORE ADMISSION						
10	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA		5		5
11	Coordinate pre-surgery services	L037D	RN/LPN/MA		20		20
12	Schedule space and equipment in facility	L037D	RN/LPN/MA		8		8
13	Provide pre-service education/obtain consent	L037D	RN/LPN/MA		20		20
14	Phone calls & prescriptions	L037D	RN/LPN/MA		7		7
16	SERVICE PERIOD - ADMISSION TO DISCHARGE						
37	99238 discharge time	L037D	RN/LPN/MA		12		12
39	POST-SERVICE - AFTER DISCHARGE						
40	99211 16 minutes						
41	99212 27 minutes				1		1
42	99213 36 minutes				2		2
43	99214 53 minutes						
44	99215 63 minutes						
45	Total Office Visit Time:	L037D	RN/LPN/MA		99		99
46	MEDICAL SUPPLIES						
47	pack, minimum multi-specialty visit	SA048	pack		3		3
48	pack, post-op incision care (suture & staple)	SA053	pack		1		1
49	EQUIPMENT						
50	Power Table	E11003	minutes		3		3

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Osetoplastic Laminectomy Reconstruction

The CPT Editorial Panel created new code 63295 *Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)* to describe osteoplastic reconstruction of a laminectomy defect. In contrast to code 22842 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (work RVU = 12.56) where pedicle screws and plates are utilized for reconstruction, 63295 is a reconstructive technique where the dorsal elements of the spinal segment, including the laminae, spinous processes, and ligamentous structures are reconstructed and replaced into the spine. This results in a more normal anatomic architecture, biomechanical properties, and a limit of post-surgical spinal deformity.

The presenters concluded that the survey median and 25th percentile RVWs were inconsistent with the difference in work between the two new laminoplasty codes (63050 and 63051 or 3.50 RVUs), which represents the work of reconstruction and would overstate the physician work of this code. The presenters instead recommended an RVW of 5.25, which is equal to the difference between 63050 work RVU 20.75 and 63051 work RVU = 24.25 multiplied by 1.5 to account for performing 63295 bilaterally. The RUC agreed not to double the difference in RVUs because the work to perform 63295 bilaterally is not twice the work to perform the reconstruction in 63051. For 630512, reconstruction is unilateral, but occurs within the body, near the spinal cord and therefore is more intense. For 63295, the laminae are removed and part of the bilateral reconstructive work is performed on the backbench, away from the spinal cord. A value that represents 1.5 times the work of the reconstruction in 63051 reasonably accounts for the additional bilateral work. **The RUC recommends a work RVU of 5.25 for code 63295.**

Practice Expense

Since this is an add on code performed only in the facility setting, the RUC recommends zero zero direct inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
+● 63295	AM1	<p>Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)</p> <p><u>(Use 63295 in conjunction with 63172, 63173, 63185, 63190, 63200-63290)</u></p> <p><u>(Do not report 63295 in conjunction with 22590-22614, 22840-22844, 630X1, 630X2)</u></p>	ZZZ	N/A	5.25

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

Recommended Work Relative Value

CPT Code:63295 Tracking Number: AM1 Global Period: ZZZ Specialty Society RVU: **5.25** RUC RVU: **5.25**

CPT Descriptor: Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 12-year-old boy, undergoing a laminectomy for a cervical spinal cord tumor, is at significant risk for developing a postoperative kyphotic deformity. An osteoplastic reconstruction of the dorsal spinal elements is performed as an add-on procedure, following the primary laminectomy procedure.

NOTE: When completing this survey, please consider only the ADDITIONAL physician work for the osteoplastic reconstruction for all levels. This code should be reported once per operative session. The primary procedure is separately reportable.

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: Additional preservice time is required for patient(family) education and informed consent regarding the permanent placement of hardware (eg, miniplates).

Description of Intra-Service Work:

Following the closure of the dura, the previously removed dorsal spinal elements (i.e., laminae, spinous process and supporting ligaments) are returned to an anatomic position for reconstruction. Using a fine drill bit, holes are drilled into the lateral aspect of each lamina and heavy sutures, wires, or miniplates are used to secure the dorsal elements, fixing the bone in position.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	John Wilson, MD (AANS/CNS) Richard Boop, MD (AANS/CNS) Charles Mick, MD (NASS)				
Specialty(s):	AANS/CNS; NASS; AAOS				
CPT Code:	63295				
Sample Size:	290	Resp n:	24	Response:	%
Sample Type:	Random				
	Low	25 th pctl	Median*	75 th pctl	High
Survey RVW:	3.26	8.00	15.00	19.38	42.00
Pre-Service Evaluation Time:			10.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		

Intra-Service Time:		20.00	30.00	45.00	60.00	90.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	0.00					
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>
22842	ZZZ	12.56

CPT Descriptor Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments

<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: 41.6 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 63295	Key Reference CPT Code: 22842
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	45.00	105.00
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	55.00	105.00

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	3.80	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	4.20
Urgency of medical decision making	3.40	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.70
Physical effort required	3.70	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.30	3.30
Outcome depends on the skill and judgment of physician	4.90	4.50
Estimated risk of malpractice suit with poor outcome	4.60	4.40

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.80	4.50
Intra-Service intensity/complexity	4.70	4.50
Post-Service intensity/complexity	4.70	4.70

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.*

AM1-6329X describes osteoplastic reconstruction of a laminectomy defect. In contrast to 22842 where pedicle screws and plates are utilized for reconstruction, AM1 is a reconstructive technique where the dorsal elements of the spinal segment, including the laminae, spinous processes, and ligamentous structures are reconstructed and replaced into the spine. This results in a more normal anatomic architecture, biomechanical properties, and a limit of post-surgical spinal deformity.

In considering the survey results for AM1, the consensus committee believed that the survey median and 25th percentile RVWs were inconsistent with the difference in work between AL1-630X1 and AL2-630X2 (or 3.50 RVUs). We are instead recommending an RVW of 5.25, which is equal to the difference between AL1 and AL2 multiplied by 1.5 to account for performing AM1 bilaterally. We specifically chose not to double the difference in RVUs because the work to perform AM1 bilaterally is not twice the work to perform the reconstruction in AL2. For AL2, reconstruction is unilateral, but occurs within the body, near the spinal cord and therefore is more intense. For AM1, the laminae are removed and part of the bilateral reconstructive work is performed on the backbench, away from the spinal cord. A value that represents 1.5 times the work of the reconstruction in AL2 reasonably accounts for the additional bilateral work that is, in part, lower intensity

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. AM1 would be reported as an add-on procedure primarily to 63285 or 63286. Additional codes that may be reported as the primary procedure include: 69990, 63270, 63275, 63276, 63280, or 63281

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64999 Unlisted procedure, nervous system

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

Specialty NS How often? Sometimes

Specialty ORT How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 900

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? 75

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. 22851 has a work RVU that is valued closer to the new code as opposed to the reference service.

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

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
ZZZ GLOBAL PERIOD - FACILITY DIRECT INPUTS**

CPT	DESCRIPTION	GLOB
63295 (AM1)	Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure	ZZZ

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

A Consensus Panel of representatives from AANS/CNS, NASS, and AAOS reviewed the details for other add-on codes.

CLINICAL STAFF TIME:

Pre-service period clinical staff time (prior to admission): For add-on code AM1, no additional pre-service clinical staff time is recommended.

Service period clinical staff time (admission to discharge): For add-on code AM1, no additional service period clinical staff time is recommended

Post-service period clinical staff time (post discharge): For add-on code AM1, no additional post-service period clinical staff time is recommended

SUPPLIES AND EQUIPMENT:

n/a

	A	B	C	D	E
1	Meeting Date: RUC April 2004	CPT:		63295 (AM1)	
2		DESCRIPTOR:		Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure	
3	Global			ZZZ	
4	Location	Code	Desc	NF	FAC
5	TOTAL TIME	L037D	RN/LPN/MA	N/A	0
6	PRE-service time	L037D	RN/LPN/MA		0
7	SERVICE time	L037D	RN/LPN/MA		0
8	POST-service time	L037D	RN/LPN/MA		0
9	PRE-SERVICE - BEFORE ADMISSION				
10	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA		0
11	Coordinate pre-surgery services	L037D	RN/LPN/MA		0
12	Schedule space and equipment in facility	L037D	RN/LPN/MA		0
13	Provide pre-service education/obtain consent	L037D	RN/LPN/MA		0
14	Phone calls & prescriptions	L037D	RN/LPN/MA		0
16	SERVICE PERIOD - ADMISSION TO DISCHARGE				
37	99238 discharge time	L037D	RN/LPN/MA		0
39	POST-SERVICE - AFTER DISCHARGE				
40	99211 16 minutes				
41	99212 27 minutes				
42	99213 36 minutes				
43	99214 53 minutes				
44	99215 63 minutes				
45	Total Office Visit Time:	L037D	RN/LPN/MA		0
46	MEDICAL SUPPLIES				
47	pack, minimum multi-specialty visit	SA048	pack		
48	pack, post-op incision care (suture & staple)	SA053	pack		
49	EQUIPMENT				
50	Power Table	E11003	minutes		

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Ciliary Endoscopic Ablation

The CPT Editorial Panel revised an existing code and added a new code to separately report endoscopic and transscleral cyclophotocoagulation for the treatment of glaucoma.

The RUC reviewed the survey results of 22 ophthalmologists from the specialty society in regard to the valuation of 66711 *Ciliary body destruction; cyclophotocoagulation, endoscopic* and determined that the reference code, 67010 *Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy* (Work RVU=6.86) was reasonable. When comparing the surveyed code to the reference code, it was determined that the surveyed code has more pre-service time than the reference code, 25 minutes and 19 minutes respectively. Furthermore, the RUC recognized that the surveyed code required more mental effort and judgment, higher technical skill, and a higher intra-service intensity than the reference code. After reviewing the survey data, the RUC discussed several issues surrounding the valuation of this code including the fact that the surveyed code has several higher intensity office visits (4-99213 and 1-99212) associated with it than the reference service code (4-99212). The specialty society explained that because these patients have severe glaucoma and have failed many other procedures, the next step would be to perform this invasive procedure. Because this procedure involves the making and closing of two incisions in the eye as well as the direct application of the endo-laser to ciliary body, this number and level of intensity follow-up office visits would be required to ensure a safe intra-ocular pressure of the eye. In addition, the RUC discussed the issue of budget neutrality with the concern that there would be a large shift of patients who would be treated with this new procedure instead of the existing potentially lower valued procedures. The specialty society explained that there would be a small shift in patients because people with little to moderate glaucoma would respond to less invasive treatments. This procedure would only be used for those patients with severe glaucoma which considering the entire pool of glaucoma patients would be a relatively small number of patients. After discussion of these issues as well as the comparison to the reference code the RUC agreed with the specialty society recommendation of the 6.60 work RVUs for 66711, the specialty society's survey median. **The RUC recommends a work relative value of 6.60 for 66711.**

Practice Expense

The specialty society recommended the standard 090 day global practice expense inputs with modifications made to the supplies to remove ten pairs of sterile gloves as they are already included in the ophthalmology visit packages. Other modifications included the

adding of half a discharge day management service to the clinical labor time. The modified practice expense recommendations are attached to this report.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
66700		<i>Ciliary body destruction; diathermy</i>	090	4.77 (No Change)
▲66710	AN1	cyclophotocoagulation, <u>transscleral</u>	090	4.77 (No Change)
●66711	AN2	cyclophotocoagulation, endoscopic <u>(Do not report 66711 in conjunction with 66990)</u>	090	6.60

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

Recommended Work Relative Value

CPT Code:66711 Tracking Number: AN2 Global Period: 090 Specialty Society RVU: **6.6** RUC RVU: **6.60**

CPT Descriptor: Ciliary body destruction; cyclophotocoagulation, endoscopic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year -old patient with a history of chronic glaucoma has progressive optic nerve damage and elevated intraocular pressure that has not been controlled by medical therapy and a previous filtering operation. The patient is pseudophakic with a miotic pupil.

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?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: During the preoperative evaluation the patient is examined at the slit lamp biomicroscope to identify surgical landmarks. Depending upon limbal anatomy, either a pars plana or peripheral clear corneal approach is decided upon. Gonioscopy is necessary to identify areas of peripheral anterior synechiae to be avoided intraoperatively. The intraocular pressure is recorded along with the visual acuity, slit lamp findings and the planned surgical approach noted.

Description of Intra-Service Work: Anesthesia is begun with periocular lidocaine. A povidone-iodine prep is performed of the conjunctiva, followed by placement of a drape. A lid speculum is inserted to allow adequate visualization. A clear corneal incision is made with the diamond blade approximately 3.4 mm in width, usually temporally. Viscoelastic is injected into the anterior chamber over the pupil and lens in order to increase and maintain anterior chamber depth. Viscoelastic is then injected under the iris root for 180 degrees in order to visualize the ciliary body processes with the endoscope. The endoscope is inserted through the temporal incision viewing the nasal ciliary processes. The ciliary processes are coagulated through the endoscope with the endpoint of shrinkage and whitening. The endoscope is moved in an arc allowing treatment of the processes over an arc of 180 degrees. A second corneal incision is made 90 degrees away and 180 degrees of ciliary processes are treated. At the end of the procedure, the surgeon has completed coagulation of 270 degrees of angle. After completion of laser therapy, the viscoelastic material is removed from the anterior segment of the eye with an irrigation and aspiration device to prevent intraocular pressure spikes. The eye is reformed with balanced salt solution. The wounds are checked for leakage and if necessary interrupted 10-0 nylon sutures are placed to seal the wound.

Description of Post-Service Work: The patient is evaluated on postoperative day one with attention to inflammation and IOP. Topical aqueous suppressant medications are used as necessary along with anti-inflammatory medications to maintain an appropriate intraocular pressure. The patient is reevaluated in one week, three weeks and 6 weeks post-operatively later to check for inflammation, chamber depth, visual acuity, IOP, and clarity of the ocular media. Topical medications are adjusted as needed at each visit. The physician provides counseling regarding postoperative care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2004
Presenter(s):	Stephen A. Kamenetzky, M.D.
Specialty(s):	Ophthalmology
CPT Code:	66711

Sample Size: 200		Resp n: 22		Response: 11.00 %		
Sample Type: Panel						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		4.00	5.54	6.60	7.05	24.00
Pre-Service Evaluation Time:				10.0		
Pre-Service Positioning Time:				5.0		
Pre-Service Scrub, Dress, Wait Time:				10.0		
Intra-Service Time:		10.00	17.50	30.00	30.00	45.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		10.00				
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:		18.0	99238x 0.50	99239x 0.00		
Office time/visit(s):		107.0	99211x 0.0	12x 1.0	13x 4.0	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>
67010	090	6.86

CPT Descriptor Removal of vitreous, anterior approach (open sky technique or limbal incision); sub-total removal with mechanical vitrectomy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
65865	090	5.59

CPT Descriptor Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechia

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

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

Number of respondents who choose Key Reference Code: 7 % of respondents: 31.8 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 66711	Key Reference CPT Code: 67010
Median Pre-Service Time	25.00	19.00
Median Intra-Service Time	30.00	45.00
Median Immediate Post-service Time	10.00	12.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	0.00
Median Office Visit Time	107.0	52.50
Median Total Time	190.00	128.50

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

The number of possible diagnosis and/or the number of management options that must be considered	4.04	3.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.91	3.26
Urgency of medical decision making	3.57	3.22

Technical Skill/Physical Effort (Mean)

Technical skill required	4.22	3.96
--------------------------	------	------

Physical effort required	3.52	3.43
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.91	3.65
---	------	------

Outcome depends on the skill and judgment of physician	4.09	4.09
--	------	------

Estimated risk of malpractice suit with poor outcome	3.74	3.52
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.00	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.*

See attached

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) N/A

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

Specialty ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

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?

2,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

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

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

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

CPT Code: 66711
Specialty Society('s) _____

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

CPT Long Descriptor: Ciliary body destruction; cyclophotocoagulation, endoscopic

Sample Size: 200 Response Rate: (%): 11 Global Period: 90

Geographic Practice Setting %: Rural 1 Suburban 53 Urban 42

Type of Practice %: 16 Solo Practice
 59 Single Specialty Group
 1 Multispecialty Group
 21 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 to 200 ophthalmologists with 22 returned. The Health Policy Committee, several of whom perform the procedure, reviewed the surveys in a conference call. The committee was pleased with the return rate considering that the code represents new technology not yet in widespread use.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff person completes pre-service diagnostic and required referral forms. The staff then coordinates and gathers all the necessary pre-services or other pertinent information needed before the procedure. The procedure is explained and all questions about the consent are answered. All telephone or other communication takes place by the staff person to allow medications and instructions to be available to the patient after the procedure.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

CPT Code: 66711
 Specialty Society('s) _____

Total Staff Time Out of Office: 237

Visits in Global Period: 5

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 (if applicable)
L038D	COMT/COT/RN/CST	60		6		5	171	

*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)
SA050	Ophthalmology visit package	5		

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

CMS's Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)
E71109	Exam lane x 5	

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

CPT Code: 66711
Specialty Society('s) _____

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: FACILITY
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>5</u>	RN, LPN, MA, Other _____
Coordinate pre-surgery services	<u>20</u>	RN, LPN, MA, Other _____
Schedule space and equipment in facility	<u>8</u>	RN, LPN, MA, Other _____
Office visit before surgery/procedure	<u>0</u>	RN, LPN, MA, Other _____
Review test and exam results		
Provide pre-service education/obtain consent	<u>20</u>	RN, LPN, MA, Other _____
Follow-up phone calls & prescriptions	<u>7</u>	RN, LPN, MA, Other _____
Other Activity (please specify)	<u>0</u>	RN, LPN, MA, Other _____

End: When patient enters hospital for surgery/procedure

Service Period

Start: Patient admitted to hospital for surgery/procedure
Pre-service services

Review charts	_____	RN, LPN, MA, Other _____
Greet patient and provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	_____	RN, LPN, MA, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____

Intra-service

Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____
--	-------	--------------------------

CPT Code: 66711
 Specialty Society('s) _____

Post-service

Monitor pt. following service/check tubes, monitors, drains	_____	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	_____	RN, LPN, MA, Other _____
Assist with ICU or hospital visits	_____	RN, LPN, MA, Other _____
Total Number of ICU visits	_____	
Total Number of hospital visits	_____	
Complete diagnostic forms, lab & X-ray requisitions	_____	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MA, Other _____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	<u>6</u>	RN, LPN, MA, Other _____
Coordination of care by staff in office	_____	RN, LPN, MA, Other _____
Other Activity (please specify)	_____	
_____	_____	RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period

Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	_____	RN, LPN, MA, 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		
		RN, LPN, MA, Other _____

List total number of office visits

A _____
 B 5

1 – 99212 (27 minutes)
 4 - 99213 (144 minutes)

Total office visit time (A * B)

171

Conduct phone calls between office visits	_____	RN, LPN, MA, Other _____
Other Activity (please specify)	_____	
_____	_____	RN, LPN, MA, Other _____

End: With last office visit before end of global period

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Dual X-Ray Absorptionmetry for Vertebral Assessment

In order to create more clarity in the service of dual energy x-ray absorptiometry, bone studies on the vertebra, the CPT Editorial Panel created code 76077 *Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment* and editorially changed code 76075 *Dual energy x-ray absorptiometry (~~DXA~~~~DEXA~~), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)* (Work RVU=0.30). The changes specify the service of vertebral fracture assessment, as a low radiation lateral examination creating an enhanced view of the vertebra to assess bone density and vertebra fracturing.

76077

The RUC reviewed the survey results for this new code and understood that it would typically be billed with code 76075 and sometimes with code 76076 *Dual energy x-ray absorptiometry (~~DXA~~~~DEXA~~), bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)* (Work RVU=0.22). The specialty society and the RUC believed that since 76077 was typically billed with another service, the pre-service and post-service physician time would be lower than the specialty's survey results indicated. **The RUC recommends one minute for pre-service, and one minute of immediate post-service physician time.**

The RUC and the specialty society believed that to establish a proper rank order code 76077 should be valued below 76075 and 76076. The specialty recommended the 25th percentile survey results to create the rank order of the family of codes. The RUC agreed with the specialty's recommendation of 0.17 work relative value units. **The RUC recommends a work relative value of 0.17 for code 76077.**

Practice Expense

The RUC reviewed the practice expense inputs for code 76077 in relation to existing codes 76075 and 76076. The RUC agreed with the practice expense inputs recommended by the specialty. The RUC recommends no practice expense inputs in the facility setting and the non-facility inputs are attached.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲76075		Dual energy x-ray absorptiometry (DXA DEXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)	XXX	0.30 (No Change)
76076		appendicular skeleton (peripheral) (eg, radius, wrist, heel)	XXX	0.22 (No Change)
•76077	AO1	vertebral fracture assessment (To report dual energy x-ray absorptiometry (DXA DEXA) body composition study, one or more sites, use Category III code 0028T)	XXX	0.17

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

CPT Code:76077 Tracking Number: A01 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.17**

RUC RVU: 0.17

CPT Descriptor: Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment

(To report dual energy x-ray absorptiometry (DXA) body composition study, one or more sites, use Category III code 0028T)

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

A 65 year-old Caucasian woman, 15 years post-menopause undergoes a bone mineral density exam (DXA scan) to determine her 1) bone density diagnosis (World Health Organization definition of normal, osteopenia, osteoporosis) and 2) assessment of her relative and absolute risk for a future osteoporotic fracture. The DXA scan results disclose a T-score of -1.9 at the lumbar spine and total hip (The T score is a comparison to a young adult mean in standard deviations). The patient's diagnosis is osteopenia by World Health Organization criteria. This patient has a 5 and 6 fold increased risk of future fracture at the lumbar spine and total hip respectively (site specific), and a 2 fold increased risk of future fracture anywhere in the body (global risk) as compared to an aged matched female with a T-score of 0.0. The National Osteoporosis Foundation suggests that postmenopausal women with a bone density T-score of less than -2 should be treated. Thus the value of this patient's T-score of -1.9 (osteopenia) would not necessarily be an indication for medical therapy. A vertebral fracture assessment using DXA equipment was used to obtain an image of the patient's thoracic and lumbar spine to determine if a previous thoracic and lumbar spine vertebral fracture had occurred. Although the patient had no history of spinal pain, 2 compression fractures were found by vertebral fracture assessment. The presence of 2 prevalent vertebral fractures using Vertebral Fracture Assessment by DXA imaging indicates a seven-fold increased risk for future vertebral fractures independent of the patients bone mineral density. Pharmacological intervention is indicated due to the presence of prevalent vertebral fractures.

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? 3%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

The physician reviews the patient's history and clinical findings to confirm the appropriateness of scanning for vertebral fracture assessment (VFA).

Description of Intra-Service Work:

The physician reviews the VFA images obtained and the post-processed measurements to assure that the measurements were accurately done and that scanning technique was satisfactory. The physician interprets the VFA thoracic and lumbar images (AP and lateral views) using accepted fracture assessment methodology, the Semiquantitative Analysis of Genant and Quantitative Morphometry, to determine the number and severity of fractures present. The physician compares the results of the VFA interpretation to previous radiographic or VFA images to determine if a significant change in vertebral anatomy has occurred in the interim. The physician dictates the report for the medical record.

Description of Post-Service Work:

The physician reviews and signs the report of the examination. The physician discusses the results with the patient and referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	Bibb Allen Jr., M.D. (ACR), Sanford Baim, M.D. (ISCD)					
Specialty(s):	American College of Radiology (ACR), International Society for Clinical Densitometry (ISCD)					
CPT Code:	7607X1					
Sample Size:	200	Resp n:	30	Response: 15 %		
Sample Type: Random						
		Low	25th pctl	Median*	75th pctl	High
Survey RVW:		0.01	0.17	0.22	0.30	3.64
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Pre-Service Time:				1.0		
Intra-Service Time:		2.00	5.00	5.00	10.00	45.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	1.00					
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>
72080	XXX	0.22

CPT Descriptor Radiologic examination, spine; thoracolumbar, two views

<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: 33.3 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 7607X1	Key Reference CPT Code: 72080
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	0.00
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	15.00	6 (Harvard Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	2.90	3.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.90	2.50
Urgency of medical decision making	2.10	2.40

Technical Skill/Physical Effort (Mean)

Technical skill required	3.40	2.70
Physical effort required	1.90	1.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.80	1.90
Outcome depends on the skill and judgment of physician	2.90	2.70
Estimated risk of malpractice suit with poor outcome	2.50	2.80

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.10	1.80
Intra-Service intensity/complexity	2.50	2.30
Post-Service intensity/complexity	2.80	2.30

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 ACR and ISCD have reviewed the survey data and determined that the median value over estimates the physician work of 7607X1.

Much of the pre and post service work of the VFA code is typically captured in 76075 (DEXA) as the VFA code is typically performed in conjunction with a standard DEXA scan. The survey participants may not have considered this as they assigned pre and post service times as well as pre and post service physician work to the VFA code.

The ACR and ISCD believe that the survey respondents included too much pre and post service time and work in their magnitude estimation, and that the 25 percentile value of 0.17 RVU more closely approximates the additional physician work associated with VFA over DEXA.

This value is similar to the physician work for a single view of the spine, 72020, at 0.15 RVU. Although two views of the spine are typically interpreted with 7607X1, these views are not of similar diagnostic quality to 72080, and the number of possible diagnoses is less. Therefore, the physician work is considered to be less than that of the reference service 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: 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) 7607X1 is not an add on code but is typically performed in conjunction with DEXA. Occasionally VFA may be performed as a stand-alone service but in the typical patient a DEXA scan will be performed concurrently.

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	Work RVU	Physician Time
76075	DEXA, axial skeleton study	0.30	15 min total (RUC time)
7607X1	VFA	0.17	5 pre / 5 intra / 5 post

We believe that much of the pre and post service time of 7607X1 is captured in 76075 and that the value can be based on additional physician time of 5 minutes intra-service and 4 minutes additional pre and post service time.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) : 72010 (Radiologic examination, spine, entire, survey study, anteroposterior and lateral) or 72020 (Radiologic examination, spine, single view, specify level).

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty :Radiology How often? Sometimes

Specialty How often?

Specialty How often?

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

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?25,000 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 %

Specialty Frequency 0 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

	A	B	C
1			76077
2	April 2004 RUC Recommendation Dual X-Ray Absorptiometry for Vertebral Fracture Assessment	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment
3	LOCATION		In Office
4	GLOBAL PERIOD		XXX
5	TOTAL CLINICAL LABOR TIME		15
6	TOTAL PRE-SERV CLINICAL LABOR TIME		
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		15
8	TOTAL POST-SERV CLINICAL LABOR TIME		
9	PRE-SERVICE PERIOD		
10	SERVICE PERIOD		
11	Start: When patient enters office/facility for surgery/procedure		
12	Pre-service		
13	Greet patient and provide gowning	L041B	
14	Provide pre-service education/obtain consent	L041B	
15	Prepare room, equipment, supplies	L041B	
16	Prepare and position patient/ monitor patient		
17	Intra-service		
18	Assist physician in performing procedure/ Acquire Images	L041B	5
19	Post-Service		
20	Clean room/equipment by physician staff	L041B	
21	Other Clinical Activity: follow up phone call		
22	-Escort patient to the waiting area	L041B	
23	- Post processing	L041B	10
24	End: Patient leaves office		
25	POST-SERVICE PERIOD		
26	MEDICAL SUPPLIES		
27	Pillow case, disposable		
28	Gown, disposable		
29			
30			
31	Equipment		
32	DEXA Room		
33	Fan Beam VFA DXA Unit		X
34			
35			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Ophthalmic Ultrasound

The CPT Editorial Panel revised four codes and created a new code to report contact B-scan and quantitative A-scan performed during the same patient encounter. This action was instigated by the potential removal of a CCI edit by CMS which did not allow the A-scan and B-scan to be performed in the same visit if the descriptor for CPT code 76512 *Ophthalmic ultrasound, echography, diagnostic; contact B-scan (with or without simultaneous A-scan)* did not include an A-scan.

76511 and 76512

Upon reviewing the specialty society's recommendations, the RUC agreed that the survey data for 76511 and 76512 was flawed. The survey appeared to indicate that performing both the A and B scan during the same inpatient encounter took the same amount of intra-service time as performing each exam separately. The society constructed the recommendations through a consensus panel and determined to maintain the value of 76511 *Ophthalmic ultrasound, diagnostic; quantitative A-scan only* (Work RVU=0.94) citing that the uterine ultrasound codes, 76801 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation* (Work RVU=0.99, Pre-Service Time=5 minutes, 15 minutes Intra-Service Time and 7 minutes Post Service Time) 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, Pre-Service Time= 5 minutes, Intra-Service Time=15 minutes, Post Service Time= 6 Minutes) that the RUC recently reviewed provided the best reference codes due to the similar intensity and physician times. The RUC agreed with this rationale and recommends maintaining the value of 76511. The specialty society also recommended that 76511 and 76512 *Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)* had equivalent intensities and technical skill. In addition, the specialty society reviewed the survey information presented by the specialty society and agreed with that 76511 and 76512 had similar physician times:

	76511	76512
Pre-Service Time	5 Minutes	10 Minutes
Intra-Service Time	15 Minutes	15 Minutes
Post-Service Time	10 Minutes	10 Minutes
Total Time	30 Minutes	35 Minutes

Therefore, the RUC agreed with the specialty society recommendation of cross-walking the recommended work RVUs from 76511 to 76512. **The RUC recommends a work relative value of 0.94 for 76511 and 76512.**

76510

Because of the flawed survey data, the specialty society used a consensus panel to develop work relative value recommendations for 76510 *Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter*. The specialty society implemented a building block methodology to determine the work RVUs for 76510 based on the recommended values for 76511 and 76512. The specialty society recommends adding the recommended work RVUs for 76511 and 76512 and then removing the work associated with the pre-service time of 76512 and half of the work associated with the post-service time of 76512 and ultimately achieved a value of 1.55 work RVUs for 76510. The calculation is as follows:

Recommended Work RVU 76511	0.94
Recommended Work RVU 76512	<u>0.94</u>
	1.88
Pre-Service Work of 76512	<u>- 0.22</u>
	1.66
Post-Service Work of 76512	<u>- 0.11</u>
	1.55 Recommended Work RVU for 76510

The RUC agreed with the specialty society recommendation. **The RUC recommends a work relative value of 1.55 for 76510.**

Practice Expense

The specialty society presented their recommendations for practice expense inputs and informed the RUC that 76512 would be reported in conjunction with an evaluation and management service and therefore made modifications to the clinical labor time accordingly. The practice expense inputs are attached to this recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 76510	AP1	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter	XXX	1.55
▲ 76511	AP2	Ophthalmic ultrasound, echography, diagnostic; quantitative A-scan only, with amplitude quantification	XXX	0.94 (No Change)
▲ 76512	AP3	contact -B-scan (with or without simultaneous superimposed non-quantitative A-scan)	XXX	0.94
76513		<i>anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy</i>	XXX	0.66 (No Change)
76514		<i>corneal pachymetry, unilateral or bilateral (determination of corneal thickness)</i>	XXX	0.17 (No Change)

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

Recommended Work Relative Value

CPT Code:76510 Tracking Number: AP1 Global Period: XXX Specialty Society RVU: **1.59** RUC RVU: **1.55**

CPT Descriptor: Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old white male is found to have a mass in the temporal retina and is referred for diagnostic ultrasound evaluation.

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?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient's history and chart are reviewed. Personal and family history of cancer is reviewed.. All retinal photographs, retinal drawings, scans, and fluorscein angiograms are studied. The referring physician's clinical impression is assessed. The ultrasound A and B probes are calibrated. The patient is placed supine on an exam table. The patient's cornea is anesthetized. Ultrasound gel is applied to the cornea.

Description of Intra-Service Work: The B scan probe is then placed on the cornea and the lesion localized. Multiple views are taken in all quadrants. Any shadowing and reflected patterns are documented. The nature of the mass is evaluated and possible extension is documented. The presence and nature of vitreous cells and overlying retinal detachment is evaluated and documented. Multiple images are taken and clinical correlation is done. The B scan probe is removed and the physician places an A-scan probe on the globe with the beam passing perpendicularly through the lesion. Multiple images in all quadrants are examined to determine diameter, elevation, and nature of internal reflectivity. Possible breach of Bruch's membrane and choroidal extension is determined. Appropriate views are documented during the scan. Integration of ultrasound findings with clinical presentation is evaluation and clinical diagnosis is formulated.

Description of Post-Service Work: The patient's cornea and lid are irrigated to remove the ultrasound gel. Lubricants are provided and the patient is told to call if symptoms of corneal irritation occur. The results are reviewed with the patient and family. The physician reviews the images and provides a dictated report for the referring physician which includes interpretation, possible diagnoses, and recommendations for further diagnostic studies.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):		Stephen A. Kamenetzky, M.D. and Ronald L. Green, M.D.				
Specialty(s):		Ophthalmology				
CPT Code:		76510				
Sample Size: 100		Resp n: 15		Response: %		
Sample Type: Panel						
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:		0.66	1.20	1.25	3.15	4.50
Pre-Service Evaluation Time:				5.0		

Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		7.00	12.25	30.00	30.00	50.00
Post-Service	Total Min**	CPT code / # of visits				
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>
92235	XXX	0.81

CPT Descriptor Fluorescein angiography (includes multiframe imaging) with interpretation and report)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99203	XXX	1.34

CPT Descriptor office/outpatient visit, new

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 40.0 %

TIME ESTIMATES (Median)

New/Revised CPT Code: 76510	Key Reference CPT Code: 92235
-----------------------------------	--

Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	30.00	0.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	45.00	0.00

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

The number of possible diagnosis and/or the number of management options that must be considered	4.53	3.66
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.46	3.13
Urgency of medical decision making	4.13	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	4.33	2.85
Physical effort required	3.13	2.42

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.60	3.20
Outcome depends on the skill and judgment of physician	4.20	3.53
Estimated risk of malpractice suit with poor outcome	4.13	3.13

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.20	2.66
Intra-Service intensity/complexity	4.30	3.12
Post-Service intensity/complexity	3.47	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.*

See attached

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: Yes

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

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

- Please provide a table listing the typical scenario where this 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) see above

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

Specialty ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7500

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?
6,000 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? 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:76511 Tracking Number: AP2 Global Period: XXX Specialty Society RVU: **0.94** RUC RVU: **0.94**

CPT Descriptor: Ophthalmic ultrasound, diagnostic; quantitative A-scan only

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year old white male is found to have a mass in the temporal retina and is referred for a diagnostic A-scan to include measurement of the height, internal reflectivity, and dimensions of the lesion.

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?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient's history and chart are reviewed. Personal and family history of cancer is reviewed. All retinal photographs, retinal drawings, scans, and fluorescein angiograms are studied. The referring physician's clinical impression is assessed. The ultrasound machine is calibrated. The patient's cornea is anesthetized. Ultrasound gel is applied.

Description of Intra-Service Work: The lesion is inspected. Cornea is anesthetized. The physician places an A-scan probe on the lids or globe with the beam passing perpendicularly through the lesion. Multiple images in all quadrants are examined to determine diameter, elevation, and nature of internal reflectivity. Possible breach of Bruch's membrane and choroidal extension is determined. Appropriate views are documented during the scan. Integration of ultrasound findings with clinical presentation is evaluated and clinical diagnosis is formulated.

Description of Post-Service Work: The patients cornea and lid are irrigated to remove the ultrasound gel. Lubricants are provided and the patient is told to call if symptoms of corneal irritation occur. The results are reviewed with the patient and family. The physician reviews the images and provides a dictated report for the referring physician which includes interpretation, possible diagnoses, and recommendations for further diagnostic studies.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	Stephen A. Kamenetzky, M.D. and Ronald L. Green, M.D.					
Specialty(s):	ophthalmology					
CPT Code:	76511					
Sample Size:	100	Resp n:	15	Response: 15.00 %		
Sample Type:	Panel					
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		0.65	0.97	1.22	1.90	3.84
Pre-Service Evaluation Time:				5.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		5.00	10.00	15.00	20.00	50.00

Post-Service	Total Min**	CPT code / # of visits
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>
92235	XXX	0.81

CPT Descriptor Fluorescein angiography (includes multiframe imaging) with interpretation and report)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99203	XXX	1.34

CPT Descriptor office/outpatient visit

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

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

Number of respondents who choose Key Reference Code: 7 % of respondents: 46.6 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 76511	Key Reference CPT Code: <u>92235</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	15.00	28.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	30.00	28.00

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	4.40	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.13
Urgency of medical decision making	4.13	3.13

Technical Skill/Physical Effort (Mean)

Technical skill required	4.40	2.78
Physical effort required	3.13	2.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.47	3.13
Outcome depends on the skill and judgment of physician	4.07	3.47
Estimated risk of malpractice suit with poor outcome	3.85	2.93

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.13	2.60
Intra-Service intensity/complexity	4.26	3.00
Post-Service intensity/complexity	3.33	3.00

ADDITIONAL RATIONALE

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

See attached

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) 76511

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

Specialty ophthalmology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 12000
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?
10,000 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? 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

PCL XL error

Warning: UndefinedFontNotRemoved - MS PCLXLFont 006

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

Recommended Work Relative Value

CPT Code:76512 Tracking Number: AP3 Global Period: XXX Specialty Society RVU: **0.98** RUC RVU: **0.94**

CPT Descriptor: Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year old white male is found to have elevated retina in the temporal posterior segment and is referred for a diagnostic contact B-scan.

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?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient's history and chart are reviewed. Personal and family history of cancer is reviewed.. All retinal photographs, retinal drawings, scans, and fluorescein angiograms are studied. The referring physician's clinical impression is assessed. The ultrasound machine is calibrated. The patient's cornea is anesthetized. Ultrasound gel is applied.

Description of Intra-Service Work: The lesion is inspected. Cornea is anesthetized. The physician places an A-scan probe on the lids or globe with the beam passing perpendicularly through the lesion. Multiple images in all quadrants are examined to determine diameter, elevation, and nature of internal reflectivity. Possible breach of Bruch's membrane and choroidal extension is determined. Appropriate views are documented during the scan. Integration of ultrasound findings with clinical presentation is evaluated and clinical diagnosis is formulated.

Description of Post-Service Work: The patient's cornea and lid are irrigated to remove the ultrasound gel. Lubricants are provided and the patient is told to call if symptoms of corneal irritation occur. The results are reviewed with the patient and family. The physician reviews the images and provides a dictated report for the referring physician that includes interpretation, possible diagnoses, and recommendations for further diagnostic studies.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	Stephen A. Kamenetzky, M.D. and Ronald I. Green, M.D.					
Specialty(s):	Ophthalmology					
CPT Code:	76512					
Sample Size:	100	Resp n:	15	Response: 15.00 %		
Sample Type:	Panel					
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		0.66	0.98	1.20	2.00	4.00
Pre-Service Evaluation Time:				10.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		4.00	9.00	15.00	20.00	40.00

Post-Service	Total Min**	CPT code / # of visits
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>
92235	XXX	0.81

CPT Descriptor Fluorescein angiography (includes multiframe imaging) with interpretation and report

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
92203	XXX	1.34

CPT Descriptor Office or other outpatient visit

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 40.0 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 76512	Key Reference CPT Code: 92235
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	15.00	28.00
Median Immediate Post-service Time	10.00 -	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	35.00	28.00

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	4.43	3.66
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.54	3.13
Urgency of medical decision making	4.14	3.24

Technical Skill/Physical Effort (Mean)

Technical skill required	4.14	2.87
Physical effort required	3.00	2.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.52	2.87
Outcome depends on the skill and judgment of physician	4.30	3.40
Estimated risk of malpractice suit with poor outcome	4.00	2.93

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.93	2.41
Intra-Service intensity/complexity	4.06	2.75
Post-Service intensity/complexity	3.26	2.75

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.*

See attached

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) 76512

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

Specialty ophthalmology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 140000

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	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
116,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

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

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

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

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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

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

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

	A	B	C	D	E	F	G	H
1								
2			CPT Code: 76511		CPT Code: 76512		CPT Code: 76510	
3	REVISED TAB 28- AAO	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Ophthalmic ultrasound, diagnostic; quantitative A-scan only		Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non- quantitative A-scan)		diagnostic; B-scan and quantitative A-scan performed during the same patient encounter	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME		32.0	0.0	23.0	0.0	43.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		5.0	0.0	5.0	0.0	5.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		27.0	0.0	18.0	0.0	38.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE							
11	Start: Following visit when decision for surgery or procedure made							
12	Complete pre-service diagnostic & referral forms	L038A COMT/COT/RN/	5	0	5	0	5	0
13	Coordinate pre-surgery services		0	0	0	0	0	0
14	Schedule space and equipment in facility		0	0	0	0	0	0
15	Provide pre-service education/obtain consent		0	0	0	0	0	0
16	Follow-up phone calls & prescriptions		0	0	0	0	0	0
17	Other Clinical Activity (please specify)		0	0	0	0	0	0
18	End: When patient enters office/facility for surgery/procedure							
19	SERVICE PERIOD							
20	Start: When patient enters office/facility for surgery/procedure							
21	Pre-service services							
22	Review charts	L038A COMT/COT/RN/ CST	3				3	
23	Greet patient and provide gowning		3				3	
24	Obtain vital signs		3				3	
25	Provide pre-service education/obtain consent		3		3		3	
26	Prepare room, equipment, supplies		2		2		3	
27	Setup scope (non facility setting only)							
28	Prepare and position patient/ monitor patient/ set up IV							
29	Sedate/apply anesthesia							
30	Intra-service							
31	Assist physician in performing procedure		10		10		20	
32	Post-Service							
33	Monitor pt. following service/check tubes, monitors, drains							
34	Clean room/equipment by physician staff		3		3		3	
35	Clean Scope							
36	Clean Surgical Instrument Package							
37	Complete diagnostic forms, lab & X-ray requisitions							
38	Review/read X-ray, lab, and pathology reports							
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions							
40	Discharge day management 99238 –12 minutes 99239 –15 minutes							
41	Other Clinical Activity (please specify)							
42	End: Patient leaves office							
43	POST-SERVICE Period							
44	Start: Patient leaves office/facility							
45	Conduct phone calls/call in prescriptions							
46	Office visits Greet patient, escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results, assist physician during exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care							
47	List Number and Level of Office Visits							
48	99211 16 minutes	16						
49	99212 27 minutes	27						
50	99213 36 minutes	36						
51	99214 53 minutes	53						
52	99215 63 minutes	63						
53	Other							
54								
55	Total Office Visit Time							
56	Other Activity (please specify)							
57	AMA Specialty Society Recommendation							

	A	B	C	D	E	F	G	H
2			CPT Code: 76511		CPT Code: 76512		CPT Code: 76510	
3	REVISED TAB 28- AAO	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Ophthalmic ultrasound, diagnostic; quantitative A-scan only		Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non- quantitative A-scan)		diagnostic; B-scan and quantitative A-scan performed during the same patient encounter	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
58	MEDICAL SUPPLIES							
59	Goniosol (2 5% ophth) ml	SH037	5		5		10	
60	Ophthalmology Visit Package A (without dilation)	SA050	1		1		1	
61	film, type 667 Polaroid (per exposure)	SK032	10		10		20	
62								
63								
64								
65	Equipment							
66								
67	Screening Lane \$28,235	E71111	1		1		1	
68	b-scan ultrasonography \$24,975	E52016			1		1	
69	a-scan quantitative \$20,000		1				1	
70								
71								
72								
73								
74								
75								

>>> "DeChane Dorsey" <ddorsey@aaodc.org> 5/21/2004 8:50:26 AM >>>
hi Todd,

This e-mail contains updated pricing information for some ophthalmology supplies/equipment. The Academy wanted to ensure that CMS has the most accurate pricing for the materials used for these procedures.

- Goniosol, 15cc \$26.65 (McKesson Medical Surgical) each of the ultrasound procedures presented during the last meeting uses 5 or 10 ml per procedure.
- 667 Polaroid Film 20 exposure pack \$28.00 (Viking Office Supply); \$20.00 (Office Depot); list price for both stores \$30.00 (each of the ultrasound procedures presented require 10 or 20 exposures per procedure)
- a-scan quantitative unit (stand alone) Ophthascan Mini-A with Polaroid Camera \$21,000 (Biophysic Medical)

I have also attached the final versions of the PEAC spreadsheet for the ophthalmic ultrasound codes presented during the April RUC meeting. I deleted the CPEP equipment code for the a-scan listed on the spreadsheet (it was for the wrong machine). The actual machine used in the procedure (see above information) is not currently in the CPEP database.

Please let me know if you have any questions. Thank you.

DeChane Dorsey, Esq.
Director of Health Policy
American Academy of Ophthalmology
1101 Vermont Ave., N.W.
Suite 700
Washington, DC 20005
(202) 737-6662 t
(202) 737-7061 f
ddorsey@aaodc.org <<mailto:ddorsey@aaodc.org>>

<<09 76511 76512 765xx spreadsheet__AAO revised 5-04.xls>>

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Doppler Velocimetry, Umbilical and Middle Cerebral Arteries

The specialty society did not present survey data to the RUC at the April 2004 meeting. The specialty will be re-surveying CPT codes 76820 *Doppler velocimetry, fetal; umbilical artery* and 76821 *Doppler velocimetry, fetal; middle cerebral artery* for presentation to the RUC at the September 2004 meeting. **Accordingly, the RUC recommends that CPT codes 76820 and 76821 be carrier priced in 2005 until the RUC has the opportunity to review recommendations expected to be presented at the September 2004 meeting.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●76820	AQ1	Doppler velocimetry, fetal; umbilical artery	XXX	Carrier Price To be presented at the September 2004 RUC Meeting
●76821	AQ2	middle cerebral artery	XXX	Carrier Price To be presented at the September 2004 RUC Meeting
▲76827		Doppler echocardiography, fetal, cardiovascular system , pulsed wave and/or continuous wave with spectral display; complete	XXX	0.58 (No Change)
▲76828		Doppler echocardiography, fetal, cardiovascular system, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study	XXX	0.56 (No Change)

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Radiopharmaceutical Therapy

In CPT Editorial Panel revised its radiopharmaceutical therapy family of codes by deleting eight CPT codes, creating 3 new codes, and editorially changing five codes to define these services according to the route of administration rather than disease specific. The RUC approached the CPT revisions in three separate issues, oral, intravenous, and intra-arterial administration. The RUC examined the CPT Panel's revisions to the family of codes regarding changes in physician work and work neutrality.

79005

Reference code 79000 *Radiopharmaceutical therapy, hyper-thyroidism; initial, including evaluation of patient* (Work RVU = 1.80, MPC listed) was reviewed in relation to new code 79005 *Radiopharmaceutical therapy, by oral administration*. The RUC believed that 79000 was the appropriate reference code for the survey instrument. 79005 *Radiopharmaceutical therapy, by oral administration*, has replaced code 79000 and the following other codes:

79001 *Radiopharmaceutical therapy, hyper-thyroidism; subsequent, each therapy* (Work RVU=1.05)

79020 *Radiopharmaceutical therapy, thyroid suppression (euthyroid cardiac disease), including evaluation of patient* (Work RVU=1.05)

79030 *Radiopharmaceutical ablation of gland for thyroid carcinoma* (Work RVU = 2.10)

79035 *Radiopharmaceutical therapy for metastases of thyroid carcinoma* (Work RVU = 2.52)

The RUC believed that the physician time elements listed as the survey results for new code 79005 may be inappropriate for the service being provided. The RUC believed the survey reported intra-service and immediate post operative work physician times were too high for the service provided. The RUC recommended lower times listed below, and were then comfortable with the physician work relative value recommended by the specialty society, which was the same as code 79000. In addition, it was understood by the RUC that the typical patient is being treated for Grave's disease, and the radiologist or nuclear medicine physician administering a radiopharmaceutical would not include an E&M service on the same day of service for 79005. **The RUC recommends that the following physician time and work relative values for code 79005.**

CPT Code	Pre-Service Time	Intra-Service Time	Immediate Post Service Time	RUC Recommended RVU
79005	20 minutes	15 minutes	10 minutes	1.80

79101

Reference code 79400 *Radiopharmaceutical therapy, nonthyroid, nonhematologic by intravenous injection* (Work RVU = 1.96) was reviewed in relation to new code 79101 *Radiopharmaceutical therapy, by intravenous administration*. The RUC believed that 79400 was the appropriate reference code for the survey instrument, and that code 79101 has appropriately replaced it and code 79100 *Radiopharmaceutical therapy, hyper-thyroidism; subsequent, each therapy* (Work RVU=1.32). The specialty society and the RUC believed that the survey data supported a work neutral relative value of 1.96, although the median survey value was 2.10. The RUC also reviewed recently reviewed code 79403 *Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion* (Work RVU = 2.25, RUC reviewed April 2003). Although the physician time components were similar for 79403 and 79101, 79403 is a much more intense service. Therefore, by valuing 79101 less than 79403, the proper rank order is established. **The RUC recommends a relative work value of 1.96 for code 79101.**

79445

The RUC agreed with the specialty society using code 79400 as its reference code for new code 79445 *Radiopharmaceutical therapy, by intra-arterial particulate administration*. The RUC also agreed that the survey results would be typical even though the response rate was low. The RUC reviewed the specialty's survey results for code 79445, and for its rank order with 79005 and 79445. The RUC agreed with the specialty's recommendation and physician time components. **The RUC recommends a relative work value of 2.40 for code 79445.**

79300

The RUC believed the CPT Editorial Panel's change in the descriptor for 79300 was editorial. **The RUC therefore recommends the physician work relative value remain at 1.60 RVUs.**

Practice Expense

The RUC reviewed the practice expense inputs for codes 79005-3 in relation to codes 79403 *Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion*. The RUC lowered some clinical staff times to eliminate any duplication in clinical staff activities. The RUC also adjusted the medical supplies to only those necessary for the procedures. **The revised RUC recommended practice expense inputs are attached for the non-facility setting. The RUC recommends no practice expense inputs in the facility setting.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲77750		<p>Infusion or instillation of radioelement solution (<u>includes three months follow-up care</u>)</p> <p><i>(For administration of radiolabeled monoclonal antibodies, use 79403)</i></p> <p><i>(For non-antibody radiopharmaceutical therapy by intravenous administration only, not requiring including three month follow-up care, use 79101)</i></p>	090	4.90 (No Change)
79000		Radiopharmaceutical therapy, hyper-thyroidism; initial, including evaluation of patient ———	XXX	N/A
79001		subsequent, each therapy	XXX	N/A
●79005	AT1	Radiopharmaceutical therapy, by oral administration	XXX	1.80
79020		Radiopharmaceutical therapy, thyroid suppression (euthyroid cardiac disease), including evaluation of patient	XXX	N/A
79030		Radiopharmaceutical ablation of gland for thyroid carcinoma	XXX	N/A
79035		<p>Radiopharmaceutical therapy for metastases of thyroid carcinoma</p> <p><u>(79000, 79001, 79020, 79030, 79035 have been deleted. To report, use 79005)</u></p>	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
79100		Radiopharmaceutical therapy, polycythemia vera, chronic leukemia, each treatment (79100 has been deleted. To report, use 79101)	XXX	N/A
● 79101	AT2	Radiopharmaceutical therapy, by intravenous administration (Do not report 79101 in conjunction with 79403, 36400, 36410, 90780, 90784, 96408) (For radiolabeled monoclonal antibody by intravenous infusion, use 79403) (For infusion or instillation of non-antibody radioelement solution that includes three months follow-up care, use 77750)	XXX	1.96
▲ 79200		<u>Radiopharmaceutical therapy, by intracavitary radioactive colloid therapy administration</u>	XXX	1.99 (No Change)
▲ 79300		<u>Radiopharmaceutical therapy, by interstitial radioactive colloid administration therapy</u>	XXX	1.60
79400		Radiopharmaceutical therapy, nonthyroid, nonhematologic (79400 has been deleted. To report, see 79005, 79101, 79445)	XXX	N/A
79403		<i>Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion</i> (For pre-treatment imaging, see 78802, 78804) (Do not report 79403 in conjunction with 79400 79445)	XXX	2.25 (No Change)

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
79420		Intravascular radiopharmaceutical therapy, particulate (79420 has been deleted. To report use 79445)	XXX	N/A
▲ 79440		<u>Radiopharmaceutical therapy, by intra-articular radiopharmaceutical therapy administration</u>	XXX	1.99 (No Change)
● 79445	AT3	Radiopharmaceutical therapy, by intra-arterial particulate administration (Do not report 79445 in conjunction with 90783, 96420) (Use appropriate procedural and radiological supervision and interpretation codes for the angiographic and interventional procedures provided pre-requisite to intra-arterial radiopharmaceutical therapy)	XXX	2.40
▲ 79999		<u>Unlisted Radiopharmaceutical therapy, therapeutic- unlisted procedure</u>	XXX	Carrier Priced

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

Recommended Work Relative Value

CPT Code:79005 Tracking Number: AT1 Global Period: XXX

Specialty Society RVU: **1.80**RUC RVU: **1.80**

CPT Descriptor: Radiopharmaceutical therapy, by oral administration

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old woman presented with symptoms of hyperthyroidism. On physical examination, she had an enlarged nodular thyroid gland. The 24-hour thyroid uptake was 43% and a thyroid scan indicated a diffusely enlarged gland with multiple areas of both increased and decreased activity bilaterally. She was referred for I131 therapy for toxic multinodular goiter.

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

Services Reported Prior To Therapy: Evaluation for radiopharmaceutical therapy, including a review of medical records, clinical interview and physical examination. Assessment of suitability for outpatient as opposed to inpatient treatment (regulatory requirements, living conditions, potential exposure to family and others). Initial education of patient and family about the treatment, and initial instructions for dosimetric measurements (as required) and for therapy.

Description of Pre-Service Work: Brief history and physical, review of any interim studies and change in clinical condition since initial consultation. Review of pretreatment imaging and dosimetric measurements. Review of the therapy procedure with patient and family, and reinforcement of education about potential exposure of family and public. Upon final determination that therapy is indicated, an informed consent is obtained from the patient.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed. The qualified physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated therapy room assists the patient in drinking the radiolabeled drug, mixed in water. The physician reviews post therapy exposure measurements. The physician discharges the patient with instructions.

Description of Post-Service Work: The physician makes arrangements for follow-up care. The physician completes all written documentation including report of treatment and all necessary and appropriate regulatory documentation requirements. The physician reviews and supervises post-therapy measurements of the administration room, and the disposal of radiopharmaceutical administration apparatus and contaminated supplies in compliance with regulatory rules. The physician reviews and signs the report for the medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Bibb Allen, Jr., M.D.(ACR), Kenneth McKusick, M.D. (SNM)				
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)				
CPT Code:	79005				
Sample Size:	450	Resp n:	27	Response: 6.00 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.32	1.80	1.80	1.83	3.60
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Pre-Service Time:			20.0		
Intra-Service Time:	3.00	20.00	15.00	30.00	90.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	10.00				
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>
79000	XXX	1.80

CPT Descriptor Radiopharmaceutical therapy, hyper-thyroidism; initial, including evaluation of patient

<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: 92.6 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 79005	Key Reference CPT Code: 79000
Median Pre-Service Time	20.00	0.00
Median Intra-Service Time	15.00	51.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	45.00	51.00
		(Harvard Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.12	3.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.28	3.24
Urgency of medical decision making	2.72	2.68

Technical Skill/Physical Effort (Mean)

Technical skill required	2.96	2.96
Physical effort required	2.24	2.24

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.32	3.32
Outcome depends on the skill and judgment of physician	3.40	3.40
Estimated risk of malpractice suit with poor outcome	2.80	2.80

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.20	3.24
Intra-Service intensity/complexity	3.28	3.24
Post-Service intensity/complexity	2.56	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.*

The American College of Radiology and Society of Nuclear Medicine RUC Committees reviewed the survey data and concluded that the median RVU is supported by the time and intensity data from the surveys as compared to the reference service 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) 79000, 79001, 79020, 79030 or 79035

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

Specialty: Radiology How often? Commonly

Specialty: Nuclear Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 36,000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty: Radiology Frequency 25,200 Percentage 70 %

Specialty: Nuclear Medicine Frequency 10,800 Percentage 30 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 12,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty: Radiology Frequency 8,400 Percentage 70 %

Specialty: Nuclear Medicine Frequency 3,600 Percentage 30 %

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

CPT Code:79101

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

CPT Code:79101 Tracking Number: AT2 Global Period: XXX

Recommended Work Relative Value

Specialty Society RVU: **2.10**

RUC RVU: **1.96**

CPT Descriptor: Radiopharmaceutical therapy, by intravenous administration

(Do not report 79101 in conjunction with 79403, 36400, 36410, 90780, 90784, 96408)

(For radiolabeled monoclonal antibody by intravenous infusion, use 79403)

(For infusion or instillation of non-antibody radioelement solution that includes three months follow-up care, see 77750)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Typical Patient: a 67-year-old male with known prostate carcinoma has extensive skeletal metastases. He complains of increasing pain in the chest, mid-thoracic and lumbar spine, and legs. He has had spot external beam radiation but now has more diffuse and generalized bone pain and requires narcotics throughout the day to obtain some relief. He also requires narcotics to sleep through the night. He is referred for Strontium 89 therapy as palliation for painful bony metastases. .

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? 4%

Is conscious sedation inherent in your reference code? No

Services Reported Prior To Therapy: Evaluation for radiopharmaceutical therapy, including a review of medical records, clinical interview and physical examination. Assessment of suitability for outpatient as opposed to inpatient treatment (regulatory requirements, living conditions, potential exposure to family and others). Initial education of patient and family about the treatment, and initial instructions for dosimetric measurements (as required) and for therapy.

Description of Pre-Service Work: Brief history and physical, review of any interim studies and change in clinical condition since initial consultation. Review of pretreatment imaging and dosimetric measurements. Review of the therapy procedure with patient and family, and reinforcement of education about potential exposure of family and public. Upon final determination that therapy is indicated, an informed consent is obtained from the patient.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed. The qualified physician supervises a certified technologist who assays the dose of the radiopharmaceutical and obtains IV access. The radiopharmaceutical is administered slowly by the physician (typically up to 10 minutes). The physician reviews post therapy exposure measurements. The physician discharges the patient with instructions.

Description of Post-Service Work: The physician makes arrangements for follow-up care. The physician completes all written documentation including report of treatment and all necessary and appropriate regulatory documentation requirements. The physician reviews and supervises post-therapy measurements of the injection room, and the disposal of injection apparatus and contaminated supplies in compliance with regulatory rules. The physician reviews and signs the report for the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2004				
Presenter(s):	Bibb Allen, Jr., M.D.(ACR), Kenneth McKusick, M.D. (SNM)				
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)				
CPT Code:	79101				
Sample Size:	450	Resp n:	23	Response: 5.11 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.32	1.96	2.10	2.61	4.50
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Pre-Service Time:			30.0		
Intra-Service Time:	15.00	28.00	30.00	30.00	75.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	<u>20.00</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>
79400	XXX	1.96

CPT Descriptor Radiopharmaceutical therapy; nonthyroid, nonhematologic by intravenous injection

<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: 52 %

TIME ESTIMATES (Median)

New/Revised
CPT Code:
79101

Key Reference
CPT Code:
79400

Median Pre-Service Time	30.00	0.00
Median Intra-Service Time	30.00	56.00
Median Immediate Post-service Time	20.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	80.00	56.00
		(Harvard Time)

INTENSITY/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	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.42
Urgency of medical decision making	3.08	3.08

Technical Skill/Physical Effort (Mean)

Technical skill required	3.33	3.33
Physical effort required	2.83	2.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.58	3.58
Outcome depends on the skill and judgment of physician	3.50	3.42
Estimated risk of malpractice suit with poor outcome	3.08	3.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.33	3.25
Intra-Service intensity/complexity	3.50	3.42
Post-Service intensity/complexity	2.92	2.83

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 Radiology and Society of Nuclear Medicine RUC Committees reviewed the survey data and concluded that the median RVU is supported by the time and intensity data from the surveys as compared to the reference service.

As an additional comparison, 79403 (Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous injection) with an RVU value was valued by the RUC in 2003. The total time is similar to 79101 however the intensity for 79403 is higher suggesting that the median value for 79101 places it in the proper rank order.

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) 79400, 79100

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

Specialty: Radiology How often? Sometimes

Specialty: Nuclear Medicine How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4,000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty: Radiology Frequency 2,600 Percentage 70 %

Specialty: Nuclear Medicine Frequency 760 Percentage 30 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty: Radiology Frequency 2,100 Percentage 70 %

Specialty: Nuclear Medicine Frequency 900 Percentage 30 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

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

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

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

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

Recommended Work Relative Value

CPT Code:79445 Tracking Number: AT3 Global Period: XXX

Specialty Society RVU: **2.40**

RUC RVU:

CPT Descriptor: Radiopharmaceutical therapy, by intra-arterial particulate administration

(Do not report 79445 in conjunction with 90783, 96420)

(Use appropriate procedural and radiological supervision and interpretation codes for the angiographic and interventional procedures provided pre-requisite to intra-arterial radiopharmaceutical therapy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year old man with colorectal cancer developed multiple liver metastases. Because of the number of liver metastasis, local therapy (e.g., surgical resection, radiofrequency ablation) was not an option, and he had failed systemic chemotherapy. The patient had no evidence of metastasis elsewhere. He was referred for possible intra-arterial radiotherapy.

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? 5%

Is conscious sedation inherent in your reference code? No

Services Reported Prior To Therapy: Evaluation for radiopharmaceutical therapy, including a review of medical records, clinical interview and physical examination. Assessment of suitability for outpatient as opposed to inpatient treatment (regulatory requirements, living conditions, potential exposure to family and others). Initial education of patient and family about the treatment, and initial instructions for dosimetric measurements (as required) and for therapy.

Description of Pre-Service Work: Brief history and physical, review of any interim studies and change in clinical condition since initial consultation. Review of pretreatment imaging and dosimetric measurements. Review of the therapy procedure with patient and family, and reinforcement of education about potential exposure of family and public. Upon final determination that therapy is indicated, an informed consent is obtained from the patient. The physician supervises the loading, calibration and set-up of the radiopharmaceutical dose.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed. The qualified physician supervises a certified technologist who assays of the dose of the radiopharmaceutical. Coordination with physicians obtaining appropriate intra-arterial access is obtained, the prerequisite arterial access, selective vascular selection(s), angiogram(s), and intervention(s) are performed and are separately coded by the relevant providing physician(s). In coordination with the operating interventionalist, the physician supervises the administration of the radiopharmaceutical. Post injection scintigraphic images are acquired and interpreted to assess the final distribution of the intra-arterial injection. The physician reviews post therapy exposure measurements and imaging data. The physician discharges the patient with instructions.

Description of Post-Service Work: The physician coordinates with the operating interventionalist and makes arrangements for follow-up care including . The physician completes all written documentation including report of treatment, post therapy doimetric and imaging data, and all necessary and appropriate regulatory documentation requirements. The physician reviews and supervises post-therapy measurements of the injection room, and the disposal of injection apparatus and contaminated supplies in compliance with regulatory rules. The physician reviews and signs the report for the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	Bibb Allen, Jr., M.D.(ACR), Kenneth McKusick, M.D. (SNM)					
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)					
CPT Code:	79445					
Sample Size:	450	Resp n:	20	Response: 4.44 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		1.50	2.03	2.40	2.60	6.70
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Pre-Service Time:				30.0		
Intra-Service Time:		3.00	40.00	45.00	56.00	60.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	20.00					
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>
79400	XXX	1.96

CPT Descriptor Radiopharmaceutical therapy; nonthyroid, nonhematologic by intravenous injection

<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: 55.0 %

TIME ESTIMATES (Median)

**New/Revised
CPT Code:
79445**

**Key Reference
CPT Code:
79400**

Median Pre-Service Time	30.00	0.00
Median Intra-Service Time	45.00	56.00
Median Immediate Post-service Time	20.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	95.00	56.00
		(Harvard Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.09	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.27	3.73
Urgency of medical decision making	2.91	3.45

Technical Skill/Physical Effort (Mean)

Technical skill required	2.82	3.36
Physical effort required	2.64	3.18

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.64	4.09
Outcome depends on the skill and judgment of physician	3.27	3.82
Estimated risk of malpractice suit with poor outcome	3.27	3.82

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.36	3.82
Intra-Service intensity/complexity	3.27	3.73
Post-Service intensity/complexity	2.82	3.36

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 Radiology and Society of Nuclear Medicine RUC Committees reviewed the survey data and concluded that the median RVU is supported by the time and intensity data from the surveys as compared to the reference service code.

Using a building block approach, the work of 79445 can be considered the sum of 79XX2 plus 78201 (2.00 RVW plus 0.44 RVU).

Note that we believe the low number of responses in the surveys is reflective of the infrequency with which this service is performed.

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) Catheter placement into the artery to be infused with radiopharmaceutical (36247 / 75726 for right hepatic artery) is performed prior to injection of the radiopharmaceutical. This is typically performed by another physician.

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.

CPT Code	RVU	Pre	Intra	Post	Total Time	Specialty
36247	6.29				86 (Harvard)	Interventional Radiology
75726	1.14				22 (Harvard)	Interventional Radiology
79445	2.40	30	45	20	95	Nuclear Medicine

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 79420

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

Specialty: Radiology How often? Rarely

Specialty: Nuclear Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty: Radiology	Frequency 140	Percentage 70 %
Specialty :Nuclear Medicine	Frequency 60	Percentage 30 %
Specialty	Frequency 0	Percentage 0.00 %

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

Specialty: Radiology	Frequency 70	Percentage 70 %
Specialty: Nuclear Medicine	Frequency 30	Percentage 30 %
Specialty	Frequency 0	Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

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

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

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

	A	B	C	D	E
1	AMA/Specialty Society Recommendation	CMS STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	79005 Radiopharmaceutical Therapy by oral administration	79101 Radiopharmaceutical therapy by intravenous administration	79445 Radiopharmaceutical therapy, by intra-arterial particulate administration
2	GLOBAL PERIOD		XXX	XXX	XXX
3	LOCATION		In Office	In Office	In Office
4	TOTAL CLINICAL TIME		53	49	N/A
5	PRE-SERVICE TIME		19	19	
6	SERVICE PERIOD		31	27	
7	POST SERVICE TOTAL		3	3	
8	Start: Following visit when decision for surgery or procedure is made.				
9					
10	(*) 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	6	6	
11	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 infusion/injection with in-house labels and records, and later resurvey and arrange disposal of syringe	NMT	13	13	
12	Coordinate the administration of the therapy (radioactive) antibody infusion, which follows within 4 hours of the IV infusion of "cold" antibody (Oncologist), requiring modification of schedule and personnel	NMT			
13	Total Pre-Service Time	NMT	19	19	
14	End: Patient enters office for surgery/procedure				
15	SERVICE PERIOD				
16	Start: When patient enters office for surgery/procedure				
17	Review charts				
18	(*) Greet patient, provide gowning if appropriate, and take to imaging/therapy area for imaging/therapy session	NMT	3	3	
25	(*) Prepare infusion/injection/therapy room, equipment, and supplies	NMT	2	2	
26	Intra-service				
27	Assist physician during drug therapy infusion to include monitoring vital signs, preparation, and assistance during possible medical emergency/antibody allergic reaction (oxygen/crash cart)	NMT			
28	(*) 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	3	
33	(*) Specific room clean up of injection area with defacement of labels, and required NRC survey and monitoring tasks	NMT	4	4	
34	Other Clinical Activity (please specify)				
35	(*) Obtain RP dose from radiopharmaceutical receiving and storage area, re-assay 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	
36	(*) Take patient to injection/administration area, set up IV, infuse/inject/administer or assist during radiopharmaceutical administration, review radiation risks, escort back to waiting area	NMT	2	8	
37	Count Patient Room Bkg & Technologist thyroid counts (liquid oral administrations)	NMT	10		
38	Service Period Total	NMT	31	27	
39	End: Patient leaves office				
40	Post-Service Period				
41	Start: Patient leaves office				
44	(*) Regulatory compliance –NRC required wipe tests and surveys of areas used, and documentation	NMT	3	3	
45	Post Service Total	NMT	3	3	
46	End: With last office visit before end of global period				
47	MEDICAL SUPPLIES				
48	RADIOPHARMACEUTICAL - STORAGE AND RECEIVING AREA				
49	Minimum Supply Pack/Multi Spec	SA048	1	1	
50	11102 Chux	SB044	1	1	
51	Sanitizing cloth-wipe (surface, instruments, equipment)	SM021	5	5	

	A	B	C	D	E
1	AMA/Specialty Society Recommendation	CMS STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	79005 Radiopharmace utical Therapy by oral administration	79101 Radiopharmace utical therapy by intravenous administration	79445 Radiopharmace utical therapy, by intra-arterial particulate administration
2	GLOBAL PERIOD		XXX	XXX	XXX
3	LOCATION		In Office	In Office	In Office
4	TOTAL CLINICAL TIME		53	49	N/A
5	PRE-SERVICE TIME		19	19	
6	SERVICE PERIOD		31	27	
7	POST SERVICE TOTAL		3	3	
52	INJECTION AREA				
53	Alcohol Swabs	SJ053		1	
54	Angiocatheter 14g-24g	SC001		1	
55	hepamn lock	SC012		1	
56					
57	Stop cock, 3 way	SC049		1	
58	Band aid	SG021		1	
59	Chux	SB044	1	1	
60	Gauze, 2x2	SG050		1	
61					
62	Sodium chloride 0.9% inj Bactenostatic (30ml uou)	SH068		1	
63	Hepamn flush	SH040		1	
64	Syrnng, 10-12cc	SC051		1	
65	Needles, 18-27 g	SC029		1	
66					
67	Sanitizing cloth-wipe (surface, instruments, equipment)	SM021	1	1	
68					
80	Equipment				
81	Radiopharmaceutical Receiving Area				
82					
83	Dose Calibrator	E51064	1	1	
84	Dedicated radiopharmacy computer and pnnter (radiopharmacy	\$20,295	1	1	
85	Calibration Source Vial Set & Check Sleeves	\$1,505	1	1	
86	Autogamma Counter (Siemens)	\$27,534	1	1	
87	Survey meter	E53004	1	1	
88	L-Block Table Shield (Pinestar NMC-2014)	\$3,670	1	1	
89	Syrnng Shields & Lead Pig Holders (6) (Pinestar)	1,860.00	1	1	
90	Lead-lined radioactive waste and lead lined Sharps box (Pinestar NMC-F-325)	\$1,500	1	1	
91	Lead shielding (Pinestar NMC-7410)	\$1,590	1	1	
92	Well Counter	E51076		1	
93	Injection Room				
94					
95	Phlebotomy-Injection Chair Nuclear Medicine Catalog	\$2,647		1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Positron Emission Tomography and Computed Tomography

The CPT Editorial Panel agreed to delete one code and added six new codes to allow for more specificity in the levels of physician work for positron emission tomography (PET). The Editorial Panel created three separate codes for tumor imaging and three additional codes for tumor imaging with CT, with varying levels of physician work.

78811-3

The entire set of new CPT codes were pre-facilitated by the RUC so that the specialty society and the RUC had a firm understanding of the physician work involved in all of the codes. It was understood by the specialty society and the RUC that the typical PET service had changed since it was first reviewed by the RUC in 1994. Newer technologies allowed for less physician time for the typical patient but a more comprehensive study is involved. The RUC reviewed the specialty society's reference code 78810 *Tumor imaging, positron emission tomography (PET), metabolic evaluation* (Work RVU = 1.93, RUC reviewed September 1994) in relation to the three new codes. The RUC believed that the work of 78810 was similar to the new code 78812 *Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck); skull base to mid-thigh*. In addition, code 78813 *Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck); whole body*, represented more physician work than code 78810, and code 78811 *Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck); limited area (eg. Chest, head/neck)* represented less work than 78810.

The RUC recommended values for 78812 and 78813 to correspond to the 25th percentile work values from the specialty's surveys. The 25th percentile value for 78811 value could not be justified based on the survey times, and therefore was calculated based on a ratio of the survey times (80% of 78812). **The RUC recommends the following relative work values for codes 78811-3 shown in the table below:**

CPT Code	Descriptor	Pre-Service Time	Intra-Service Time	Post-Service Time	Total Time	IWPUT	RUC Recommended Work RVU
78811	Tumor imaging, PET; limited area (eg, chest, head/neck)	10	20	10	40	.055	1.54

78812	Tumor imaging, PET; skull base to mid-thigh	10	30	10	50	.049	1.93
78813	Tumor imaging, PET; whole body	15	30	10	55	.048	2.00

78814-6

Codes 78814-6 were reviewed in relation to the specialty society's reference code 78810 *Tumor imaging, positron emission tomography (PET), metabolic evaluation* (Work RVU = 1.93, RUC reviewed September 1994). The RUC believed that the 25th percentile survey results for these three codes would best represent the work associated with 78814, 78815, and 78816. This was validated by the RUC based on the intra service work per unit of time (IWPUT) for each of the codes. **The RUC recommends the following relative work values for codes 78814-6 shown in the table below:**

CPT Code	Descriptor	Pre-Service Time	Intra-Service Time	Post-Service Time	Total Time	IWPUT	RUC Recommended Work RVU
78814	Tumor imaging, PET with concurrently acquired CT for attenuation correction and anatomical localization; limited area (eg, chest, head/neck)	15	30	15	60	.051	2.20
78815	Tumor imaging, PET with concurrently acquired CT for attenuation correction and anatomical localization; skull base to mid-thigh	15	35	15	65	.051	2.44
78816	Tumor imaging, PET with concurrently acquired CT for attenuation correction and anatomical localization; whole body	15	40	15	70	.046	2.50

Practice Expense for 78811-X6

The RUC reviewed the practice expense inputs for codes 78811-X6 in relation to codes 78306 *Bone and/or joint imaging; whole body* and 78803 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)*. The RUC lowered some clinical staff times to eliminate any duplication in clinical staff activities. The RUC also adjusted the medical supplies to only those necessary for the procedures. **The revised RUC recommended practice expense inputs are attached.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●78811	AS1	Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck) (Report 78811-78816 only once per imaging session)	XXX	1.54
●78812	AS2	skull base to mid-thigh (Report 78811-78816 only once per imaging session)	XXX	1.93
●78813	AS3	whole body (Report 78811-78816 only once per imaging session)	XXX	2.00
78810		Tumor imaging, positron emission tomography (PET), metabolic evaluation (78810 has been deleted. To report, see 78811-78813) (For PET of brain, see 78608, 78609) (For PET myocardial imaging, see 78491, 78492)	XXX	N/A
●78814	AS4	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg, chest, head/neck)	XXX	2.20

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Report 78811-78816 only once per imaging session)		
●78815	AS5	skull base to mid-thigh (Report 78811-78816 only once per imaging session)	XXX	2.44
●78816	AS6	whole body (Report 78811-78816 only once per imaging session) (CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site specific CT code with modifier 59)	XXX	2.50

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

CPT Code:78811 Tracking Number: AS1 Global Period: XXX	Recommended Work Relative Value Specialty Society RVU: 1.54 RUC RVU: 1.54
--	--

CPT Descriptor: Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck)

(Report 78811-78816 only once per imaging session)
 (78810 has been deleted. To report, see 78811-78813)
 (For PET of brain, see 78608, 78609)
 (For PET myocardial imaging, see 78491, 78492)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 42-year-old female with a history of invasive ductal carcinoma of the left breast. The initial tumor was 4.5 centimeters in largest diameter by mammography. She has now completed neoadjuvant chemotherapy and assessment of treatment response is requested prior to surgical resection. A limited PET scan of the chest is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 10%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the technologist in the acquisition and reconstruction of the data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The physician reviews the study for adequacy and need for additional acquisitions. All images are interpreted by the physician with correlation with prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	Bibb Allen, Jr., M.D. (ACR), Kenneth McKusick, M.D. (SNM)					
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)					
CPT Code:	78811					
Sample Size:	450	Resp n: 52		Response: 11.55%		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		0.96	1.80	1.93	2.51	5.00
Pre-Service Evaluation Time:				0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Pre-Service Time:				10.0		
Intra-Service Time:		4.00	10.00	20.00	30.00	70.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		10.00				
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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 24 % of respondents: 46.1 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78811	Key Reference CPT Code: 78810
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	20.00	68.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	40.00	68.00 (RUC TIME)

INTENSITY/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	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.42	3.50
Urgency of medical decision making	3.04	3.04

Technical Skill/Physical Effort (Mean)

Technical skill required	2.08	2.08
Physical effort required	3.08	2.58

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.58	2.50
Outcome depends on the skill and judgment of physician	3.67	3.46
Estimated risk of malpractice suit with poor outcome	3.13	3.13

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.04	3.13
Intra-Service intensity/complexity	3.38	3.42
Post-Service intensity/complexity	3.21	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.*

Background Information

PET imaging for tumor evaluation, (78810, Tumor imaging, positron emission tomography, metabolic evaluation) was initially reviewed by the RUC in September 1994. Since that time the natural evolution of PET imaging has led to three typical scenarios for PET imaging in oncology patients as described by the three new codes in this family that will replace code 78810.

New code 78811 (Tumor imaging, positron emission tomography (PET); limited area (e.g. chest, head and neck)) is designed to evaluate a pulmonary nodule, local recurrence or regional disease and was the typical examination when 78810 was valued in 1994. New code 7881X2 (Tumor imaging, positron emission tomography (PET); skull base to mid thigh) is typically used for initial staging and evaluating the result of therapy. New code 78813 (Tumor imaging, positron emission tomography (PET); whole body) is reserved for patients with neoplasms such as melanoma that have a propensity for metastases to unusual locations.

7881X2 and 78813 Represent New Physician Work

In 1994, the RUC approved a work value of 1.95 RVU for 78810. As noted above, and supported by the clinical vignettes in the RUC database for 78810, the typical examination and valuation at that time was the 78811 vignette. It is therefore the opinion of the ACR and SNM that 7881X2 and 78813 represent new physician work and that budget neutrality should not be applied to this family of codes. We request that the RUC formally concur that based on the vignettes in the RUC database for 78810 that 7881X2 and 78813 represent new physician work.

There are additional issues that must be considered. CMS does not reimburse PET imaging under CPT code 78810. CMS has established a series HCPCS G Codes for providers to report PET. These codes based on the site and/or pathologic diagnosis of the primary tumor, such as colon cancer or lymphoma, rather than the complexity of the examination. As such, there are no claims data available to determine the distribution of 78811, 7881X2 and 78813. Surveys of the members of the ACR and SNM suggest that the vast majority of PET examinations will be 7881X2.

Valuation of 78811

78811 is considered by the ACR and SNM to represent the service valued by the RUC in 1994, and the median value of 1.93 from the survey suggests that the respondents considered this to be the case as well. However, the RUC committees of the ACR and SNM have evaluated the survey data and have concluded that the survey median RVU cannot be supported by the time. Therefore, we have recommended the 25 percentile value of 1.80 for 78811.

Valuation of 7881X2 and 78813

For 7881X2 and 78813, the ACR and SNM believe that the median values of 2.00 and 2.10 are supported by the survey data. Although the respondents indicate that the intra-service work requires a similar amount of time for 7881X2 and 78813, the pre-service work is more complex for the whole body scan due to the increased time required for review of studies, determining that a whole body scan is necessary and the time spent with the technologist for setting up a whole body scan as compared to the torso scan. This additional 5 minutes justifies the slightly higher work RVU for 78813.

Comparison To 78810

The RUC will note that 78810 was presented to the RUC in 1994 with total time of 68 minutes, all of which has been assigned to the intra-service period. Since there were only 18 survey respondents in 1994, one could

legitimately question the validity of the time data in the RUC database. However, there are additional explanations as well. In 1994, most physicians doing PET stayed at the console during image acquisition for monitoring and review of the data sets on the monitor. This was associated with a considerable period (typically 30 to 45 minutes) of waiting for the images to be acquired. This may have resulted in the relatively low intensity per unit time for PET imaging seen in the RUC database for 78810. Furthermore, in 1994, PET interpretation was largely qualitative.

In current practice, the expectations for PET imaging are significantly higher requiring detailed correlation of both anatomic and functional information. Compared to current practice, the intensity per unit time of 78810 is significantly underestimated by the RUC database. In current practice, the physician time for performing and interpreting PET is less than indicated in 1994. In our current surveys, total times are 40 minutes for 78811, 50 minutes for 7881X2 and 55 minutes for 78813. It is no longer the practice of physicians performing PET to stay at the acquisition console during the entire examination. Independent consoles are available for monitoring the examination and for review and interpretation of the data. As compared to 1994, the number imaging planes reviewed and the number of images reviewed and interpreted has increased dramatically.

Improvements in spatial resolution have made highly accurate anatomic correlation possible and this has become the clinical expectation of PET imaging. Without question, the intensity per unit time has significantly increased since 1994 with a conversion from time spent waiting for images to be acquired to time spent in active interpretation of more complex PET images as well as more difficult correlation with CT and MR images. This increase in intensity is only partially captured in the intensity questions on the current surveys because there is no venue for respondents to compare PET in 1994 to PET in 2004. In the current survey, respondents are merely comparing limited, torso and whole body PET to 78810 as it is performed today, not as to how it was performed in 1994.

Comparison To Other RUC Surveyed Imaging Codes

Some respondents chose codes other than 78810 as their key reference service. CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes with 20 minutes being the intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 788X1, 13 additional minutes for 7881X2, and 18 additional minutes for 78813.

Comparison To RUC Surveyed Non-Radiology Imaging Codes

Although none of the respondents chose 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) as a key reference service code, the code was surveyed for the RUC valuation in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the probe in the esophagus but otherwise, and the recommended values for the PET codes compare favorably with this code as well.

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) : 78810, G0125, G0210-G0222, G0224-G0234, G0236, G0252-G0254, G0296

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

Specialty: Radiology How often? Commonly

Specialty: Nuclear Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 33,000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty: Radiology Frequency 23,100 Percentage 70 %

Specialty: Nuclear Medicine Frequency 9,900 Percentage 30 %

Specialty Frequency 0 Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 13,200 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty: Radiology Frequency 9,240 Percentage 70 %

Specialty: Nuclear Medicine Frequency 3,960 Percentage 30 %

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. Non-Surgical

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

<p>CPT Code: Tracking Number: AS2 Global Period: XXX</p> <p>CPT Descriptor: Tumor imaging, positron emission tomography (PET); skull base to mid-thigh</p> <p>(Report 78811-78816 only once per imaging session)</p> <p>(78810 has been deleted. To report, see 78811-78813)</p> <p>(For PET myocardial imaging, see 78491, 78492)</p>	<p>Recommended Work Relative Value</p> <p>Specialty Society RVU: 1.93</p> <p>RUC RVU: 1.93</p>
--	---

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year-old man with a long history of smoking presents with a new 2.0 cm nodule on chest x-ray. A chest CT scan is performed and demonstrates an indeterminate solitary pulmonary nodule. A transthoracic needle aspiration biopsy demonstrates a non-small cell lung cancer. A PET scan is performed from skull base to mid thigh for initial staging of lung cancer.

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? 8%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the technologist in the acquisition and reconstruction of the data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The physician reviews the study for adequacy and need for additional acquisitions. All images are interpreted by the physician with correlation with prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	Bibb Allen, Jr., M.D. (ACR), Kenneth McKusick, M D (SNM)					
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)					
CPT Code:	7881X2					
Sample Size:	450	Resp n: 50		Response: 11.11 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		1.18	1.93	2.00	3.00	7.20
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Pre-Service Time:				10.0		
Intra-Service Time:		5.00	15 00	30.00	35 00	80.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		10.00				
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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 26 % of respondents: 52.0 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78812	Key Reference CPT Code: 78810
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	30.00	68.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	50.00	68.00 (RUC Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.46	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.54
Urgency of medical decision making	3.15	3.19

Technical Skill/Physical Effort (Mean)

Technical skill required	3.23	3.31
Physical effort required	2.12	2.15

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.65	2.62
Outcome depends on the skill and judgment of physician	3.69	3.58
Estimated risk of malpractice suit with poor outcome	3.08	3.04

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.15	3.15
Intra-Service intensity/complexity	3.65	3.54
Post-Service intensity/complexity	3.27	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.*

Background Information

PET imaging for tumor evaluation, (78810, Tumor imaging, positron emission tomography, metabolic evaluation) was initially reviewed by the RUC in September 1994. Since that time the natural evolution of PET imaging has led to three typical scenarios for PET imaging in oncology patients as described by the three new codes in this family that will replace code 78810.

New code 78811 (Tumor imaging, positron emission tomography (PET); limited area (e.g. chest, head and neck)) is designed to evaluate a pulmonary nodule, local recurrence or regional disease and was the typical examination when 78810 was valued in 1994. New code 78812 (Tumor imaging, positron emission tomography (PET); skull base to mid thigh) is typically used for initial staging and evaluating the result of therapy. New code 78813 (Tumor imaging, positron emission tomography (PET); whole body) is reserved for patients with neoplasms such as melanoma that have a propensity for metastases to unusual locations.

7881X2 and 78813 Represent New Physician Work

In 1994, the RUC approved a work value of 1.95 RVU for 78810. As noted above, and supported by the clinical vignettes in the RUC database for 78810, the typical examination and valuation at that time was the 78811 vignette. It is therefore the opinion of the ACR and SNM that 7881X2 and 78813 represent new physician work and that budget neutrality should not be applied to this family of codes. We request that the RUC formally concur that based on the vignettes in the RUC database for 78810 that 7881X2 and 78813 represent new physician work.

There are additional issues that must be considered. CMS does not reimburse PET imaging under CPT code 78810. CMS has established a series HCPCS G Codes for providers to report PET. These codes based on the site and/or pathologic diagnosis of the primary tumor, such as colon cancer or lymphoma, rather than the complexity of the examination. As such, there are no claims data available to determine the distribution of 78811, 7881X2 and 78813. Surveys of the members of the ACR and SNM suggest that the vast majority of PET examinations will be 7881X2.

Valuation of 78811

78811 is considered by the ACR and SNM to represent the service valued by the RUC in 1994, and the median value of 1.93 from the survey suggests that the respondents considered this to be the case as well. However, the RUC committees of the ACR and SNM have evaluated the survey data and have concluded that the survey median RVU cannot be supported by the time. Therefore, we have recommended the 25 percentile value of 1.80 for 78811.

Valuation of 7881X2 and 78813

For 7881X2 and 78813, the ACR and SNM believe that the median values of 2.00 and 2.10 are supported by the survey data. Although the respondents indicate that the intra-service work requires a similar amount of time for 7881X2 and 78813, the pre-service work is more complex for the whole body scan due to the increased time required for review of studies, determining that a whole body scan is necessary and the time spent with the technologist for setting up a whole body scan as compared to the torso scan. This additional 5 minutes justifies the slightly higher work RVU for 78813.

Comparison To 78810

The RUC will note that 78810 was presented to the RUC in 1994 with total time of 68 minutes, all of which has been assigned to the intra-service period. Since there were only 18 survey respondents in 1994, one could legitimately question the validity of the time data in the RUC database. However, there are additional explanations as well. In 1994, most physicians doing PET stayed at the console during image acquisition for monitoring and review of the data sets on the monitor. This was associated with a considerable period (typically 30 to 45 minutes) of waiting for the images to be acquired. This may have resulted in the relatively low intensity per unit time for PET imaging seen in the RUC database for 78810. Furthermore, in 1994, PET interpretation was largely qualitative.

In current practice, the expectations for PET imaging are significantly higher requiring detailed correlation of both anatomic and functional information. Compared to current practice, the intensity per unit time of 78810 is significantly underestimated by the RUC database. In current practice, the physician time for performing and interpreting PET is less than indicated in 1994. In our current surveys, total times are 40 minutes for 78811, 50 minutes for 7881X2 and 55 minutes for 78813. It is no longer the practice of physicians performing PET to stay at the acquisition console during the entire examination. Independent consoles are available for monitoring the examination and for review and interpretation of the data. As compared to 1994, the number imaging planes reviewed and the number of images reviewed and interpreted has increased dramatically.

Improvements in spatial resolution have made highly accurate anatomic correlation possible and this has become the clinical expectation of PET imaging. Without question, the intensity per unit time has significantly increased since 1994 with a conversion from time spent waiting for images to be acquired to time spent in active interpretation of more complex PET images as well as more difficult correlation with CT and MR images. This increase in intensity is only partially captured in the intensity questions on the current surveys because there is no venue for respondents to compare PET in 1994 to PET in 2004. In the current survey, respondents are merely comparing limited, torso and whole body PET to 78810 as it is performed today, not as to how it was performed in 1994.

Comparison To Other RUC Surveyed Imaging Codes

Some respondents chose codes other than 78810 as their key reference service. CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes with 20 minutes being the intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 788X1, 13 additional minutes for 7881X2, and 18 additional minutes for 78813.

Comparison To RUC Surveyed Non-Radiology Imaging Codes

Although none of the respondents chose 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) as a key reference service code, the code was surveyed for the RUC valuation in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the probe in the esophagus but otherwise, and the recommended values for the PET codes compare favorably with this code as well.

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) : 78810, G0125, G0210-G0222, G0224-G0234, G0236, G0252-G0254, G0296

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Radiology How often? Commonly

Specialty: Nuclear Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 278,000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty: Radiology	Frequency 194,600	Percentage 70 %
----------------------	-------------------	-----------------

Specialty: Nuclear Medicine	Frequency 83,400	Percentage 30 %
-----------------------------	------------------	-----------------

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

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

111,200 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty: Radiology	Frequency 77,840	Percentage 70 %
----------------------	------------------	-----------------

Specialty: Nuclear Medicine	Frequency 33,360	Percentage 30 %
-----------------------------	------------------	-----------------

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**

Recommended Work Relative Value

CPT Code:78813 Tracking Number: AS3 Global Period: XXX

Specialty Society RVU: **2.00**RUC RVU: **2.00**

CPT Descriptor: Tumor imaging, positron emission tomography (PET); whole body

(Report 78811-78816 only once per imaging session)

(78810 has been deleted. To report, see 78811-78813)

(For PET of brain, see 78608, 78609)

(For PET myocardial imaging, see 78491, 78492)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 33-year-old man with a history of a malignant melanoma resected from his back, inferior to the right scapula, eight months previously. A small non-painful left axillary lymph node has developed in the previous month. All recent laboratory and imaging studies have been unremarkable. He is referred for staging prior to left axillary resection. A whole body PET scan is performed.

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? 7%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the technologist in the acquisition and reconstruction of the data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The physician reviews the study for adequacy and need for additional acquisitions. All images are interpreted by the physician with correlation with prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s).	Bibb Allen, Jr., M.D. (ACR), Kenneth McKusick, M.D. (SNM)					
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)					
CPT Code:	78813					
Sample Size:	450	Resp n:	50	Response: 11 11 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		1.30	2.00	2.10	2.87	9.00
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Pre-Service Time:				15.0		
Intra-Service Time:		5.00	16.00	30.00	40 00	90.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	10.00					
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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 27 % of respondents: 54.0 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78813	Key Reference CPT Code: 78810
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	30.00	68.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	55.00	68.00 (RUC Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.58	3.54
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.54	3.46
Urgency of medical decision making	3.19	3.19

Technical Skill/Physical Effort (Mean)

Technical skill required	3.31	3.23
Physical effort required	2.12	2.08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.65	2.62
Outcome depends on the skill and judgment of physician	3.65	3.58
Estimated risk of malpractice suit with poor outcome	3.12	3.08

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.44	3.37
Intra-Service intensity/complexity	3.81	3.67
Post-Service intensity/complexity	3.41	3.26

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.*

Background Information

PET imaging for tumor evaluation, (78810, Tumor imaging, positron emission tomography, metabolic evaluation) was initially reviewed by the RUC in September 1994. Since that time the natural evolution of PET imaging has led to three typical scenarios for PET imaging in oncology patients as described by the three new codes in this family that will replace code 78810.

New code 78811 (Tumor imaging, positron emission tomography (PET); limited area (e.g. chest, head and neck)) is designed to evaluate a pulmonary nodule, local recurrence or regional disease and was the typical examination when 78810 was valued in 1994. New code 7881X2 (Tumor imaging, positron emission tomography (PET); skull base to mid thigh) is typically used for initial staging and evaluating the result of therapy. New code 78813 (Tumor imaging, positron emission tomography (PET); whole body) is reserved for patients with neoplasms such as melanoma that have a propensity for metastases to unusual locations.

7881X2 and 78813 Represent New Physician Work

In 1994, the RUC approved a work value of 1.95 RVU for 78810. As noted above, and supported by the clinical vignettes in the RUC database for 78810, the typical examination and valuation at that time was the 78811 vignette. It is therefore the opinion of the ACR and SNM that 7881X2 and 78813 represent new physician work and that budget neutrality should not be applied to this family of codes. We request that the RUC formally concur that based on the vignettes in the RUC database for 78810 that 7881X2 and 78813 represent new physician work.

There are additional issues that must be considered. CMS does not reimburse PET imaging under CPT code 78810. CMS has established a series HCPCS G Codes for providers to report PET. These codes based on the site and/or pathologic diagnosis of the primary tumor, such as colon cancer or lymphoma, rather than the complexity of the examination. As such, there are no claims data available to determine the distribution of 78811, 7881X2 and 78813. Surveys of the members of the ACR and SNM suggest that the vast majority of PET examinations will be 7881X2.

Valuation of 78811

78811 is considered by the ACR and SNM to represent the service valued by the RUC in 1994, and the median value of 1.93 from the survey suggests that the respondents considered this to be the case as well. However, the RUC committees of the ACR and SNM have evaluated the survey data and have concluded that the survey median RVU cannot be supported by the time. Therefore, we have recommended the 25 percentile value of 1.80 for 78811.

Valuation of 7881X2 and 78813

For 7881X2 and 78813, the ACR and SNM believe that the median values of 2.00 and 2.10 are supported by the survey data. Although the respondents indicate that the intra-service work requires a similar amount of time for 7881X2 and 78813, the pre-service work is more complex for the whole body scan due to the increased time required for review of studies, determining that a whole body scan is necessary and the time spent with the technologist for setting up a whole body scan as compared to the torso scan. This additional 5 minutes justifies the slightly higher work RVU for 78813.

Comparison To 78810

The RUC will note that 78810 was presented to the RUC in 1994 with total time of 68 minutes, all of which has been assigned to the intra-service period. Since there were only 18 survey respondents in 1994, one could legitimately question the validity of the time data in the RUC database. However, there are additional explanations as well. In 1994, most physicians doing PET stayed at the console during image acquisition for monitoring and review of the data sets on the monitor. This was associated with a considerable period (typically 30 to 45 minutes) of waiting for the images to be acquired. This may have resulted in the relatively low intensity per unit time for PET imaging seen in the RUC database for 78810. Furthermore, in 1994, PET interpretation was largely qualitative.

In current practice, the expectations for PET imaging are significantly higher requiring detailed correlation of both anatomic and functional information. Compared to current practice, the intensity per unit time of 78810 is significantly underestimated by the RUC database. In current practice, the physician time for performing and interpreting PET is less than indicated in 1994. In our current surveys, total times are 40 minutes for 78811, 50 minutes for 7881X2 and 55 minutes for 78813. It is no longer the practice of physicians performing PET to stay at the acquisition console during the entire examination. Independent consoles are available for monitoring the examination and for review and interpretation of the data. As compared to 1994, the number imaging planes reviewed and the number of images reviewed and interpreted have increased dramatically.

Improvements in spatial resolution have made highly accurate anatomic correlation possible and this has become the clinical expectation of PET imaging. Without question, the intensity per unit time has significantly increased since 1994 with a conversion from time spent waiting for images to be acquired to time spent in active interpretation of more complex PET images as well as more difficult correlation with CT and MR images. This increase in intensity is only partially captured in the intensity questions on the current surveys because there is no venue for respondents to compare PET in 1994 to PET in 2004. In the current survey, respondents are merely comparing limited, torso and whole body PET to 78810 as it is performed today, not as to how it was performed in 1994.

Comparison To Other RUC Surveyed Imaging Codes

Some respondents chose codes other than 78810 as their key reference service. CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes with 20 minutes being the intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 788X1, 13 additional minutes for 7881X2, and 18 additional minutes for 78813.

Comparison To RUC Surveyed Non-Radiology Imaging Codes

Although none of the respondents chose 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) as a key reference service code, the code was surveyed for the RUC valuation in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the probe in the esophagus but otherwise, and the recommended values for the PET codes compare favorably with this code as well.

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.

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

Recommended Work Relative Value

CPT Code:78814 Tracking Number: AS4 Global Period: XXX

Specialty Society RVU: **2.20**RUC RVU: **2.20****CPT Descriptor:**

Tumor imaging, positron emission tomography (PET) with concurrently acquired CT for attenuation correction and anatomical localization; limited area (eg, chest, head/neck)

(Report 78811-78816 only once per imaging session)

(CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site specific CT code with modifier 59)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 52-year old man with a remote history of adenoid cystic carcinoma of the left parotid gland. The patient recently re-presents with facial weakness and paresthesia. MRI shows abnormal tissue in the parotid bed, but it is unclear whether this is recurrent tumor or post-operative scar. A PET-CT scan of the head / neck and chest is performed to evaluate the extent of recurrent tumor and document precise anatomic distribution prior to consideration for surgery and/or radiation therapy.

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? 13%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the acquisition of CT data in the areas of interest. The physician supervises the technologist in the acquisition and reconstruction of the PET data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The interpreting physician, using a computer workstation, creates or directly supervises the creation of composite images for anatomic correlation by precisely overlying PET and CT images. The physician reviews 3 sets of images - emission PET scans, the CT anatomical localization data, and a fusion of the two images which contain the PET and CT data anatomically superimposed over each other. PET images are interpreted by the physician and correlated with the CT localization data obtained as well as to relevant prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Bibb Allen, Jr., M.D (ACR), Kenneth McKusick, M.D. (SNM)				
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)				
CPT Code:	78814				
Sample Size:	450	Resp n:	45	Response:	10.0 %
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.40	2.20	2.40	3.78	6.00
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Pre-Service Time:			15.0		
Intra-Service Time:	5.00	20.00	30.00	45.00	90.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	15.00				
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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 51.1 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78814	Key Reference CPT Code: 78810
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	30.00	68.00
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	60.00	68.00 (RUC Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.65	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.83
Urgency of medical decision making	3.13	3.30

Technical Skill/Physical Effort (Mean)

Technical skill required	3.48	3.57
Physical effort required	2.17	2.39

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.91	3.04
Outcome depends on the skill and judgment of physician	3.74	3.87
Estimated risk of malpractice suit with poor outcome	3.09	3.26

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.30	3.43
Intra-Service intensity/complexity	3.96	3.78
Post-Service intensity/complexity	3.39	3.57

ADDITIONAL RATIONALE

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

Background

Three new codes, 78814, 7881X5 and 78816 have been approved that describe the additional physician work and practice expense of performing PET imaging with the concomitant acquisition of data that is used for attenuation correction and anatomic localization. Anatomic localization, also known as PET-CT fusion, provides highly accurate anatomic localization of foci of abnormal uptake on PET imaging. The additional physician work associated with PET-CT fusion includes not only the recognition of the anatomic areas of abnormal uptake but more importantly the ability to localize disease in anatomically normal lymph nodes and solid organs that can be problematic in comparison of PET images to CT studies without anatomic fusion. Additionally, anatomic abnormalities that are not associated with abnormal uptake must be recognized, and as such the anatomic localization data must be reviewed and evaluated by the physician even in the absence of abnormal uptake on PET imaging. It must be noted that the typical CT data acquired as part of the PET-CT examination is not of similar diagnostic quality to standard CT examinations as slice thickness tends to be greater and oral and IV contrast are typically not administered as this may interfere with the attenuation correction process.

Evaluation of the Survey Data

The RUC committees of the ACR and the SNM reviewed the survey results and believe that the median RVU values of 2.40 RVU for 78814, 2.73 RVU for 7881X5 and 3.00 for 78816. These are supported by the higher survey times compared to PET imaging alone for each of the codes. Using the median values from the survey data, the respondents considered the additional physician work of CT localization over PET imaging alone to be 0.6 RVU for 78814, 0.73 RVU for 7881X5 and 0.9 RVU for 78816. This incremental increase is explained by the progressive increase in volume of the CT data that must be reviewed for each code. 78814 requires review of CT data from one body area, 7881X5 requires review of CT data from 4 body areas and 78816 requires review of CT data from 6 body areas. The survey respondents indicated that there is an increase in the pre-service, intra-service, and post-service time required for interpretation of the PET-CT studies. They are 20 minutes for 78814, 15 minutes for 7881X5 and 20 minutes for 78816, which supports the additional physician work RVUs for this family of codes.

Comparison to the Reference Service and Other RUC Surveyed Imaging Codes

Most respondents chose 78810 as the reference service, and the issues surrounding the changing service since 1994 are described in the rationale for 78811 through 7881X3 and will not be repeated here. As before, some respondents chose codes other than 78810 as their key reference service. As noted in the rationale for the PET codes, CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes and 20 minutes intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 78811, 13 additional minutes for 7881X2, and 18 additional minutes for 7881X3. Comparison to 93312 provides a cross-specialty comparison for an imaging code not used by radiology. Code 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) was surveyed by the RUC in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the

probe in the esophagus but otherwise, and the recommended values for the PET-CT codes compare favorably with this code as well.

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.

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) : 78810, G0125, G0210-G0222, G0224-G0234, G0236, G0252-G0254, G0296

Specialty: Radiology

Specialty	How often?
-----------	------------

Specialty: Radiology	Frequency 7,000	Percentage 70 %
----------------------	-----------------	-----------------

Specialty: Nuclear Medicine Frequency 3,000 Percentage 30 %

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
4,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty: Radiology Frequency 2,800 Percentage 70 %

Specialty: Nuclear Medicine	Frequency 1,200	Percentage 30 %
-----------------------------	-----------------	-----------------

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

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:78815 Tracking Number: AS5 Global Period: XXX	Recommended Work Relative Value
	Specialty Society RVU: 2.44
	RUC RVU: 2.44

CPT Descriptor:

Tumor imaging, positron emission tomography (PET) with concurrently acquired CT for attenuation correction and anatomical localization; skull base to mid-thigh

(Report 78811-78816 only once per imaging session)

(CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site specific CT code with modifier 59)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old woman with colon carcinoma, has had a right hemicolectomy, radiation and chemotherapy, is asymptomatic but now has rising CEA tumor markers. A PET-CT scan from skull base to mid thigh is performed to assess tumor recurrence and document precise anatomic distribution.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 6%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the acquisition of CT data in the areas of interest. The physician supervises the technologist in the acquisition and reconstruction of the PET data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The interpreting physician, using a computer workstation, creates or directly supervises the creation of composite images for anatomic correlation by precisely overlying PET and CT images. The physician reviews 3 sets of images - emission PET scans, the CT anatomical localization data, and a fusion of the two images which contain the PET and CT data anatomically superimposed over each other. PET images are interpreted by the physician and correlated with the CT localization data obtained as well as to relevant prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	Bibb Allen, Jr., M.D. (ACR), Kenneth McKusick, M D. (SNM)					
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)					
CPT Code:	78815					
Sample Size:	450	Resp n:	49	Response: 10.88 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		1.40	2.44	2.73	3.93	11.01
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Pre-Service Time:				15.0		
Intra-Service Time:		5.00	26.00	35.00	50.00	100.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	15.00					
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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 26 % of respondents: 53.0 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78815	Key Reference CPT Code: 78810
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	35.00	68.00
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	70.00	68.00 (RUC Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.04	3.81
Urgency of medical decision making	3.19	3.31

Technical Skill/Physical Effort (Mean)

Technical skill required	3.65	3.65
Physical effort required	2.15	2.31

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.28	3.00
Outcome depends on the skill and judgment of physician	4.08	3.92
Estimated risk of malpractice suit with poor outcome	3.23	3.35

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.24	3.44
Intra-Service intensity/complexity	4.20	3.92
Post-Service intensity/complexity	3.44	3.52

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.*

Background

Three new codes, 7881X4, 78815 and 78816 have been approved that describe the additional physician work and practice expense of performing PET imaging with the concomitant acquisition of data that is used for attenuation correction and anatomic localization. Anatomic localization, also known as PET-CT fusion, provides highly accurate anatomic localization of foci of abnormal uptake on PET imaging. The additional physician work associated with PET-CT fusion includes not only the recognition of the anatomic areas of abnormal uptake but more importantly the ability to localize disease in anatomically normal lymph nodes and solid organs that can be problematic in comparison of PET images to CT studies without anatomic fusion. Additionally, anatomic abnormalities that are not associated with abnormal uptake must be recognized, and as such the anatomic localization data must be reviewed and evaluated by the physician even in the absence of abnormal uptake on PET imaging. It must be noted that the typical CT data acquired as part of the PET-CT examination is not of similar diagnostic quality to standard CT examinations as slice thickness tends to be greater and oral and IV contrast are typically not administered as this may interfere with the attenuation correction process.

Evaluation of the Survey Data

The RUC committees of the ACR and the SNM reviewed the survey results and believe that the median RVU values of 2.40 RVU for 7881X4, 2.73 RVU for 78815 and 3.00 for 78816. These are supported by the higher survey times compared to PET imaging alone for each of the codes. Using the median values from the survey data, the respondents considered the additional physician work of CT localization over PET imaging alone to be 0.6 RVU for 7881X4, 0.73 RVU for 78815 and 0.9 RVU for 78816. This incremental increase is explained by the progressive increase in volume of the CT data that must be reviewed for each code. 7881X4 requires review of CT data from one body area, 78815 requires review of CT data from 4 body areas and 78816 requires review of CT data from 6 body areas. The survey respondents indicated that there is an increase in the pre-service, intra-service, and post-service time required for interpretation of the PET-CT studies. They are 20 minutes for 7881X4, 15 minutes for 78815 and 20 minutes for 78816, which supports the additional physician work RVUs for this family of codes.

Comparison to the Reference Service and Other RUC Surveyed Imaging Codes

Most respondents chose 78810 as the reference service, and the issues surrounding the changing service since 1994 are described in the rationale for 78811 through 7881X3 and will not be repeated here. As before, some respondents chose codes other than 78810 as their key reference service. As noted in the rationale for the PET codes, CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes and 20 minutes intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 78811, 13 additional minutes for 7881X2, and 18 additional minutes for 7881X3. Comparison to 93312 provides a cross-specialty comparison for an imaging code not used by radiology. Code 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) was surveyed by the RUC in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the probe in the esophagus but otherwise, and the recommended values for the PET-CT codes compare favorably with this code as well.

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) : 78810, G0125, G0210-G0222, G0224-G0234, G0236, G0252-G0254, G0296

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Radiology How often? Commonly

Specialty: Nuclear Medicine How often? Commonly

Specialty	How often?
------------------	-------------------

Estimate the number of times this service might be provided nationally in a one-year period? 85,000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty: Radiology	Frequency 595,000	Percentage 70 %
----------------------	-------------------	-----------------

Specialty: Nuclear Medicine	Frequency 25,5000	Percentage 30 %
-----------------------------	-------------------	-----------------

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 34,000. If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty: Radiology	Frequency 23,800	Percentage 70 %
----------------------	------------------	-----------------

Specialty: Nuclear Medicine Frequency 10,200 Percentage 30 %

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:78816 Tracking Number: AS6 Global Period: XXX	Recommended Work Relative Value Specialty Society RVU: 2.50 RUC RVU: 2.50
--	--

CPT Descriptor:

Tumor imaging, positron emission tomography (PET) with concurrently acquired CT for attenuation correction and anatomical localization; whole body

(Report 78811-78816 only once per imaging session)

(CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site specific CT code with modifier 59)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old woman had a malignant melanoma resected from her scalp 14 months previously, followed by right supraclavicular nodal recurrence eight months later. Imaging studies, including PET were abnormal only in that known recurrence site. She has undergone further resection and is now referred for evaluation of her response to chemotherapy and for whole body restaging. A whole body PET-CT scan is performed

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 9%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, and prior imaging studies. The physician interviews the patient. A decision is made whether the appropriate study has been requested. Physician reviews result of finger stick blood glucose level (included in the procedure). The physician discusses with the technologist patient positioning and other specifics of the examination including hydration, imaging time after injection, need for Foley catheter, etc.

Description of Intra-Service Work: An appropriate dose of radiopharmaceutical is prescribed by the physician. The physician supervises a certified technologist who assays of the dose of the radiopharmaceutical, instructs the patient on the procedure, and in a designated injection room injects the radiopharmaceutical where the patient remains during the uptake period. The physician supervises the acquisition of CT data in the areas of interest. The physician supervises the technologist in the acquisition and reconstruction of the PET data in multiple planes including transmission scans, and for the non-attenuation corrected and attenuation corrected emission scans. The interpreting physician, using a computer workstation, creates or directly supervises the creation of composite images for anatomic correlation by precisely overlying PET and CT images. The physician reviews 3 sets of images - emission PET scans, the CT anatomical localization data, and a fusion of the two images which contain the PET and CT data anatomically superimposed over each other. PET images are interpreted by the physician and correlated with the CT localization data obtained as well as to relevant prior imaging studies. Quantification of an abnormality is made by the calculation of the standardized uptake value (SUV) when clinically indicated. The physician dictates report for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The physician discusses results with referring physician, patient and family. Regulatory review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Bibb Allen, Jr., M.D. (ACR), Kenneth McKusick, M.D. (SNM)				
Specialty(s):	American College of Radiology (ACR), Society of Nuclear Medicine (SNM)				
CPT Code:	78816				
Sample Size:	450	Resp n:	47	Response: 10.44 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.40	2.50	3.00	4.20	12.60
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Pre-Service Time:			15.0		
Intra-Service Time:	5.00	30.00	40.00	50.00	120.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	<u>15.00</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>
78810	XXX	1.93

CPT Descriptor Tumor imaging, positron emission tomography (PET), metabolic evaluation

<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: 49 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 78816	Key Reference CPT Code: 78810
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	40.00	68.00
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	70.00	68.00 (RUC Time)

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

The number of possible diagnosis and/or the number of management options that must be considered	3.82	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.78
Urgency of medical decision making	3.22	3.39

Technical Skill/Physical Effort (Mean)

Technical skill required	3.52	3.52
Physical effort required	2.26	2.43

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.96	2.96
Outcome depends on the skill and judgment of physician	3.96	3.87
Estimated risk of malpractice suit with poor outcome	3.35	3.35

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.35	3.43
Intra-Service intensity/complexity	4.26	3.83
Post-Service intensity/complexity	3.48	3.57

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.*

Background

Three new codes, 78814, 78815 and 78816 have been approved that describe the additional physician work and practice expense of performing PET imaging with the concomitant acquisition of data that is used for attenuation correction and anatomic localization. Anatomic localization, also known as PET-CT fusion, provides highly accurate anatomic localization of foci of abnormal uptake on PET imaging. The additional physician work associated with PET-CT fusion includes not only the recognition of the anatomic areas of abnormal uptake but more importantly the ability to localize disease in anatomically normal lymph nodes and solid organs that can be problematic in comparison of PET images to CT studies without anatomic fusion. Additionally, anatomic abnormalities that are not associated with abnormal uptake must be recognized, and as such the anatomic localization data must be reviewed and evaluated by the physician even in the absence of abnormal uptake on PET imaging. It must be noted that the typical CT data acquired as part of the PET-CT examination is not of similar diagnostic quality to standard CT examinations as slice thickness tends to be greater and oral and IV contrast are typically not administered as this may interfere with the attenuation correction process.

Evaluation of the Survey Data

The RUC committees of the ACR and the SNM reviewed the survey results and believe that the median RVU values of 2.40 RVU for 78814, 2.73 RVU for 78815 and 3.00 for 78816. These are supported by the higher survey times compared to PET imaging alone for each of the codes. Using the median values from the survey data, the respondents considered the additional physician work of CT localization over PET imaging alone to be 0.6 RVU for 78814, 0.73 RVU for 78815 and 0.9 RVU for 78816. This incremental increase is explained by the progressive increase in volume of the CT data that must be reviewed for each code. 78814 requires review of CT data from one body area, 78815 requires review of CT data from 4 body areas and 78816 requires review of CT data from 6 body areas. The survey respondents indicated that there is an increase in the pre-service, intra-service, and post-service time required for interpretation of the PET-CT studies. They are minutes for 78814, 15 minutes for 78815 and 20 minutes for 78816, which supports the additional physician work RVUs for this family of codes.

Comparison to the Reference Service and Other RUC Surveyed Imaging Codes

Most respondents chose 78810 as the reference service, and the issues surrounding the changing service since 1994 are described in the rationale for 78811 through 7881X3 and will not be repeated here. As before, some respondents chose codes other than 78810 as their key reference service. As noted in the rationale for the PET codes, CT angiography of the head and CT angiography neck, valued by the RUC in April 2000 provides an in-specialty comparison using RUC surveyed codes. For example, 70498 (Computed tomographic angiography, neck, without material(s), followed by contrast material(s) and additional images, including image post-processing) has a physician work value of 1.75 RVU with a total time of 37 minutes and 20 minutes intra-service time. The intensity of this service is similar to PET and the higher values for PET are justified by 3 minutes additional time for 78811, 13 additional minutes for 7881X2, and 18 additional minutes for 7881X3. Comparison to 93312 provides a cross-specialty comparison for an imaging code not used by radiology. Code 93312 (Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording, including probe placement, image acquisition, interpretation and report) was surveyed by the RUC in 1996. It has a physician work RVU of 2.20 with 43 minutes total time and intra-service time of 13 minutes. Code 93312 has a higher intensity because the service involves placement of the probe in the esophagus but otherwise, and the recommended values for the PET-CT codes compare favorably with this code as well.

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.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Protein Electrophoresis

The CPT Editorial Panel revised two existing codes and created two additional codes to describe the differing resources required for the analysis of serum, urine and other specimen sources by gel and capillary electrophoresis methods and to differentiate the different electrophoresis techniques (e.g. gel vs. capillary) and procedures for various specimens.

The specialty society has requested to maintain the work relative value units for the revised codes 84165 *Protein, electrophoretic fractionation and quantitation; serum* and 86334 *Immunofixation electrophoresis*, which both currently have a 0.37 work RVUs. In addition the society requests that the work relative value units for the new protein electrophoresis codes (84166 *Protein, electrophoretic fractionation and quantitation; other fluids with concentration (eg, urine, CSF)* and 86335 *Immunofixation electrophoresis; other fluids with concentration (eg, urine, CSF)*) be cross walked to these existing codes (84165 and 86334). The RUC reviewed this request and felt that it was appropriate because this work relative value recommendation is consistent with other laboratory tests, which are billed with a 26 modifier for professional interpretation of services and report. In addition, the professional liability cross walk for the new codes should also be cross walked from the existing codes. **The RUC recommends that the physician times for 84165 (3 minutes of pre-service time, 5 minutes of intra-service time and 5 minutes of post-service time) be cross-walked to 84166 and the time for 86334 (4 minutes of pre-service time, 6 minutes of intra-service time and 5 minutes of post-service time) be cross-walked to 86335. The RUC recommends 0.37 work RVUs for 84165, 84166, 86334, and 86335.**

Practice Expense:

The RUC reviewed the practice expense recommendations for 84165, 84166, 86334 and 86335. The RUC agreed with the specialty society to crosswalk the clinical labor time (8 minutes) from the existing codes to the new codes. However, the RUC felt that these inputs should be interim until the Practice Expense Subcommittee reviews with the specialty society the overall rationale of assigning practice expense inputs to the professional component of the pathology services.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲84165	AU1	Protein, electrophoretic fractionation and quantitation; <u>serum</u>	XXX	0.37
●84166	AU2	other fluids with concentration (eg, urine, CSF)	XXX	0.37
▲86334	AU3	Immunofixation electrophoresis; <u>serum</u>	XXX	0.37
●86335	AU4	other fluids with concentration (eg, urine, CSF)	XXX	0.37



College of American Pathologists
325 Waukegan Road, Northfield, Illinois 60093-2750
800-323-4040 • <http://www.cap.org>

Advancing Excellence

Direct Response To

DIVISION OF GOVERNMENT
AND PROFESSIONAL AFFAIRS
1350 I Street, NW, Suite 590
Washington, DC 20005-3305
202-354-7100 Fax: 202-354-7155
800-392-9994 • <http://www.cap.org>

April 13, 2004

William Rich, MD
Chairman
Relative Value Update Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Dear Dr. Rich:

The College of American Pathologists request that work relative value unit (RVW) for the new protein electrophoresis codes (84166 and 86335) be cross walked to the existing codes 84165 and 86334. Further, we request that the revised 84165 and 86334 retain their current work RVW of 0.37. This RVW is consistent with the RUC approved value of these and other professional interpretation codes. Two new CPT codes were approved at the February CPT Editorial Panel meeting for reporting protein and immunofixation electrophoresis procedures for fluids other than serum with concentration. Also, existing codes 84165 and 86334 were revised to specify analysis of serum.

The revised codes represent a division of an existing code based solely on specimen type which would not affect physician work. These codes are reported primarily under the clinical laboratory fee schedule and the distinction was made in CPT to address differences in these electrophoresis codes for the clinical lab. The Centers for Medicare and Medicaid Services does allow payment under the physician fee schedule for these codes with a 26 modifier for the professional services involved in a pathologist's interpretation and report for protein electrophoresis when necessary. The current 0.37 RVW is consistent with other laboratory tests, which are billed with the 26 modifier for professional interpretation and report. The 0.37 RVW was also recommended for these professional interpretation codes when they were considered by the RUC.

Thank you for your consideration of this request.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen N. Bauer".

Stephen N. Bauer, MD, FCAP
RUC Advisor

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

CPT Long Descriptors:

84165	[Interpretation of] Protein, electrophoretic fractionation and quantitation; serum
84166	[Interpretation of] Protein, electrophoretic fractionation and quantitation; other fluids with concentration (eg, urine, CSF)
86334	[Interpretation of] Immunofixation electrophoresis; serum
86335	[Interpretation of] Immunofixation electrophoresis; other fluids with concentration (eg, urine, CSF)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The recommendations for CPT codes 84165 and 86334 approved by the PEAC were developed by the CAP Practice Expense Work Group (11 pathologists with all geographic and practice arrangements represented). The initial recommendations were submitted for independent review to the members of two other CAP committees. Total review included 28 pathologists.**

The CAP Practice Expense Work Group reviewed the new and revised codes and agreed to crosswalk the direct inputs of the new and revised codes to the existing interpretation codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **The lab tech/histotech assists the pathologist with the interpretation by reviewing the clinical laboratory test results to determine additional information that is needed, obtaining the information from archives, completing the technical information required for the consultation form, entering the new data into the computer, and providing the pathologist with all the data, electrophoretic gel, worksheet and other information.**

Intra-Service Clinical Labor Activities: **None**

Post-Service Clinical Labor Activities: **None**

Supplies and equipment: **None**

Please see attached spreadsheet for labor details.

	A	B	C	D	E	F	G	H
1								
2			CPT Code: 84165		CPT Code: 84166		CPT Code: 86334	
3	Meeting Date RUC 2004, Specialty Society CAP	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Code Descriptor: [Interpretation of] Protein, electrophoretic fractionation and quantitation, serum		Code Descriptor: [Interpretation of] Protein, electrophoretic fractionation and quantitation, other fluids with concentration (eg, unne, CSF)		Code Descriptor: [Interpretation of] Immunofixation electrophoresis, serum	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		XXX		XXX		XXX	
6	TOTAL CLINICAL LABOR TIME	L035A	8.0	0.0	8.0	0.0	8.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L035A	8.0	0.0	8.0	0.0	8.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE							
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) Assist pathologist with the interpretation by reviewing the clinical laboratory test results to determine additional information that is needed, obtaining the information from archives, completing the technical information required on the consultation form, entering the new data into the computer, and providing the pathologist with all the data, electrophoretic gel, worksheet and other information	L035A	8		8		8	
16	End: When specimen is ready for examination by pathologist							
17	SERVICE PERIOD							
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							
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)							
22	Assemble and deliver slides with paperwork to pathologists							
23	Clean room/equipment while performing service							
24	Coordinate care							
25	Other Clinical Activity (please specify)							
26	End: When specimen examination by pathologist is complete							
27	POST-SERVICE Period							
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)							
30	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste							
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							
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)							

	A	B	C	D	E	F	G	H
2			CPT Code: 84165		CPT Code: 84166		CPT Code: 86334	
		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Code Descriptor: [Interpretation of] Protein, electrophoretic fractionation and quantitation, serum		Code Descriptor: [Interpretation of] Protein, electrophoretic fractionation and quantitation, other fluids with concentration (eg, urine, CSF)		Code Descriptor: [Interpretation of] Immunofixation electrophoresis, serum	
3	Meeting Date RUC 2004, Specialty Society CAP							
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
37	MEDICAL SUPPLIES							
38			None		None		None	
39								
40	Equipment							
41			None		None		None	
42								
43								
44								

	A	B	I	J	K
1					
2			CPT Code: 86335		
3	Meeting Date RUC 2004, Specialty Society CAP	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Description: [Interpretation of] Immunofixation electrophoresis, other fluids with concentration (eg, urine, CSF)		
4	LOCATION		Non Facility	Facility	
5	GLOBAL PERIOD		XXX		
6	TOTAL CLINICAL LABOR TIME	L035A	8.0	0.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L035A	8.0	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: 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) Assist pathologist with the interpretation by reviewing the clinical laboratory test results to determine additional information that is needed, obtaining the information from archives, completing the technical information required on the consultation form, entering the new data into the computer, and providing the pathologist with all the data, electrophoretic gel, worksheet and other information	L035A	8		
16	End: When specimen is ready for examination by pathologist.				
17	SERVICE PERIOD				
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				
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)				
22	Assemble and deliver slides with paperwork to pathologists				
23	Clean room/equipment while performing service				
24	Coordinate care				
25	Other Clinical Activity (please specify)				
26	End: When specimen examination by pathologist is complete				
27	POST-SERVICE Period				
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)				
30	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste				
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				
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)				

	A	B	I	J	K
2			CPT Code 86335		
3	Meeting Date RUC 2004, Specialty Society CAP	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Description: [Interpretation, of] Immunofixation electrophoresis, other fluids with concentration (eg, urine, CSF)		
4	LOCATION		Non Facility	Facility	
37	MEDICAL SUPPLIES				
38			None		
39					
40	Equipment				
41			None		
42					
43					
44					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Flow Cytometry

The CPT codes descriptors for CPT codes 88184 – 88189 describing flow cytometry were not finalized until the May 2004 CPT Editorial Panel meeting. Therefore, the RUC was unable to review recommendations for these services at our April 2004 meeting. The RUC anticipates that it will review recommendations for these services at the September 2004 RUC meeting. **The RUC does not submit any recommendations for CPT codes 88184-88189 at this time.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
88180		Flow cytometry; each cell surface, cytoplasmic or nuclear marker	XXX	N/A
• 88184	AV1	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker	XXX	No RUC Recommendation (To be reviewed at the Sept 2004 RUC Meeting)
+ • 88185	AV2	each additional marker (List separately in addition to code for first marker) (Report 88185 in conjunction with 88184)	ZZZ	No RUC Recommendation (To be reviewed at the Sept 2004 RUC Meeting)
• 881872	AV3	Flow cytometry, interpretation; 2 to 8 markers	XXX	No RUC Recommendation (To be reviewed at the Sept 2004 RUC Meeting)
• 88188	AV4	9 to 15 markers	XXX	No RUC Recommendation (To be reviewed at the Sept 2004 RUC Meeting)
• 88189	AV5	16 or more markers	XXX	No RUC Recommendation (To be reviewed at the Sept 2004 RUC Meeting)

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

In Situ Hybridization (eg FISH) Procedures

The specialty society responsible for developing work relative value recommendations for the CPT codes describing in situ hybridization was unable to identify physicians who had a familiarity with these procedures resulting in an inaccurate low response rate. Therefore, the RUC was unable to review recommendations for these services at our April 2004 meeting. The RUC anticipates that it will review recommendations for these services at the September 2004 RUC meeting. **The RUC does not submit any recommendations for CPT codes 88360, 88361, 88365, 88367 and 88368 at this time.**

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 88360	AW1	<u>Morphometric analysis</u> , tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; <u>manual</u>	XXX	No RUC Recommendation (To be reviewed at the Sept 2004 RUC Meeting)
●88361	AW2	using computer assisted technology (Do not report 88360 or 88361 with 88342 unless each procedure is for a different antibody) (For morphometric analysis, in situ hybridization, see 88367, 88368)	XXX	No RUC Recommendation (To be reviewed at the Sept 2004 RUC Meeting)

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲88365	AW3	Tissue In situ hybridization (eg, FISH), interpretation and report <u>each probe</u> (Do not report 88365 in conjunction with 88367 or 88368 for the same probe)	XXX	No RUC Recommendation (To be reviewed at the Sept 2004 RUC Meeting)
●88367	AW4	Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; using computer-assisted technology	XXX	No RUC Recommendation (To be reviewed at the Sept 2004 RUC Meeting)
●88368	AW5	manual	XXX	No RUC Recommendation (To be reviewed at the Sept 2004 RUC Meeting)

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	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	0.17	7	90471
90466	each additional vaccine	0.15	7	90472
90467	Immunization administration under age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day	0.17	7	90473
90468	each additional vaccine	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 <u>90468</u> 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></p> <p><i>(For allergy testing, see 95004 et seq)</i></p> <p><i>(For skin testing of bacterial, viral, fungal extracts, see 86485-86586)</i></p> <p><i>(For therapeutic or diagnostic injections, see 901782-90799)</i></p>				
●90465	N5	<p>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</p> <p><u>(Do not report 90465 in conjunction with 90467)</u></p>	XXX	0.17
+●90466	N6	<p>each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)</p> <p><u>(Use 90466 in conjunction with 90465 or 90467)</u></p>	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, <u>and</u> intramuscular and jet injections); 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	<p>each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)</p> <p>(Use 90474 in conjunction with <u>90471</u> or 90473)</p>	ZZZ	<p>0.15</p> <p>(Previous RUC Recommendation)</p>

9047X1-9047X4 January 2004 RUC									
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
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
PRE-SERVICE									
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									
SERVICE PERIOD									
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
Intra-service									
Assist physician in performing procedure									
Draw up serum, administer vaccine	L042A	2	0	2	0	2	0	2	0
Post-Service									
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									
POST-SERVICE PERIOD									
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		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Conduct phone calls between office visits									
Other Activity (please specify)									
End: with last office visit before end of global period									

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.

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.

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
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 and/or intranasal or oral administration); 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 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	two or more <u>each additional vaccine</u> (single or combination vaccine/toxoid) (List 90472 in conjunction with 90471)	ZZZ	.15

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 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):

1999 RVW	Global	CPT	Descriptor
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
Time Estimates (Median)			
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
Mental Effort and Judgment			
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
Technical Skill/physical Effort			
Technical skill required	2.29	1.86	3.10
Physical effort required	2.11	1.57	2.60
Psychological Stress			
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	1.83	3.40
Time Segments			
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

Survey RVW	Low: 0.12	25th%: 0.17	Med: 0.18	75th%: 0.33	High: 0.88
-------------------	-----------	-------------	------------------	-------------	------------

Survey Total Time	Low: 3	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

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

	<i>Mean</i> Intensity/Complexity Measures		
	90472	94010	N/A*
Time Estimates (Median)			
PRE-service time	n/a	n/a	--
INTRA-service time (TOTAL time for XXX global)	7	6	--
POST-service time	n/a	n/a	--
Mental Effort and Judgment			
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	--
Technical Skill/physical Effort			
Technical skill required	2.23	1.83	--
Physical effort required	2.13	1.50	--
Psychological Stress			
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	--
Time Segments			
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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2004

Gastroesophageal Reflux Procedures and Esophagus – GE Junction Impedance Test

Work Recommendations

CPT created four new codes and deleted two existing codes to describe a new method of monitoring intra-esophageal pH levels. This new technology is a telemetry-based system for measuring acid reflux involving the placement of a monitoring capsule that is temporarily inserted and attached to the patient's esophagus. The capsule monitors the presence of acid and transmits pH levels via radiofrequency telemetry to an external receiver that the patient wears for up to 72 hours. Current codes do not accurately describe this procedure.

The RUC voted that this family of codes should have a 000 day global period rather than an XXX global period requested by the presenters. The RUC was unconvinced that the codes included physician intra-service work for the placing of the catheter and concluded that this is included in the clinical staff work for three of the four codes. For these codes, 91034, 91037, and 91038, only pre-service and post-service physician work should be included in the value of the code.

91034 and 91037

The RUC identified other codes that would serve as a proxy for the pre and post service work for codes 91034 *Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation* and 91037, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation*. The RUC agreed that the preservice work for all four codes under review was equivalent to a 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= .45; total time=15 minutes). The post service work was equated to the physician interpretation work associated with code 93224 *Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation* (work RVU= .52; total time 16 minutes). Therefore, the recommended RVU and physician time would be a combination of the values from these two reference codes (.45 + .52 = .97 and 15 minutes + 16 minutes = 31 minutes).

The RUC recommends a work RVU of .97 and total physician time of 31 minutes for codes 91034 and 91037

91038

For code 91038 *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* a slightly higher value is warranted since it describes prolonged monitoring. The RUC agreed that an extra 10 minutes of monitoring time is typically needed for this procedure. The value assigned was determined to be 25% of the value of the reference code used previously for the post service work, code 93224 ($.25 \times .52\text{rvu} = .13$). The total value would be $.97 + .13 = 1.10$.

The RUC recommends a work value of 1.10 and total physician time of 41 minutes for code 91038.

91035

For code 91035 *Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation* the RUC agreed that the physician typically places the catheter and therefore this code should include a physician work value reflecting this activity. The pre and post service work for this code is the same as codes 91034 and 91037 for a total work RVU of .97. The RUC concluded that the intra-service work time should equal 20 minutes as the survey results indicated and the intensity would be equivalent to E/M intensity at .031 for an RVU of .62 ($20 \times .031$).

The RUC recommends a work RVU of 1.59 and total physician time of 51 minutes for code 91035.

Practice Expense

The RUC revised the practice expense direct inputs by reducing the clinical labor times for certain activities to better reflect current standards.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
91032		Esophagus, acid reflux test, with intraluminal pH electrode for detection of gastroesophageal reflux;	000	N/A
91033		prolonged recording (91032 and 91033 have been deleted. To report, see 91034 or 91035)	000	N/A
●91034	O1	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation	000	0.97
●91035	O2	with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	000	1.59
●91037	O3	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;	000	0.97
●91038	O4	prolonged (greater than 1 hour, up to 24 hours)	000	1.10

AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
Non-Facility and Facility Direct Inputs

CPT	DESCRIPTION	GLOBAL
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation	XXX
91035	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	XXX
91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;	XXX
91038	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)	XXX

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

A consensus committee of representatives of the American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) jointly prepared the details for direct inputs for these services.

SUPPLIES AND EQUIPMENT:

Supplies and equipment necessary on the day of service and for post-op visits are indicated on the spreadsheet. New item pricing and instrument pack details are shown below.

New Supply Items:

<u>phix strips</u>					
Sources					Unit Price
Medtronic (9012D1031)	quote	50	item	70.00	1.400

<u>sensor, pH capsule (Bravo)</u>					
Sources					Unit Price
Medtronic (9012B1011)		5	item	1125.00	225.000

<u>viscous swallow challenge medium</u>					
Sources					Unit Price
Sandhill	email	12	item	240.00	20.000

New Equipment Items:

<u>pH ambulatory recorder (Digitrapper)</u>	
Medtronic (5143G0202)	\$ 6,900

<u>pH ambulatory recording workstation w-software (Digitrapper)</u>	
Medtronic (9043A0161 and 9043S0421)	\$ 11,490

<u>pH ambulatory recorder (Bravo)</u>	
Medtronic (9043K0102)	6900

<u>pH ambulatory recording workstation w-software (Bravo)</u>	
Medtronic (9043A0161 and 9043S0421)	\$ 11,490

<u>vacuum pump, for Bravo system</u>	
Medtronic	\$ 990

<u>catheter, multi-channel, with impedance sensors</u>	
Sandhill (Konigsberg)	\$ 13,465

<u>impedance recording workstation w-software</u>	
Sandhill (InSight)	\$ 36,805

CPT Code: 91034

Tracking No: 01

Global: 000 XXX

Recommended RVW: .97

Specialty Recommendation: 1-30

Descriptor: Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement recording, analysis and interpretation

Vignette Used in Survey:

A 54-year-old woman presents with a three-year history of heartburn, regurgitation and throat soreness. She has no dysphagia, weight loss, or GI bleeding. She has not improved with over the counter medications. Her diagnostic testing, including an upper GI and esophagogastroduodenoscopy (EGD), was normal. She is suspected to have GERD and was placed on pharmacological agents with initial improvement, but continues to have breakthrough regurgitation symptoms despite adjusting pharmacological management.

Percentage of Survey Respondents who found Vignette to be Typical: 93% of the respondents indicated vignette to be typical. 7% of the respondents indicated their patients would be pediatric.

Clinical Description Of Service:

Pre-procedure:

- Review patient history, including prior studies
- Explain procedure and its purpose to the patient
- Counsel patient to maintain normal activity and food consumption during the test
- Answer patient questions and obtain informed consent
- Verify that all necessary instruments and supplies are readily available
- Supervise patient positioning and prepping

Procedure:

Following nasal spray administration of 2% xylocaine, a thin plastic catheter is passed through one nostril, down the back of the throat, and into the esophagus as the patient swallows. The tip of the catheter contains a sensor that is positioned in the esophagus so that it is just above the lower esophageal sphincter. In this position the sensor records each reflux of acid. The catheter protruding from the nose is connected to a recorder that registers each reflux of acid.

The patient is counseled again to go about his or her usual activities, for example, eating, sleeping, and working. Meals, periods of sleep, and symptoms are recorded by the patient in a diary and/or by pushing buttons on the recorder. The patient is discharged with the catheter and recorder in place. The patient returns to the site of service, typically the next day, and the catheter is removed.

Post-procedure:

- *[Staff will download the recorder data into a computer, where it is summarized and put into graphic form.]* The computer tracings are analyzed by the physician for the presence of acid pH in the distal esophagus and correlation with symptoms as recorded by the patient.
 - Treatment recommendations and decisions are made based on the data, including the potential need for additional medical, pharmacologic, endoscopic, and/or surgical intervention.
 - Report and outcome letter is dictated for referring physician and/or insurance company
-

SURVEY DATA

Presenter(s):	Joel Brill, MD (AGA) Michael Levy, MD (ASGE)				
Specialty(s):	American Gastroenterological Association (AGA) American Society for Gastrointestinal Endoscopy (ASGE)				
CPT Code:	91034				
Sample Size:	200	Resp n:	28	Resp %:	14%
Sample Type:	Random				
	Low	25th pctl	Median	75th pctl	High
Survey RVW:	1.00	1.29	1.29	1.49	6.00
Pre-Procedure Time:			15		
Procedure Time:	2	10	0	20	30
Post-Procedure Time:			16		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	new '04 RVW	Glob
91033	Esophagus, acid reflux test, with intraluminal pH electrode for detection of gastroesophageal reflux; prolonged recording	1.30	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 91034	Ref CPT 91033
Pre-service	15	
Intra-service	0	40
Same Day Immediate Post-service	16	
TOTAL TIME	31	40

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below	23	23
--	----	----

TIME SEGMENTS

Pre-service	2.76	2.74
Intra-service	3.10	2.94
Post-service	3.00	2.89

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.11
Urgency of medical decision making	2.36	2.56

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.18	3.28
Physical effort required	2.30	2.22

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	1.95	1.78
Outcome depends on the skill and judgment of physician	3.27	3.39
Estimated risk of malpractice suit with poor outcome	2.09	2.00

ADDITIONAL RATIONALE

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

Esophageal pH electrode monitoring is a diagnostic procedure involving the placement of an indwelling electrode into the lower esophagus, to determine the presence of gastric reflux and to measure abnormal esophageal acid exposure. In current practice, ambulatory esophageal pH-monitoring typically occurs over a 24 hour period. Because this service extends beyond the definition of a 000-day global period, we are recommending that an XXX global period assigned for 91034. This global period is consistent with other diagnostic procedures that involve ambulatory monitoring. We note that the original Harvard Phase 3 data shows that 91032 and 91033 were studied as XXX-global services. For some unknown reason, the global periods for these codes were reassigned by CMS to 000-day between the Phase 3 report and the first Medicare fee schedule publication. However, we believe that XXX is a more correct global period and recommend that new code 91034 be assigned an XXX global period.

New code 91034 replaces codes 91032 and 91033. Historically, code 91033 has a reported frequency that is significantly greater than 91032. Code 91033 was chosen by 23 of the 28 respondents as the best reference code. In current practice, monitoring typically occurs over a 24 hour period corresponding with 91033 or "prolonged."

We are recommending the survey median RVW of 1.30 for 91034, which is the same value as 91033. We would, however, like to note that 91033 was valued at 1.80 in the 1992 MFS, and was reduced to 1.30 by the RUC in 1995 during the first five year review. The rationale to accept the CMD's recommendation to decrease the value for this code included the fact that the CMDs believed the work of 91033 was not different than 36489 which had an RVW of 1.22 in 1995. Subsequent to that decision, 36489 went through the second five year review and was increased to 2.50, a value that was maintained by the RUC after the recent CPT revisions to the central venous access codes. Although, we do not believe the intensity of 91034 is equal to 36489, we disagree that the intensity should be less than half of an evaluation and management service (see Table 1). However, because CPT revision of this code is outside a five-year review, we will recommend that the RVW of 1.30 for 91033 be maintained for 91034.

Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? **NO**
2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. **N/A**

FREQUENCY INFORMATION**How was this service previously reported**

91032 Esophagus, acid reflux test, with intraluminal pH electrode for detection of gastroesophageal reflux;

91033 Esophagus, acid reflux test, with intraluminal pH electrode for detection of gastroesophageal reflux; prolonged recording

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

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: It is estimated that 50,000-60,000 acid reflux studies are performed annually, where the percentage for each new/revised code is as follows: 91034, 50%; 91035, 38%; 91037, 3%; 91038, 9%

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: It is estimated each new/revised code will have Medicare frequency as follows:
91034, 8500; 91035, 6500; 91037, 500; 91038, 1500

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

CPT Code: 91035

Tracking No: 02

Global: 000 XXX

Recommended RVW: 1.59

Specialty Recommendation: 1-50

Descriptor: Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation

Vignette Used in Survey:

A 40-year-old man presents with severe chest pain. A thorough cardiac evaluation suggested no cardiac abnormality. The patient was placed on pharmacological agents, but symptoms have persisted. An esophagogastroduodenoscopy (EGD) revealed mild distal esophageal erythema, otherwise unremarkable..

Percentage of Survey Respondents who found Vignette to be Typical: 93% of the respondents indicated vignette to be typical. 7% of the respondents indicated their patients would be pediatric.

Clinical Description Of Service:

Pre-procedure:

- Review patient history, including prior studies
- Explain procedure and its purpose to the patient
- Counsel patient to maintain normal activity and food consumption during the test
- Answer patient questions and obtain informed consent
- Verify that all necessary instruments and supplies are readily available
- Supervise patient positioning and prepping

Procedure:

Following administration of 2% xylocaine, a capsule that contains an acid sensing probe, a battery, and a transmitter is introduced into the esophagus on a catheter through the nose or mouth and is attached to the lining of the esophagus with a clip. The catheter then is detached from the capsule and removed.

The patient is counseled again to go about his or her usual activities, for example, eating, sleeping, and working. Meals, periods of sleep, and symptoms are recorded by the patient in a diary and/or by pushing buttons on the recorder. The patient is discharged with a recorder in place. The patient returns to the site of service, typically the next day, to return the recorder. [Note: The capsule can transmit for two days, and then the battery dies. Five to seven days later, the capsule falls off and is passed in the stool.]

Post-procedure:

- *[Staff will download the recorder data into a computer, where it is summarized and put into graphic form.]* The computer tracings are analyzed by the physician for the presence of acid pH in the distal esophagus and correlation with symptoms as recorded by the patient.
 - Treatment recommendations and decisions are made based on the data, including the potential need for additional medical, pharmacologic, endoscopic, and/or surgical intervention.
 - Report and outcome letter is dictated for referring physician and/or insurance company
-

SURVEY DATA

Presenter(s):	Joel Brill, MD (AGA) Michael Levy, MD (ASGE)				
Specialty(s):	American Gastroenterological Association (AGA) American Society for Gastrointestinal Endoscopy (ASGE)				
CPT Code:	91035				
Sample Size:	200	Resp n:	28	Resp %:	14%
Sample Type:	Random				
	Low	25th pctl	Median	75th pctl	High
Survey RVW:	1.00	1.50	2.00	2.46	3.23
Pre-Procedure Time:			15		
Procedure Time:	2	13	20	20	30
Post-Procedure Time:			16		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	new '04 RVW	Glob
91033	Esophagus, acid reflux test, with intraluminal pH electrode for detection of gastroesophageal reflux; prolonged recording	1.30	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 91034	Ref CPT 91033
Pre-service	15	
Intra-service	20	40
Post-service	16	
TOTAL TIME	51	40

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below	14	14
--	----	----

TIME SEGMENTS

Pre-service	2.91	2.64
Intra-service	3.64	3.18
Post-service	3.09	2.73

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.31	3.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.23
Urgency of medical decision making	2.38	2.31

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.54	3.23
Physical effort required	2.69	2.38

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.62	2.23
Outcome depends on the skill and judgment of physician	3.54	3.31
Estimated risk of malpractice suit with poor outcome	2.54	2.23

ADDITIONAL RATIONALE

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

Esophageal pH telemetry monitoring is a diagnostic procedure involving the attachment of a capsule electrode into the lower esophagus, to determine the presence of gastric reflux and to measure abnormal esophageal acid exposure. In current practice, ambulatory esophageal pH-monitoring typically occurs over a 24 hour period. The capsule battery life is currently 48 hours. Because this service extends beyond the definition of a 000-day global period, we are recommending that an XXX global period assigned for 91035. This global period is consistent with other diagnostic procedures that involve ambulatory monitoring.

We are recommending the survey 25th percentile RVW of 1.50 for 91035. This value is slightly higher than 91034 to accounts for additional skill in placement of the sensor. We note that the IWPUT is less than an evaluation and management service.

Services Reported with Multiple CPT Codes

1. Is this new/revised code **typically** reported on the same date with other CPT codes? **NO**
2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. **N/A**

FREQUENCY INFORMATION**How was this service previously reported**

91299 Unlisted diagnostic gastroenterology 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: gastroenterology

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: It is estimated that 50,000-60,000 acid reflux studies are performed annually, where the percentage for each new/revised code is as follows: 91034, 50%; 91035, 38%; 91037, 3%; 91038, 9%

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: It is estimated each new/revised code will have Medicare frequency as follows:
91034, 8500; 91035, 6500; 91037, 500; 91038, 1500

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

CPT Code: 91037 **Tracking No:** O3 **Global:** 000 XXX **Recommended RVW:** .97
Specialty Recommendation: 1.50

Descriptor: Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;

Vignette Used in Survey:

A 56-year-old female is referred for evaluation of difficulty in swallowing and heartburn. The patient has tried a variety of pharmacologic agents without relief of symptoms.

Percentage of Survey Respondents who found Vignette to be Typical: 89% of the respondents indicated vignette to be typical. 11% of the respondents indicated their patients would be pediatric.

Clinical Description Of Service:

Pre-procedure:

- Review patient history, including prior studies
- Explain procedure and its purpose to the patient
- Answer patient questions and obtain informed consent
- Verify that all necessary instruments and supplies are readily available
- Supervise patient positioning and prepping

Procedure:

Following nasal spray administration of xylocaine, a multi-channel catheter with impedance sensors is inserted via the nose to a depth of 60cm. The patient was allowed some time to accommodate the catheter. The catheter's distal impedance sensor is then positioned 5cm above the LES. The patient is instructed to perform 10 swallows of 5 ml saline material at 20-30 second intervals. Time and impedance measurements are taken as the bolus material moves through the esophagus into the stomach. The patient is then instructed to perform 10 swallows of 5 ml viscous material at 20-30 second intervals. Time and impedance measurements are recorded as the bolus material moved through the esophagus into the stomach. At the conclusion of the procedure, the catheter is withdrawn and the patient discharged to home.

Post-procedure:

- The physician reviews the data, analyzing the bolus transit parameters and assessing for completeness of bolus transit for all swallows.
 - Treatment recommendations and decisions are made based on the data, including the potential need for additional medical, pharmacologic, endoscopic, and/or surgical intervention.
 - Report and outcome letter is dictated for referring physician and/or insurance company
-

SURVEY DATA

Presenter(s):	Joel Brill, MD (AGA) Michael Levy, MD (ASGE)				
Specialty(s):	American Gastroenterological Association (AGA) American Society for Gastrointestinal Endoscopy (ASGE)				
CPT Code:	91037				
Sample Size:	110	Resp n:	19	Resp %:	17%
Sample Type:	Random - response rate low due to low initial volume with new procedure				
		Low	25th pctl	Median	75th pctl
Survey RVW:		1.24	1.50	1.80	2.20
Pre-Procedure Time:				15	
Procedure Time:		2	15	0	30
Post-Procedure Time:				16	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	new '04 RVW	Glob
91010	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study;	1.25	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 91037	Ref CPT 91010
Pre-service	15	
Intra-service	0	36
Post-service	16	
TOTAL TIME	31	36

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below	6	6
--	---	---

TIME SEGMENTS

Pre-service	2.00	2.20
Intra-service	3.00	3.00
Post-service	3.00	2.50

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	3.00
Urgency of medical decision making	2.00	2.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.20	3.00
Physical effort required	1.80	1.80

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	1.80	1.80
Outcome depends on the skill and judgment of physician	3.40	3.20
Estimated risk of malpractice suit with poor outcome	1.80	1.80

ADDITIONAL RATIONALE

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

The procedure component of 91037 is typically performed in one day (ie, not ambulatory monitoring). However, the analysis of the results is often done on a different (later) day. Similar to the other new/revised codes being presented in this family (91034, 91035, 91038), we recommend that this service be assigned an XXX global period because the post-procedure work is most typically performed outside the definition of the 000-day global period.

Traditional prolonged pH monitoring involves placing a pH catheter, which is connected to a data recording device, in the patient's esophagus, however, the pH catheter monitors only acid reflux patterns which are correlated to symptoms suggestive of gastroesophageal reflux. Approximately 25% of reflux is nonacid. Gastroesophageal reflux impedance testing monitors all reflux, both acid and nonacid. The impedance modality is used to provide comprehensive definition of all reflux regardless of acidity. Nonacid reflux is associated with symptoms such as chest pain, regurgitation, cough, asthma, laryngitis, wheezing, and recurrent pneumonia in patients. Impedance is a **new technology** providing information that, in combination with manometric and pH information, will allow better care of patients.

We are recommending the survey 25th percentile RVW of 1.50 for 91037. This value correctly places this new code above 91010 and 91034 and the same as 91037. We note that the IWPUT is significantly less than an evaluation and management service.

Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? **NO**
 2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. **N/A**
-

FREQUENCY INFORMATION

How was this service previously reported

91299 Unlisted diagnostic gastroenterology 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: gastroenterology 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: It is estimated that 50,000-60,000 acid reflux studies are performed annually, where the percentage for each new/revised code is as follows: 91034, 50%; 91035, 38%; 91037, 3%; 91038, 9%

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: It is estimated each new/revised code will have Medicare frequency as follows:
91034, 8500; 91035, 6500; 91037, 500; 91038, 1500

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

CPT Code: 91038 **Tracking No:** O4 **Global:** 000 XXX **Recommended RVW:** 1.10
Specialty Recommendation: 1-95

Descriptor: Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)

Vignette Used in Survey:

The patient is a 44-year-old male with a complaint of frequent heartburn. The patient has tried a variety of pharmacologic agents without relief of symptoms. An esophagogastroduodenoscopy (EGD) was unremarkable. An esophageal pH test failed to elucidate the etiology of the patient's symptoms.

Percentage of Survey Respondents who found Vignette to be Typical: 89% of the respondents indicated vignette to be typical. 11% of the respondents indicated their patients would be pediatric.

Clinical Description Of Service:

Pre-procedure:

- Review patient history, including prior studies
- Explain procedure and its purpose to the patient
- Counsel patient to maintain normal activity and food consumption during the test
- Answer patient questions and obtain informed consent
- Verify that all necessary instruments and supplies are readily available
- Supervise patient positioning and prepping

Procedure:

Following nasal spray administration of 2% xylocaine, a multi-channel catheter with impedance sensors is inserted via the nose to a depth of 60cm. After the catheter is positioned, it is taped securely at the nares to prevent movement over the prolonged monitoring period. The patient is then instructed in the usage of a recording device to monitor symptom occurrences, body position and meal periods. After completing the patient instructions, the recording is started and the patient discharged from the laboratory. The patient is instructed to keep a log book of symptoms. Upon completion of the monitoring period, the patient returns to the lab, the catheter is withdrawn and the patient is discharged.

Post-procedure:

- *[Staff will download the recorder data into a computer, where it is summarized.]* The computer summary is analyzed by the physician considering correlations with symptoms as recorded by the patient..
 - Treatment recommendations and decisions are made based on the data, including the potential need for additional medical, pharmacologic, endoscopic, and/or surgical intervention.
 - Report and outcome letter is dictated for referring physician and/or insurance company
-

SURVEY DATA

Presenter(s):	Joel Brill, MD (AGA) Michael Levy, MD (ASGE)				
Specialty(s):	American Gastroenterological Association (AGA) American Society for Gastrointestinal Endoscopy (ASGE)				
CPT Code:	91037				
Sample Size:	110	Resp n:	19	Resp %:	17%
Sample Type:	Random - response rate low due to low initial volume with new procedure				
		Low	25th pctl	Median	75th pctl
Survey RVW:		1.29	1.50	1.95	2.40
Pre-Procedure Time:				15	
Procedure Time:		10	15	0	20
Post-Procedure Time:				26	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	new '04 RVW	Glob
91033	Esophagus, acid reflux test, with intraluminal pH electrode for detection of gastroesophageal reflux; prolonged recording	1.30	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 91038	Ref CPT
Pre-service	15	
Intra-service	0	40
Post-service	26	
TOTAL TIME	41	40

INTENSITY/COMPLEXITY MEASURES (MEAN)

Response count for mean measures shown below	9	9
--	---	---

TIME SEGMENTS

Pre-service	2.43	2.00
Intra-service	3.29	2.86
Post-service	4.00	3.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.57	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	3.00
Urgency of medical decision making	2.43	2.14

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.29	3.14
Physical effort required	2.29	2.29

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	1.43	1.43
Outcome depends on the skill and judgment of physician	3.71	3.29
Estimated risk of malpractice suit with poor outcome	1.86	1.71

ADDITIONAL RATIONALE

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

The components of 91038 typically occur over a 24 hour period. Similar to the other new/revised codes being presented in this family (91034, 91035, 91037), we recommend that this service be assigned an XXX global period because the post-procedure work is most typically performed outside the definition of the 000-day global period.

Traditional prolonged pH monitoring involves placing a pH catheter, which is connected to a data recording device, in the patient's esophagus, however, the pH catheter monitors only acid reflux patterns which are correlated to symptoms suggestive of gastroesophageal reflux. Approximately 25% of reflux is nonacid. Gastroesophageal reflux impedance testing monitors all reflux, both acid and nonacid. The impedance modality is used to provide comprehensive definition of all reflux regardless of acidity. Nonacid reflux is associated with symptoms such as chest pain, regurgitation, cough, asthma, laryngitis, wheezing, and recurrent pneumonia in patients. Impedance is a new technology providing information that, in combination with manometric and pH information, will allow better care of patients.

We are recommending the survey median RVW of 1.95 for 91038. This value correctly places this new code above 91010, 91034-X2. We note that the IWP/UT is similar to an evaluation and management service.

Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? **NO**
 2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. **N/A**
-

FREQUENCY INFORMATION**How was this service previously reported**

91299 Unlisted diagnostic gastroenterology 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: gastroenterology ~~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: It is estimated that 50,000-60,000 acid reflux studies are performed annually, where the percentage for each new/revised code is as follows: 91034, 50%; 91035, 38%; 91037, 3%; 91038, 9%

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: It is estimated each new/revised code will have Medicare frequency as follows:
91034, 8500; 91035, 6500; 91037, 500; 91038, 1500

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

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
Non-Facility and Facility Direct Inputs**

CPT	DESCRIPTION	GLOBAL
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation	XXX
91035	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	XXX
91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;	XXX
91038	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)	XXX

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

A consensus committee of representatives of the American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) jointly prepared the details for direct inputs for these services.

SUPPLIES AND EQUIPMENT:

Supplies and equipment necessary on the day of service and for post-op visits are indicated on the spreadsheet. New item pricing and instrument pack details are shown below.

New Supply Items:

phix strips					
Sources					Unit Price
Medtronic (9012D1031)	quote	50	item	70.00	1.400

sensor, pH capsule (Bravo)					
Sources					Unit Price
Medtronic (9012B1011)		5	item	1125.00	225.000

viscous swallow challenge medium					
Sources					Unit Price
Sandhill	email	12	item	240.00	20.000

New Equipment Items:

pH ambulatory recorder (Digitrapper)	
Medtronic (5143G0202)	\$ 6,900

pH ambulatory recording workstation w-software (Digitrapper)	
Medtronic (9043A0161 and 9043S0421)	\$ 11,490

pH ambulatory recorder (Bravo)	
Medtronic (9043K0102)	6900

pH ambulatory recording workstation w-software (Bravo)	
Medtronic (9043A0161 and 9043S0421)	\$ 11,490

vacuum pump, for Bravo system	
Medtronic	\$ 990

catheter, multi-channel, with impedance sensors	
Sandhill (Konigsberg)	\$ 13,465

impedance recording workstation w-software	
Sandhill (InSight)	\$ 36,805

	A	B	C	D	E	F	G
1		staff, supply, equip		91034		91035	
2	Meeting Date: January 2004 Specialties: AGA and ASGE	CODE	DESC	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation		Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	
3	LOCATION			Non Fac	Facility	Non Fac	Facility
4	GLOBAL PERIOD			0	0	0	0
5	TOTAL TIME	L037D	RN/LPN/MTA	60	22	58	22
6	PRE-service time	L037D	RN/LPN/MTA	9	19	9	19
7	SERVICE time	L037D	RN/LPN/MTA	46	0	44	0
8	POST-service time	L037D	RN/LPN/MTA	5	3	5	3
9	PRE-SERVICE - BEFORE ADMISSION						
10	Start: Following decision for surgery visit						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5	3	5
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3
17	End: When pt enters site for service						
18	SERVICE PERIOD - ADMISSION TO DISCHARGE						
19	Start: When pt enters site for procedure						
20	Pre-service services						
21	Review charts	L037D	RN/LPN/MTA	2		2	
22	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		3	
23	Obtain vital signs	L037D	RN/LPN/MTA	3		3	
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3		3	
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
27	Prepare and position pt/ monitor pt/ set up IV	L037D	RN/LPN/MTA	2		2	
28	Conscious sedation	L037D	RN/LPN/MTA				
29	Intra-service						
30	Assist physician in performing procedure @ 2/3 for X1 only	L037D	RN/LPN/MTA	15		13	
31	Post-Service						
32	Monitor pt. - check tubes, monitors, drains	L037D	RN/LPN/MTA	5		5	
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
36	Complete diag forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
37	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3	
39	Dischg day mgmt outpt=6" 99238=12" 99239=15"	L037D	RN/LPN/MTA				
40	Other Clinical Activity: Clean equipment	L037D	RN/LPN/MTA	5		5	
41	End: Patient leaves office/facility						
42	POST-SERVICE Period - AFTER DISCHARGE						
43	Start: Patient leaves office/facility						
44	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3
53	Total Office Visit Time	L037D	RN/LPN/MTA				
54	Other Activity: Download data from recorder to workstation, print report, and prepare file for MD review			2		2	
55	End: last office visit - end of global period						

	A	B	C	D	E	F	G
1		staff, supply, equip		91034		91035	
2	Meeting Date: January 2004 Specialties: AGA and ASGE	CODE	DESC	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation		Esophagus; gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	
3	LOCATION			Non Fac	Facility	Non Fac	Facility
56	MEDICAL SUPPLIES						
57	<u>Procedure Scrub, Dress</u>						
58	pack, minimum multi-specialty visit	SA048	pack	1		1	
59	basin, emesis	SJ010	item	1		1	
60	tongue depressor	SJ061	item	1		1	
61	gloves, non-sterile	SB022	pair				
62	mask, surgical, with face shield	SB034	item	1		2	
63	gown, staff, impervious	SB027	item	1		2	
64	cap, surgical	SB001	item	1		2	
65	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1	
66	canister, suction	SD009	item	1		1	
67	tubing, suction, non-latex (6ft uou)	SD132	item	1		1	
68	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		1	
69	gauze, sterile 4in x 4in	SG055	item	5		5	
70	lubricating jelly (K-Y) (5gm uou)	SJ032	item	4		4	
71	lidocaine 4% soln, topical (Xylocaine)	SH050	ml	20		20	
72	tape, surgical paper 1in (Micropore)	SG079	inch	12			
73	denture cup	SJ016	item				
74	cup, drinking	SK018	item				
75	viscous swallow challenge medium	NEW	item				
76	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1	
77	electrode, internal for pH	SD060	item	1			
78	sensor, pH capsule (Bravo)	NEW	item			1	
79	phix strips	NEW	item	5		5	
80	pH buffer solution	SJ039	ml	1000			
81	computer media, floppy disk 1.44mb	SK014	item	1		1	
82	Equipment						
83	exam table	E11001		X		X	
84	exam lamp	E30006		X		X	
85	suction machine, Gomco	E30001		X		X	
86	pH ambulatory recorder (Bravo)	NEW				X	
87	pH recording workstation w-software (Bravo)	NEW				X	
88	pH ambulatory recorder (Digitrapper)	NEW		X			
89	pH recording workstation w-software (Digitrapper)	NEW		X			
90	catheter, multi-channel, with impedance sensors	NEW					
91	impedance recording workstation w-software	NEW					

	A	B	C	H	I	J	K
1		staff, supply, equip		91037		91038	
2	Meeting Date: January 2004 Specialties: AGA and ASGE	CODE	DESC	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;		Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged	
3	LOCATION			Non Fac	Facility	Non Fac	Facility
4	GLOBAL PERIOD			0	0	0	0
5	TOTAL TIME	L037D	RN/LPN/MTA	60	22	65	22
6	PRE-service time	L037D	RN/LPN/MTA	9	19	9	19
7	SERVICE time	L037D	RN/LPN/MTA	46	0	51	0
8	POST-service time	L037D	RN/LPN/MTA	5	3	5	3
9	PRE-SERVICE - BEFORE ADMISSION						
10	Start: Following decision for surgery visit						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5	3	5
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3
17	End: When pt enters site for service						
18	SERVICE PERIOD - ADMISSION TO DISCHARGE						
19	Start: When pt enters site for procedure						
20	Pre-service services						
21	Review charts	L037D	RN/LPN/MTA	2		2	
22	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		3	
23	Obtain vital signs	L037D	RN/LPN/MTA	3		3	
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3		3	
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
27	Prepare and position pt/ monitor pt/ set up IV	L037D	RN/LPN/MTA	2		2	
28	Conscious sedation	L037D	RN/LPN/MTA				
29	Intra-service						
30	Assist physician in performing procedure @ 2/3 for X1 only	L037D	RN/LPN/MTA	15		20	
31	Post-Service						
32	Monitor pt. - check tubes, monitors, drains	L037D	RN/LPN/MTA	5		5	
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
36	Complete diag forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
37	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3	
39	Dischg day mgmt outpt=6" 99238=12" 99239=15"	L037D	RN/LPN/MTA				
40	Other Clinical Activity: Clean equipment	L037D	RN/LPN/MTA	5		5	
41	End: Patient leaves office/facility						
42	POST-SERVICE Period - AFTER DISCHARGE						
43	Start: Patient leaves office/facility						
44	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3
53	Total Office Visit Time	L037D	RN/LPN/MTA				
54	Other Activity: Download data from recorder to workstation, print report, and prepare file for MD review			2		2	
55	End: last office visit - end of global period						

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	H	I	J	K
1		staff, supply, equip		91037		91038	
2	Meeting Date: January 2004 Specialties: AGA and ASGE	CODE	DESC	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;		Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged	
3	LOCATION			Non Fac	Facility	Non Fac	Facility
56	MEDICAL SUPPLIES						
57	<u>Procedure Scrub, Dress</u>						
58	pack, minimum multi-specialty visit	SA048	pack	1		1	
59	basin, emesis	SJ010	item	1		1	
60	tongue depressor	SJ061	item	1		1	
61	gloves, non-sterile	SB022	pair				
62	mask, surgical, with face shield	SB034	item	1		1	
63	gown, staff, impervious	SB027	item	1		1	
64	cap, surgical	SB001	item	1		1	
65	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1	
66	canister, suction	SD009	item	1		1	
67	tubing, suction, non-latex (6ft uou)	SD132	item	1		1	
68	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		1	
69	gauze, sterile 4in x 4in	SG055	item	5		5	
70	lubricating jelly (K-Y) (5gm uou)	SJ032	item	4		4	
71	lidocaine 4% soln, topical (Xylocaine)	SH050	ml	20		20	
72	tape, surgical paper 1in (Micropore)	SG079	inch	12		12	
73	denture cup	SJ016	item				
74	cup, drinking	SK018	item	4			
75	viscous swallow challenge medium	NEW	item	1			
76	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1			
77	electrode, internal for pH	SD060	item				
78	sensor, pH capsule (Bravo)	NEW	item				
79	phix strips	NEW	item	5		5	
80	pH buffer solution	SJ039	ml				
81	computer media, floppy disk 1.44mb	SK014	item	1		1	
82	Equipment						
83	exam table	E11001		X		X	
84	exam lamp	E30006		X		X	
85	suction machine, Gomco	E30001		X		X	
86	pH ambulatory recorder (Bravo)	NEW					
87	pH recording workstation w-software (Bravo)	NEW					
88	pH ambulatory recorder (Digitrapper)	NEW					
89	pH recording workstation w-software (Digitrapper)	NEW					
90	catheter, multi-channel, with impedance sensors	NEW		X		X	
91	impedance recording workstation w-software	NEW		X		X	

phix strips

Sources					Unit Price
Medtronic (9012D1031)	quote	50	item	70.00	1.400

sensor, pH capsule (Bravo)

Sources					Unit Price
Medtronic (9012B1011)		5	item	1125.00	225.000

viscous swallow challenge medium

Sources					Unit Price
Sandhill	email	12	item	240.00	20.000

pH ambulatory recorder (Digitrapper)

Medtronic (5143G0202)	\$	6,900
-----------------------	----	-------

pH ambulatory recording workstation w-software (Digitrapper)

Medtronic (9043A0161 and 9043S0421)	\$	11,490
-------------------------------------	----	--------

pH ambulatory recorder (Bravo)

Medtronic (9043K0102)		6900
-----------------------	--	------

pH ambulatory recording workstation w-software (Bravo)

Medtronic (9043A0161 and 9043S0421)	\$	11,490
-------------------------------------	----	--------

vacuum pump, for Bravo system

Medtronic	\$	990
-----------	----	-----

catheter, multi-channel, with impedance sensors

Sandhill (Konigsberg)	\$	13,465
-----------------------	----	--------

impedance recording workstation w-software

Sandhill (InSight)	\$	36,805
--------------------	----	--------

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Esophageal Balloon Provocation

The CPT Editorial Panel created this code to describe an esophageal balloon distention provocation study, a test which helps identify an esophageal cause for non-cardiac chest pain. Current tests such as code 91030 *Esophagus, acid perfusion (Bernstein) test for esophagitis*, lack sensitivity and specificity needed to treat these patients. Other current CPT codes only examine acid causes for chest pain in patients with gastroesophageal reflux (GERD).

91040

The RUC reviewed the survey results for 91040 *Esophageal balloon distension provocation study*. The survey respondents indicated that 91040 was comparable to the reference service code 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study* (Work RVU=1.25). However, the specialty society indicated that the reference code 91010 is not a good comparison when examining service time and intensity associated with this code. Accordingly, the specialty society based their recommended values for 91040 on the work value assigned to codes 91034 *Esophagus, gastroesophageal reflux test, with nasal catheter PH electrode(s), recording, analysis and interpretation* (Work RVU=0.97) and 91037 *Esophageal function test, with nasal catheter intraluminal impedance electrode(s) recording, analysis and interpretation* (Work RVU=0.97) presented at the January 2004 RUC meeting. The RUC felt that these codes were comparable in terms of the time and intensity. In addition, this valuation will keep this family of diagnostic codes in the proper rank order. **The RUC recommends adjusting the surveyed physician pre-service time to 15 minutes, adjusting the surveyed intra-service time to 15 minutes and use the survey post-service time of 15 minutes, totaling 45 minutes. Therefore, the RUC recommends a work RVU of 0.97 and total physician time of 45 minutes for code 91040.**

CPT Code	Pre-Service	Intra-Service	Post-Service	Recommended RVU
91040	15 minutes	15 minutes	15 minutes	0.97

Practice Expense

The RUC reviewed and agreed with the specialty society's intra-service clinical labor time in the non- facility setting of 10 minutes and decreased the discharge day management time from five minutes to zero. In addition the supplies and equipment were assessed, modified and accepted by the RUC.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●91040	AY1	Esophageal balloon distension provocation study (For balloon dilatation with endoscopy, see 43220, 43249, 43456, or 43458)	000	0.97

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

CPT Code:91040 Tracking Number: AY1 Global Period: 000 **Recommended Work Relative Value**
Specialty Society RVU: **0.97** RUC RVU: **0.97**

CPT Descriptor: Esophageal balloon distention provocation study

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year old man is referred for evaluation of recurrent unexplained chest pain and dysphagia. Cardiac workup and Esophagogastroduodenoscopy (EGD) have been unremarkable.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

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 patient history, including prior studies
- Explain procedure and its purpose to the patient
- Counsel patient to maintain normal activity and food consumption during the test
- Answer patient questions and obtain informed consent
- Verify that all necessary instruments and supplies are readily available
- Supervise patient positioning and prepping

Description of Intra-Service Work: After informed consent is obtained, the patient is brought to the Gastroenterology Laboratory. Following topical anesthesia of a nare with 2% Xylocaine, a 4.5 mm catheter with a 45mm latex balloon attached to a single air perfusion port is inserted in the mid esophagus. Serial insufflations using air or water are performed in 2 cc increments from 0 to 30 cc's, with the patient blinded to the volume infused. With each insufflation, the patient is asked if they experienced reproduction of symptoms. Once a positive response was obtained, several insufflations at similar volumes and sham insufflations are performed to confirm the positive response. A record of the insufflation volume and symptoms generated is kept. At the completion of the test, the catheter was withdrawn, and the patient was discharged.

Description of Post-Service Work: Physician discharges the patient.

Physician interprets the data and generates a report

- Treatment recommendations and decisions are made based on the data, including the potential need for additional medical, pharmacologic, endoscopic, and/or surgical intervention
- Report and outcome letter is dictated for referring physician and/or insurance company

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2004
Presenter(s):	Joel V. Brill, M.D. (AGA) Michael Levy, M.D. (ASGE)
Specialty(s):	Gastroenterology
CPT Code:	91040

Sample Size: 35		Resp n: 28		Response: 80.00 %		
Sample Type: Random						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		0.95	1.34	1.91	2.00	2.50
Pre-Service Evaluation Time:				8.0		
Pre-Service Positioning Time:				4.0		
Pre-Service Scrub, Dress, Wait Time:				3.0		
Intra-Service Time:		5.00	20.00	15.00	48.80	60.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		15.00				
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>
91010	000	1.25

CPT Descriptor Esophageal manometry

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99213	000	0.67

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 57.1 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 91040	Key Reference CPT Code: 91010
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	15.00	36.00
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	45.00	36.00

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	3.00	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	2.90	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.00
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.40	2.50
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	2.00	2.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.00	2.00
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	2.00	2.00

ADDITIONAL RATIONALE

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

We are recommending a work value of 0.97 for each of these codes, which is much less than the 25th percentile of the data. We are basing the values on the work value assigned to codes 91034 (Esophagus, gastroesophageal reflux test, with nasal catheter PH electrode(s), recording, analysis and interpretation) and 91037, (Esophageal function test, with nasal catheter intraluminal impedance electrode(s) recording, analysis and interpretation) at the January 2004 RUC meeting. We think these codes are comparable in terms of time and intensity to these 2 codes and this valuation will keep this family of diagnostic codes in the proper rank order.

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) 91299

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

Specialty Gastroenterology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Gastroenterology Frequency 3400 Percentage 97.14 %

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? 800
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Gastroenterology Frequency 780 Percentage 97.50 %

Specialty Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 91037 is the final reference service used.

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

	A	B	C	D	E	F	G
1		staff, supply, equip		91120		91040	
	Meeting Date: April 2004 Specialties: AGA and ASGE			Rectal sensation, tone and compliance test (ie, response to graded balloon distention)		Esophageal balloon distention provocation study	
2		CODE	DESC				
3	LOCATION			Non Fac	Facility	Non Fac	Facility
4	GLOBAL PERIOD			000	000	000	000
5	TOTAL TIME	L037D	RN/LPN/MTA	50	22	50	22
6	PRE-service time	L037D	RN/LPN/MTA	9	19	9	19
7	SERVICE time	L037D	RN/LPN/MTA	36	0	36	0
8	POST-service time	L037D	RN/LPN/MTA	5	3	5	3
9	PRE-SERVICE - BEFORE ADMISSION						
10	Start: Following decision for surgery visit						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5	3	5
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3
17	End: When pt enters site for service						
18	SERVICE PERIOD - ADMISSION TO DISCHARGE						
19	Start: When pt enters site for procedure						
20	Pre-service services						
21	Review charts	L037D	RN/LPN/MTA	2		2	
22	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		3	
23	Obtain vital signs	L037D	RN/LPN/MTA	3		3	
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3		3	
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
26	Prepare and position pt/ monitor pt/ set up IV	L037D	RN/LPN/MTA	2		2	
27	Conscious sedation	L051A	RN				
28	Intra-service						
29	Assist physician in performing procedure @ 2/3	L037D	RN/LPN/MTA	10		10	
30	Post-Service						
31	Monitor pt. - check tubes, monitors, drains	L037D	RN/LPN/MTA	5		5	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
33	Complete diag forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
34	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
35	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3	
36	Dischg day mgmt outpt=6" 99238=12" 99239=15"	L037D	RN/LPN/MTA				
37	Other Clinical Activity:	L037D	RN/LPN/MTA				
38	End: Patient leaves office/facility						
39	POST-SERVICE Period - AFTER DISCHARGE:						
40	Start: Patient leaves office/facility						
41	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3
50	Total Office Visit Time	L037D	RN/LPN/MTA				
51	Other Activity: Download data from recorder to workstation, print report, and prepare file for MD review	L037D	RN/LPN/MTA	2		2	
52	End: last office visit - end of global period						

	A	B	C	D	E	F	G
1		staff, supply, equip		91120		91040	
2	Meeting Date: April 2004 Specialties: AGA and ASGE	CODE	DESC	Rectal sensation, tone and compliance test (ie, response to graded balloon distention)		Esophageal balloon distention provocation study	
3	LOCATION			Non Fac	Facility	Non Fac	Facility
53	MEDICAL SUPPLIES						
54	pack, minimum multi-specialty visit	SA048	pack	1		1	
55	basin, emesis	SJ010	item			1	
56	tounge depressor	SJ061	item			1	
57	mask, surgical, with face shield	SB034	item	1		1	
58	gown, staff, impervious	SB027	item	1		1	
59	cap, surgical	SB001	item	1		1	
60	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1	
61	canister, suction	SD009	item	1		1	
62	tubing, suction, non-latex (6ft uou)	SD132	item	1		1	
63	gauze, 4in x 4in	SG051	item	5		5	
64	lubricating jelly (K-Y)(5gm uou)	SJ032	item	4		4	
65	lidocaine 4% soln, topical (Xylocaine)	SH050	item			20	
66	tape, surgical paper 1in (Micropore)	SG079	inch	6		6	
67	denture cup	SJ016	item			1	
68	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1	
69	computer media, floppy disk 1.44mb	SK014	item	1		1	
70	Equipment						
71	exam table	E11001		X		X	
72	surgical lamp	E30009		X		X	
73	Distender series II, barostat pump (G&J Electronics; model DSII-01; price \$22,000)	NEW	item	X		X	
74	Perception panel (G&J Electronics; model PP-01)		item	X		X	
75	Protocol plus software (model PPS-01)			X		X	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Rectal Barostat Sensation Test

The CPT Editorial Panel created this code to describe the comprehensive assessment of sensory, motor and biomechanical function of the rectum in patients with irritable bowel syndrome, constipation and/or fecal incontinence.

91120

The RUC reviewed the specialty's survey results for 91120 *Rectal sensation, tone, and compliance test (ie, response to graded balloon distention)*. The survey respondents recommended a median work RVU of 2.0, a 25th percentile work RVU of 1.70 and low work RVU of 1.30. The survey respondents indicated that 91120 was comparable to the reference service code 91122 *Anorectal manometry* (Work RVU=1.77). However, the specialty society indicated that the reference code 91122 is not a good comparison when examining service time and intensity associated with this code. Accordingly, the specialty society based the values on the work value assigned to codes presented at the January 2004 RUC meeting, 91034 *Esophagus, gastroesophageal reflux test, with nasal catheter PH electrode(s), recording, analysis and interpretation* (Work RVU=0.97) and 91037 *Esophageal function test, with nasal catheter intraluminal impedance electrode(s) recording, analysis and interpretation* (Work RVU=0.97). The RUC felt that these codes were comparable in terms of the time and intensity. In addition, this valuation will keep this family of diagnostic codes in the proper rank order. **The RUC recommends adjusting the physician pre-service time to 15 minutes, the intra-service time of 15 minutes and the post-service time of 15 minutes, totaling 45 minutes. Therefore, the RUC recommends a work RVU of 0.97 and total physician time of 45 minutes for code 91120.**

CPT Code	Pre-Service	Intra-Service	Post-Service	Recommended RVU
91120	15 minutes	15 minutes	15 minutes	0.97

Practice Expense

The RUC reviewed and agreed with the specialty society's intra-service clinical labor time in the non- facility setting of 10 minutes and decreased the discharge day management time from five minutes to zero. In addition the supplies and equipment were assessed, modified and accepted by the RUC.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
90911		<i>Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry</i> <i><u>(For incontinence treatment by pulsed magnetic neuromodulation, use Category III code 0029T)</u></i> <i><u>(For testing of rectal sensation, tone and compliance, use 91120)</u></i>	000	0.81 (No Change)
●91120	AX1	Rectal sensation, tone, and compliance test (ie, response to graded balloon distention) <i><u>(For biofeedback training, see 90911)</u></i> <i><u>(For anorectal manometry, see 91122)</u></i>	000	0.97

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

CPT Code:91120 Tracking Number: AX1 Global Period: 000 **Recommended Work Relative Value**
Specialty Society RVU: **0.97** RUC RVU: **0.97**

CPT Descriptor: Rectal sensation, tone, and compliance test (ie., response to graded balloon distention)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old woman presents with three-year history of constipation. She has no desire to defecate and manually disimpacts her bowel once every 2-3 weeks. On examination, the abdomen was distended. Rectal exam showed impaired rectal sensation and hard stools, of which patient was completely unaware.

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:

- Review of patient history, including prior studies
- Explain procedure and its purpose to the patient
- Counsel patient to maintain normal activity and food consumption during the test
- Answer patient questions and obtain informed consent
- Verify that all necessary instruments and supplies are readily available
- Supervise patient positioning and prepping

Description of Intra-Service Work: After informed consent was obtained, the patient underwent rectal cleansing. The patient is placed in the left lateral position. A 5 mm diameter probe, with a 10 cm long, highly compliant balloon was placed into the rectum and taped in position. The balloon was connected to a computerized distending device. Stepwise graded balloon distentions were performed to assess the intra operating pressure (IOP). Baseline rectal tone is assessed over a 30 minute period. Intermittent balloon distentions are then performed at 4 mm Hg increments until the patient reports sensation, desire to defecate, and urgency to defecate. Pain on maximum tolerable volume is recorded. While being monitored, the patient is asked to defecate the balloon. After a 15-minute rest, the balloon is re-inserted into the rectum, and then inflated to IOP. The patient is then fed a standardized 1000 K cal meal. Rectal tone and sensory changes are then recorded for a subsequent 60 minute period. At the conclusion of the test, the balloon is deflated, and the balloon and probe are removed. The patient is discharged.

Description of Post-Service Work: Physician discharges the patient.

Physician calculates and interprets the rectal sensory thresholds, rectal pressure, compliance and rectal tone changes at rest and after provocation.

- Treatment recommendations and decisions are made based on the data, including the potential need for additional medical, pharmacologic, endoscopic, and/or surgical intervention
- Report and outcome letter is dictated for referring physician and/or insurance company

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2004
----------------------------	---------

Presenter(s):	Joel V. Brill, M.D. (AGA) Michael Levy, M.D. (ASGE)					
Specialty(s):	Gastroenterology					
CPT Code:	91120					
Sample Size:	45	Resp n:	26	Response: 57.77 %		
Sample Type:	Random					
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:		1.20	1.70	2.00	2.37	3.60
Pre-Service Evaluation Time:				7.0		
Pre-Service Positioning Time:				4.0		
Pre-Service Scrub, Dress, Wait Time:				4.0		
Intra-Service Time:		15.00	20.00	15.00	45.00	60.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	15.00					
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>
91122	000	1.77

CPT Descriptor Anorectal manometry

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99204	000	2.00

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components: a comprehensive history, a comprehensive examination; and medical decision making of moderate complexity.

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 65.3 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 91120	Key Reference CPT Code: <u>91122</u>
Median Pre-Service Time	15.00	20.00
Median Intra-Service Time	15.00	30.00
Median Immediate Post-service Time	15.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	45.00	65.00

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	3.31	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	3.42
Urgency of medical decision making	2.23	2.08

Technical Skill/Physical Effort (Mean)

Technical skill required	3.92	3.42
Physical effort required	3.00	2.92

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	1.92
Outcome depends on the skill and judgment of physician	3.91	3.83
Estimated risk of malpractice suit with poor outcome	2.15	1.92

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.77	3.00
Intra-Service intensity/complexity	3.70	3.36
Post-Service intensity/complexity	3.15	2.82

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 are recommending a work value of 0.97 for each of these codes, which is much less than the 25th percentile of the data. We are basing the values on the work value assigned to codes 91034 (Esophagus, gastroesophageal reflux test, with nasal catheter PH electrode(s), recording, analysis and interpretation) and 91037, (Esophageal function test, with nasal catheter intraluminal impedance electrode(s) recording, analysis and interpretation) at the January 2004 RUC meeting. We think these codes are comparable in terms of time and intensity to these 2 codes and this valuation will keep this family of diagnostic codes in the proper rank order.

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) 91299

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

Specialty Gastroenterology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Gastroenterology Frequency 3400 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? 800

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

Specialty Gastroenterology Frequency 780 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. 91037 was the final reference code.

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

	A	B	C	D	E	F	G
1		staff, supply, equip		91120		91040	
	Meeting Date: April 2004 Specialties: AGA and ASGE			Rectal sensation, tone and compliance test (ie, response to graded balloon distention)		Esophageal balloon distention provocation study	
2		CODE	DESC				
3	LOCATION			Non Fac	Facility	Non Fac	Facility
4	GLOBAL PERIOD			000	000	000	000
5	TOTAL TIME	L037D	RN/LPN/MTA	50	22	50	22
6	PRE-service time	L037D	RN/LPN/MTA	9	19	9	19
7	SERVICE time	L037D	RN/LPN/MTA	36	0	36	0
8	POST-service time	L037D	RN/LPN/MTA	5	3	5	3
9	PRE-SERVICE - BEFORE ADMISSION						
10	Start: Following decision for surgery visit						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5	3	5
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3
17	End: When pt enters site for service						
18	SERVICE PERIOD - ADMISSION TO DISCHARGE						
19	Start: When pt enters site for procedure						
20	Pre-service services						
21	Review charts	L037D	RN/LPN/MTA	2		2	
22	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		3	
23	Obtain vital signs	L037D	RN/LPN/MTA	3		3	
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3		3	
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
26	Prepare and position pt/ monitor pt/ set up IV	L037D	RN/LPN/MTA	2		2	
27	Conscious sedation	L051A	RN				
28	Intra-service						
29	Assist physician in performing procedure @ 2/3	L037D	RN/LPN/MTA	10		10	
30	Post-Service						
31	Monitor pt. - check tubes, monitors, drains	L037D	RN/LPN/MTA	5		5	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
33	Complete diag forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
34	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
35	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3	
36	Dischg day mgmt outpt=6" 99238=12" 99239=15"	L037D	RN/LPN/MTA				
37	Other Clinical Activity:	L037D	RN/LPN/MTA				
38	End: Patient leaves office/facility						
39	POST-SERVICE Period - AFTER DISCHARGE						
40	Start: Patient leaves office/facility						
41	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3
50	Total Office Visit Time	L037D	RN/LPN/MTA				
51	Other Activity: Download data from recorder to workstation, print report, and prepare file for MD review	L037D	RN/LPN/MTA	2		2	
52	End: last office visit - end of global period						

	A	B	C	D	E	F	G
1		staff, supply, equip		91120		91040	
2	Meeting Date: April 2004 Specialties: AGA and ASGE	CODE	DESC	Rectal sensation, tone and compliance test (ie, response to graded balloon distention)		Esophageal balloon distention provocation study	
3	LOCATION			Non Fac	Facility	Non Fac	Facility
53	MEDICAL SUPPLIES						
54	pack, minimum multi-specialty visit	SA048	pack	1		1	
55	basin, emesis	SJ010	item			1	
56	tounge depressor	SJ061	item			1	
57	mask, surgical, with face shield	SB034	item	1		1	
58	gown, staff, impervious	SB027	item	1		1	
59	cap, surgical	SB001	item	1		1	
60	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1	
61	canister, suction	SD009	item	1		1	
62	tubing, suction, non-latex (6ft uou)	SD132	item	1		1	
63	gauze, 4in x 4in	SG051	item	5		5	
64	lubricating jelly (K-Y)(5gm uou)	SJ032	item	4		4	
65	lidocaine 4% soln, topical (Xylocaine)	SH050	item			20	
66	tape, surgical paper 1in (Micropore)	SG079	inch	6		6	
67	denture cup	SJ016	item			1	
68	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1	
69	computer media, floppy disk 1.44mb	SK014	item	1		1	
70	Equipment						
71	exam table	E11001		X		X	
72	surgical lamp	E30009		X		X	
73	Distender series II, barostat pump (G&J Electronics; model DSII-01; price \$22,000)	NEW	item	X		X	
74	Perception panel (G&J Electronics; model PP-01)		item	X		X	
75	Protocol plus software (model PPS-01)			X		X	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
February 2004
ECG Vest

The CPT Editorial Panel created code 93745 *Initial set-up and programming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events*. The specialty indicated that they did not have a sufficient sample size of physicians who had been trained with this product to ensure a successful RUC survey validation for the September 2003 RUC meeting. In February 2004, the specialty indicated that they attempted a survey of 75 physicians, whose contact information had been provided by the manufacturer of the ECG vest. However only ten physicians responded to the survey. Those that responded indicated that they had minimal experience with the service (1 to 5 services performed within the year). The specialty requested that the RUC recommend that the service be carrier priced. The RUC, however, was concerned that based on the few number of physicians who are actually providing this service, that this should be described as a Category III CPT code. *At a subsequent meeting of the CPT Editorial Panel, the Panel agreed with the specialty to implement the code as a Category I. The RUC offers no recommendation for this service.*

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●93745	B1	Initial set-up and programming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events (Do not report 93745 in conjunction with 93741, 93742)	XXX	No RUC Recommendation
▲93741	B2	Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber <u>or wearable cardioverter-defibrillator system</u> , without reprogramming (Do not report 93741 in conjunction with 93745)	XXX	0.80 Editorial Change
▲93742	B3	single chamber <u>or wearable cardioverter-defibrillator system</u> , with reprogramming (Do not report 93742 in conjunction with 93745)	XXX	0.91 Editorial Change

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2004

Intracranial Artery Transcranial Doppler Studies

The CPT Editorial Panel created three new codes to describe a cerebrovascular reactivity test and an embolus detection monitoring test not provided for in the standard complete transcranial doppler examination.

93890

The RUC reviewed the survey results for code 93890 *Transcranial Doppler study of the intracranial arteries; vasoreactivity study*. The survey respondents indicated that this new service described in 93890 is more intense and requires more technical skill, mental effort and judgment than the reference service code 93886 *Transcranial Doppler study of the intracranial arteries; complete study* (Work RVU=0.94). In addition, the total time for the surveyed code (35 minutes) is longer than that of the reference code (25 minutes). Therefore, the RUC agreed with the specialty societies' recommendation of the survey median for 93890. **The RUC recommends a work relative value for 93890 of 1.00.**

93892

The RUC reviewed the survey results for 93892 *Transcranial Doppler study of the intracranial arteries; emboli detection without IV microbubble injection*. The survey respondents indicated that this new service described in 93892 is more intense and requires more technical skill, mental effort and judgment than the reference service code 93886 *Transcranial Doppler study of the intracranial arteries; complete study* (Work RVU=0.94). In addition the total time for the surveyed code (40 minutes) is longer than that of the reference code (25 minutes). Therefore the RUC agreed with the specialty societies' recommendation of the survey median for 93892. **The RUC recommends a work relative value for 93892 of 1.15.**

93893

The RUC reviewed the survey results for 93893 *Transcranial Doppler study of the intracranial arteries; emboli detection with IV microbubble injection*. The survey respondents indicated that this new service described in 93893 is more intense and requires more technical skill, mental effort and judgment than the reference service code 93886 *Transcranial Doppler study of the intracranial arteries; complete study* (Work RVU=0.94). In addition the total time for the surveyed code (40 minutes) is longer than that of the

reference code (25 minutes). Although the survey median was 1.00 RVUs, the specialty societies advised the RUC that this survey median was inappropriate because it would lead to a rank order anomaly. This rank order anomaly is illustrated in the IWPUT calculations. Using the societies' recommended RVU and survey times, the specialty societies calculated the IWPUT for the new codes: 93890 – 0.0368, 93892 – 0.0351 and 93893 – 0.0351. Using the survey median RVU and survey times, the IWPUT for the codes would be 93890 – 0.0368, 93892 – 0.0351 and 93893 – 0.0276.

	IWPUT Using the Survey Median and Survey Times	IWPUT Using the Societies' Recommended RVU and Survey Times
93890	0.0368	0.0368
93892	0.0351	0.0351
93893	0.0276	0.0351

The societies demonstrated and the RUC agreed that the median survey times for 93892 and 93893 are the same and they have similar intensity and complexity. Therefore, the RUC recommended the same work value for 93892 for 93893. **The RUC recommends a work relative value for 93893 of 1.15.**

The RUC, when reviewing these codes, was informed by the specialty society that the new codes would never be billed with 93888 *Transcranial Doppler study of the intracranial arteries; limited study*. Therefore, a request was made to the CPT Editorial Panel to add a parenthetical note to this section to preclude reporting codes 93890-93893 in addition to code 93888.

Practice Expense:

The RUC reviewed the practice expense inputs for 93890, 93892 and 93893. These inputs were modified to reflect PEAC accepted standards of clinical labor time, supplies and equipment. **The RUC recommends accepting the practice expense inputs as defined in the attached spreadsheets**

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<u>A complete transcranial Doppler (TCD) study (93886) includes ultrasound evaluation of the right and left anterior circulation territories and the posterior circulation territory (to include vertebral arteries and basilar artery). In a limited TCD study (93888) there is ultrasound evaluation of two or fewer of these territories. For TCD, ultrasound evaluation is a reasonable and concerted attempt to identify arterial signals through an acoustic window.</u>				
93886		Transcranial Doppler study of the intracranial arteries; complete study	XXX	0.94 (No Change)
93888		limited study	XXX	0.62 (No Change)
●93890	P1	vasoreactivity study	XXX	1.00
●93892	P2	emboli detection without IV microbubble injection	XXX	1.15
●93893	P3	emboli detection with IV microbubble injection (Do not report 93890-93893 in addition to 93888)	XXX	1.15

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

CPT Code:93890 Tracking Number: P1 Global Period:XXX **Recommended RVW: 1.00**

CPT Descriptor: Transcranial Doppler study of the intracranial arteries; vasoreactivity study
(Do not report 93890-93893 in addition to 93888)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year old man is referred to the TCD laboratory because a carotid duplex ultrasound examination identified 90% left internal carotid artery stenosis. The patient is scheduled to undergo coronary artery bypass surgery. TCD Vasoreactivity testing is ordered to assess cerebrovascular reserve adequacy of collateral flow, to assist with decision making about doing a left carotid endarterectomy during the heart surgery.

Percentage of Survey Respondents who found Vignette to be Typical: 100.00%

Description of Pre-Service Work: Review patient demographic, symptoms, and suspected diagnosis. Help technologist decide which vessels to insonate.

Description of Intra-Service Work: Review acquired Doppler spectral waveforms, flow direction, mean, systolic, and diastolic flow velocities, depth of sampling, pulsatility index values, and capnometer values, in the resting values for the arterial segments studied. Document procedure results. Integrate findings with clinical presentation to formulate and document exam interpretation.

Description of Post-Service Work: Dictate, review, and approve the report. Contact referring physician for alert values or to rectify differences between preliminary and final reports when appropriate. Discuss findings with patient and referring physician when appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		01/2004			
Presenter(s):	James Anthony, MD; Charles Tegeler, MD; Gary Seabrook, MD				
Specialty(s):	American Academy of Neurology and Society for Vascular Surgery				
CPT Code:	93890				
Sample Size:	100	Resp n:	27	Resp %: 27.0%	
Sample Type:	Panel				
	Low	25 th pctl	Median*	75th pctl	High
Survey RVW:	0.40	0.90	1.00	1.50	3.50
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		

Intra-Service Time:		5.00	10.00	15.00	20.00	30.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	10.00					
Critical Care time/visit(s):	0.00	99291x 0	99292x 0			
Other Hospital time/visit(s):	0.00	99231x 0	99232x 0	99233x 0		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00

To calculate above and below time recommendations, tab here

**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>
93886	XXX	0.94

CPT Descriptor Transcranial Doppler study of the intracranial arteries; complete study

<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: 17

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 93890	Key Reference CPT Code: 93886
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	15.00	25.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	35.00	25.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Calculate total
reference time
tab here

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.82	3.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.06	3.59

Urgency of medical decision making	3.76	3.65
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.71
--------------------------	------	------

Physical effort required	3.35	3.06
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.12	2.24
---	------	------

Outcome depends on the skill and judgement of physician	3.76	3.53
---	------	------

Estimated risk of malpractice suit with poor outcome	2.82	2.47
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.35	3.12
----------------------------------	------	------

Intra-Service intensity/complexity	4.12	3.59
------------------------------------	------	------

Post-Service intensity/complexity	3.65	3.41
-----------------------------------	------	------

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.*

An expert panel of neurologists and vascular surgeons reviewed the survey results. The panel felt the median RVU was appropriate and recommends 1.00. With our recommended RVU and survey times, we calculated the IWPUT for the new codes. $93890 = 0.0368$ $93892 = 0.0351$ $93893 = 0.0351$ (see attached worksheet for calculations)

Using the survey median RVU, the IWPUT for the codes would have been $93890 = 0.0368$ $93892 = 0.0351$ $93893 = 0.0276$ This would create a rank order anomaly. The median survey times for 93892 and 93893 are the same. They have similar intensity and complexity. Therefore, the panel recommends an RVU of 1.15 for 93893.

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.)

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

CPT Code:93892 Tracking Number: P2 Global Period:XXX **Recommended RVW: 1.15**

CPT Descriptor: Transcranial Doppler study of the intracranial arteries; emboli detection without IV microbubble injection
(Do not report 93890-93893 in addition to 93888)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 44-year-old woman is referred to the TCD laboratory after presenting with a moderate right hemisphere infarct, producing hemineglect, hemiparesis, and dysphagia. CT angiogram of the neck is normal. Transthoracic echocardiogram is normal. Transesophageal echocardiogram is attempted, but cannot be performed due to the patient's dysphagia, preventing passage of the esophageal probe. TCD Embolus Detection is ordered to assess evidence of a proximal embolic source and assist with decisions about the need for anticoagulation, further testing, and treatment.

Percentage of Survey Respondents who found Vignette to be Typical: 96.70%

Description of Pre-Service Work: Review patient demographics, symptoms, and suspected diagnosis. Help technologist decide which vessels to insonate.

Description of Intra-Service Work: Review acquired Doppler spectral waveforms, flow direction, mean, systolic, and diastolic flow velocity, depth of sampling, and pulsatility index values, including waveforms throughout the monitoring epoch. Identify and review each high intensity transient signal event recorded and classify as genuine embolic signals or artifact. Count total number of embolic signals occurring spontaneously, and document vessel segment(s) in which they occurred, as well as the length of the period of monitoring. Document procedure results. Integrate findings with clinical presentation to formulate and document exam interpretation.

Description of Post-Service Work: Dictate, review, and approve the report. Contact referring physician for alert values or to rectify differences between preliminary and final reports when appropriate. Discuss findings with patient and referring physician when appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		01/2004					
Presenter(s):	James Anthony, MD; Charles Tegeler, MD; Gary Seabrook, MD						
Specialty(s):	American Academy of Neurology and Society for Vascular Surgery						
CPT Code:	93892						
Sample Size:	100	Resp n:	30	Resp %: 30.0%			
Sample Type:	Panel						
			Low	25 th pctl	Median*	75th pctl	High

Survey RVW:	0.40	0.97	1.15	1.50	2.82
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	13.75	20.00	30.00	65.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	<u>10.00</u>				
Critical Care time/visit(s):	<u>0.00</u>	99291x 0 99292x 0			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0			
Office time/visit(s):	<u>0.00</u>	99211x 0.0 12x 0.00 13x 0.00 14x 0.00 15x 0.0			

To calculate above and below time recommendations, tab here

**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>
93886	XXX	0.94

CPT Descriptor Transcranial Doppler study of the intracranial arteries; complete study

<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: 20

TIME ESTIMATES (Median)

	New/Revised CPT Code: 93892	Key Reference CPT Code: 93886
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	20.00	25.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	40.00	25.00

Calculate total
reference time
tab here**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.90	3.60
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.60
--	------	------

Urgency of medical decision making	3.90	3.35
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.05	3.65
--------------------------	------	------

Physical effort required	3.15	2.85
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.70	2.05
---	------	------

Outcome depends on the skill and judgement of physician	3.85	3.60
---	------	------

Estimated risk of malpractice suit with poor outcome	2.80	2.40
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.32	2.90
----------------------------------	------	------

Intra-Service intensity/complexity	4.21	3.50
------------------------------------	------	------

Post-Service intensity/complexity	3.79	3.40
-----------------------------------	------	------

ADDITIONAL RATIONALE

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

An expert panel of neurologists and vascular surgeons reviewed the survey results. The panel felt the median RVU was appropriate and recommends 1.00. With our recommended RVU and survey times, we calculated the IWPUT for the new codes. $93890 = 0.0368$ $93892 = 0.0351$ $93893 = 0.0351$ (see attached worksheet for calculations)

Using the survey median RVU, the IWPUT for the codes would have been $93890 = 0.0368$ $93892 = 0.0351$

93893 = 0.0276 This would create a rank order anomaly. The median survey times for 93892 and 93893 are the same. They have similar intensity and complexity. Therefore, the panel recommends an RVU of 1.15 for 93893.

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) 93886 or 93888

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

Specialty Neurology How often? Rarely

Specialty Vascular Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 13000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Neurology	Frequency 6000	Percentage	46.15%
Specialty Vascular Surgery	Frequency 650	Percentage	5.00%
Specialty	Frequency 0	Percentage	0.00%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,437 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

CPT Code:93892

Specialty Neurology	Frequency 2021	Percentage	45.54%
Specialty Vascular Surgery	Frequency 221	Percentage	-498.08%
Specialty	Frequency	Percentage	

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

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

CPT Code:93893 Tracking Number: P3 Global Period:XXX **Recommended RVW: 1.15**

CPT Descriptor: Transcranial Doppler study of the intracranial arteries; emboli detection with IV microbubble injection
(Do not report 93890-93893 in addition to 93888)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36-year-old man experienced a 20-minute episode of aphasia and right hemiparesis, which spontaneously cleared with no residual deficits. MRI shows scattered T2 hyperintensities bilaterally, while carotid ultrasound, TCD and routine transthoracic echo are unremarkable. TCD with agitated saline injection is ordered to assess for a patent foramen ovale, or other right to left intracardiac shunt.

Percentage of Survey Respondents who found Vignette to be Typical: 96.80%

Description of Pre-Service Work: Review patient demographics, symptoms, and suspected diagnosis. Help technologist decide which vessels to insonate.

Description of Intra-Service Work: Review acquired Doppler spectral waveforms, flow direction, mean, systolic, and diastolic flow velocity, depth of sampling, and pulsatility index values, including waveforms obtained before, during, and after the agitated saline injection(s). Identify and review any high intensity transient signal events and classify as embolic or artifact. Count total number of post-injection embolic signals and note any "shower" or "curtain" appearance of embolic signals, and the vessel segment(s) in which they were identified. Record relationship to time after intravenous injection and to Valsalva maneuver. Document procedure results. Integrate findings with clinical presentations to formulate and document exam interpretation.

Description of Post-Service Work: Dictate, review, and approve the report. Contact referring physician for alert values or to rectify differences between preliminary and final reports when appropriate. Discuss findings with patient and referring physician when appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)						01/2004					
Presenter(s):			James Anthony, MD; Charles Tegeler, MD; Gary Seabrook, MD								
Specialty(s):			American Academy of Neurology and Society for Vascular Surgery								
CPT Code:			93893								
Sample Size:			100		Resp n:		31		Resp %: 31.0%		
Sample Type:			Panel								
						Low	25 th pctl	Median*	75th pctl	High	
Survey RVW:						0.40	0.90	1.00	1.80	3.00	

Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	10.00	10.00	20.00	20.00	70.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	10.00				
Critical Care time/visit(s):	0.00	99291x 0 99292x 0			
Other Hospital time/visit(s):	0.00	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0			
Office time/visit(s):	0.00	99211x 0.0 12x 0.00 13x 0.00 14x 0.00 15x 0.0			

To calculate above and below time recommendations, tab here

**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	Global	Work RVU
93886	XXX	0.94

CPT Descriptor Transcranial Doppler study of the intracranial arteries; complete study

Other Reference CPT Code	Global	Work RVU
--------------------------	--------	----------

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 93893	Key Reference CPT Code: 93886
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	20.00	0.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	40.00	

Calculate total
reference time
tab here**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.45	3.65
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.95	3.60
--	------	------

Urgency of medical decision making	3.45	3.30
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.10	3.75
--------------------------	------	------

Physical effort required	3.40	2.90
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.80	2.00
---	------	------

Outcome depends on the skill and judgement of physician	3.80	3.70
---	------	------

Estimated risk of malpractice suit with poor outcome	2.55	2.45
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.20	2.89
----------------------------------	------	------

Intra-Service intensity/complexity	4.15	3.63
------------------------------------	------	------

Post-Service intensity/complexity	3.70	3.42
-----------------------------------	------	------

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.*

An expert panel of neurologists and vascular surgeons reviewed the survey results. The panel felt the median RVU was appropriate and recommends 1.00. With our recommended RVU and survey times, we calculated the IWP/UT for the new codes. 93890 = 0.0368 93892 = 0.0351 93893 = 0.0351 (see attached worksheet for calculations)

Using the survey median RVU, the IWP/UT for the codes would have been 93891 = 0.0368 93892 = 0.0351

93893 = 0.0276 This would create a rank order anomaly. The median survey times for 93892 and 93893 are the same. They have similar intensity and complexity. Therefore, the panel recommends an RVU of 1.15 for 93893.

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) 93886 or 93888

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology

How often? Rarely

Specialty Vascular Surgery

How often? Rarely

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 13000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Neurology

Frequency 6000

Percentage

46.15%

Specialty Vascular Surgery

Frequency 650

Percentage

5.00%

Specialty

Frequency 0

Percentage

0.00%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 4,437 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Neurology	Frequency 2021	Percentage	45.54%
Specialty Vascular Surgery	Frequency 221	Percentage	-498.08%
Specialty	Frequency	Percentage	

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

	A	B	C	E	G	N
1						
2			93890	93892	93893	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	the intracranial arteries; vasoreactivity study	detection without IV microbubble injection	detection with IV microbubble injection	
4	LOCATION		Non Facility	Non Facility	Non Facility	
5	GLOBAL PERIOD		XXX	XXX	XXX	
6	TOTAL CLINICAL LABOR TIME	L054A Vascular	78.0	88.0	81.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME		3.0	3.0	3.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		70.0	80.0	73.0	
9	TOTAL POST-SERV CLINICAL LABOR TIME		5.0	5.0	5.0	
10	PRE-SERVICE					
11	Start: Following visit when decision for surgery or procedure made					
12	Complete pre-service diagnostic & referral forms		3	3	3	
13	Coordinate pre-surgery services					
14	Schedule space and equipment in facility					
15	Provide pre-service education/obtain consent					
16	Follow-up phone calls & prescriptions					
17	Other Clinical Activity (please specify)					
18	End: When patient enters office/facility for surgery/procedure					
19	SERVICE PERIOD					
20	Start: When patient enters office/facility for surgery/procedure					
21	Pre-service services					
22	Review charts		2	2	2	
23	Greet patient and provide gowning		3	3	3	
24	Obtain vital signs		3	3	3	
25	Provide pre-service education/obtain consent		3	3	3	
26	Prepare room, equipment, supplies		2	2	2	
27	Calibrate the capnometer to monitor exhaled CO2		5			
28	Setup scope (non facility setting only)					
29	Prepare and position patient/ monitor patient/ set up IV		2	2	5	
30	Sedate/apply anesthesia					
31	Intra-service					
32	Assist physician in performing procedure					
33	Attach probes, identify and optimize doppler signal		15	15	15	
34	Perform procedure		25	40	30	
35	Clean gel from all places on patient head		2	2	2	
36						
37	Post-Service					
38	Assemble a record of all waveforms for physician review		5	5	5	
39	Clean room/equipment by physician staff		3	3	3	
40	Monitor pt following service/check tubes, monitors, drains					
41	Clean Scope					
42	Clean Surgical Instrument Package					
43	Complete diagnostic forms, lab & X-ray requisitions					
44	Review/read X-ray, lab, and pathology reports					
45	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
46	Discharge day management 99238 –12 minutes 99239 –15 minutes					
47	Other Clinical Activity (please specify)					
48	End: Patient leaves office					
49	POST-SERVICE Period					
50	Start: Patient leaves office/facility					
51	Conduct phone calls/call in prescriptions					
52	Quality assurance documentation		5	5	5	
53	End: with last office visit before end of global period					
54	MEDICAL SUPPLIES					
55	PEAC multispecialty supply package		1	1	1	
56	Post-op incision care kit					
57	drape, non-sterile, sheet 40in x 60in	SB006	1	1	1	
58	ultrasound transmission gel	SJ062	60 ml	40 ml	40 ml	
59	Noseclips	SD102	1 pair			
60	mouthpiece (for respiratory air collection bag)	SD098	1			
61	needle, 19-25g, butterfly	SC030			1	
62	swab-pad, alcohol	SJ053			1	
63	tape, porous-hypoallergenic 2in (Scanpore)	SG077			6 in	
64	bandage, strip 0.75in x 3in	SG021			1	
65	tourniquet, non-latex 1in x 18in	SD124			1	

	A	B	C	E	G	N
2			93890	93892	93893	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	the intracranial arteries; vasoreactivity study	detection without IV microbubble injection	detection with IV microbubble injection	
4	LOCATION		Non Facility	Non Facility	Non Facility	
76	syringe 10-12ml	SC051			6	
77	gauze, sterile 2in x 2in	SG053	8		6	
78	Saline flush	-			5cc	
79	albumin saline	SH004			30 cc	
80	stop cock, 3-way	SC049			1	
81	Patient education booklet	SK062	1	1	1	
82	swab-pad, alcohol	SJ053	1	1	1	
83	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	1	1	1	
84	video tape, VHS	SK086	1	1	1	
85	cover-condom, transducer or ultrasound probe	SB005				
86						
87	Equipment					
88	Ultrasound room	E52018	1	1	1	
89	Sony Color Video Printer	E52010	1	1	1	
90	SVHS Video Recorder	E52012	1	1	1	
91	CO2 Tank		1			
92	CO2 monitor		1			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2004

High Altitude Hypoxia Simulation Test

Work Recommendations

CPT created two new codes to accurately describe a high altitude simulation test (HAST). To identify patients at risk of hypoxia during routine commercial flights, (HAST) was developed almost 20 years ago, however there isn't a code to describe the test. The presenters explained that HAST is now routinely performed in many hospital pulmonary function laboratories and in large group practices; and all commercial airlines have policies and procedures for providing in-flight supplemental oxygen to patients based upon the results of HAST. As a result of more widespread use, code 94452 *High altitude simulation test (HAST), with physician interpretation and report* and code 94453 *High altitude simulation test (HAST), with physician interpretation and report; with supplemental oxygen titration* were created.

The RUC examined these codes in detail and focused on identifying existing codes with similar physician work to serve as reference points. The RUC discussed the physician work involved in 94452 and concluded the work was less than the reference code 94450 *Breathing response to hypoxia (hypoxia response curve)* (work RVU=.40). However, the RUC agreed that this was an appropriate reference for 94453. The RUC also identified other services that had work similar to 94452. In particular the RUC agreed that code 94060 *Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)* (work RVU = .31) was similar to 94452. Also examined was code 94240 *Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method* (work RVU=.26). The RUC agreed that 94452 had more physician work and time in comparison to 94240. In particular there is more physician skill and stress due to the possibility of risk to the patient. Code 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU=.30) also was felt to have similar physician work. The RUC concluded that the code 94060 (work RVU = .31) was the best reference and code 94452 should have the same work value as 94060. This value would also place the code in proper rank order with the other codes used as references.

The RUC recommends a work RVU of .31 for code 94452.

After examining the work involved in 94452 the RUC agreed that 94453 should be valued at a higher RVU and agreed with the original recommendation of .40, which is the 25th percentile survey value. This value is also the same as the survey reference code of 94450 *Breathing response to hypoxia (hypoxia response curve)* (work RVU=.40), which the RUC thought was an appropriate code comparison.

The RUC recommends a work RVU of .40 for code 94453.

Practice Expense

The RUC reviewed the practice expense inputs and made minor adjustments to the clinical labor activities to remove any duplication with physician work and added equipment required for performing these tests. The RUC recommends zero practice expenses in the facility setting.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
94450		Breathing response to hypoxia (hypoxia response curve) (For high altitude simulation test (HAST), see 94452-94453)	XXX	0.40 (No Change)
●94452	Q1	High altitude simulation test (HAST), <u>with physician interpretation and report;</u> (For obtaining arterial blood gases, see 36600) (Do not report 94452 in conjunction with 94453, 94760, 94761)	XXX	0.31
●94453	Q2	with supplemental oxygen titration (For obtaining arterial blood gases, see 36600) (Do not report 94453 in conjunction with 94760, 94761, 94452)	XXX	0.40

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

CPT Code:94452 Tracking Number: Q1 Global Period:XXX

Recommended RVW: .31
Specialty Recommendation -.40

CPT Descriptor: High altitude simulation test (HAST) with physician interpretation and report; (For obtaining arterial blood gases, see 36600) (Do not report 94452 in conjunction with 94760, 94761)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year old male with known chronic obstructive lung disease reports to his physician that he became short of breath during a commercial airlight. The physician orders a High Altitude Simulation Test. The patient breathes a hypoxic gas mixture (i.e., 15% oxygen and 85% N₂) at rest of 15 minutes. Oxygen saturation remains above 88% throughout the procedure so that supplemental oxygen is not felt to be necessary. Test results are analyzed and a report written by the performing physician and sent to the ordering physician (if appropriate).

Percentage of Survey Respondents who found Vignette to be Typical: 94.00%

Description of Pre-Service Work: Discuss patient's signs and symptoms with ordering physician and, then with patient. Review records, including history, pertinent lab data, and medication history.

Description of Intra-Service Work: Following the breathing of the hypoxic gas mixture for 15 minutes, the physician determines if oxygen titration is necessary.

Description of Post-Service Work: Analyze results. Discuss with patient and ordering physician. Write a report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		01/2004				
Presenter(s):	Scott Manaker, MD, PhD, FCCP & Alan Plummer, MD, FCCP					
Specialty(s):	American College of Chest Physicians & American Thoracic Society					
CPT Code:	94452					
Sample Size:	1794	Resp n:	47	Resp %:	2.6	
Sample Type:	Random					
		Low	25th pctl	Median*	75th pctl	High
Survey RVW:		0.12	0.40	0.50	1.59	3.00
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		0.00	5.00	10.00	20.00	60.00
Post-Service	Total Min**	CPT code / # of visits				

Immed. Post-time:	<u>10.00</u>	
Critical Care time/visit(s):	<u>0.00</u>	99291x 0 99292x 0
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0 99232x 0 99233x 0
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0
Office time/visit(s):	<u>0.00</u>	99211x 0.0 12x 0.00 13x 0.00 14x 0.00 15x 0.0

To calculate above and below time recommendations, tab here

****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>
94450	XXX	0.40

CPT Descriptor Breathing response to hypoxia (hypoxia response curve)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
94010	XXX	0.17

CPT Descriptor Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

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

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

Number of respondents who choose Key Reference Code: 26

TIME ESTIMATES (Median)

	<u>New/Revised CPT Code: 94452</u>	<u>Key Reference CPT Code: 94450</u>
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	10.00	21.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	30.00	21.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Calculate total
reference time
tab here

Mental Effort and Judgement (Mean)

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

Urgency of medical decision making	3.00	3.00
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.00
--------------------------	------	------

Physical effort required	2.00	2.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.00
---	------	------

Outcome depends on the skill and judgement of physician	3.00	3.00
---	------	------

Estimated risk of malpractice suit with poor outcome	3.00	3.00
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.00	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.*

An electronic 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 member of the practice management committees of the two societies who agreed to the recommendations. The representatives from the committees were 10 in number. Additionally, there wer 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? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

94450, 94620, 94761, and 94799.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonary Medicine

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1962

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency	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?

1,462 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

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

CPT Code:94453 Tracking Number: Q2 Global Period:XXX **Recommended RVW: 0.40**

CPT Descriptor: High altitude simulation test (HAST) with physician interpretation and report; with supplemental oxygen titration (For obtaining arterial blood gases, see 36600) (Do not report 94453 in conjunction with 94760, 94761)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year old female with documented chronic obstructive lung disease and prior blood gases have revealed mild hypoxemia. She reports to his physician that she became short of breath during a commercial airlight. The physician orders a High Altitude Simulation Test. The patient breathes a hypoxic gas mixture (i.e., 15% oxygen and 85% N2) at rest of 15 minutes. Oxygen saturation drops below 88%, necessitating supplemental oxygen. Oxygen is supplied by nasal cannula, and flow rate is titrated until saturation is approximately 90%. Test results are analyzed; a report written by the performing physician and sent to the ordering physician (if appropriate). An air travel prescription is written and the appropriate documentation is sent both to the ordering physician (if appropriate) and the commercial airline.

Percentage of Survey Respondents who found Vignette to be Typical: 95.00%

Description of Pre-Service Work: Discuss patient's signs and symptoms with ordering physician and, then with patient. Review records, including history, pertinent lab data, and medication history.

Description of Intra-Service Work: Following the breathing of the hypoxic gas mixture for 15 minutes, the physician determines if oxygen titration is necessary.

Description of Post-Service Work: Analyze results. Discuss with patient and ordering physician. Write a report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		01/2004			
Presenter(s):	Scott Manaker, MD, PhD, FCCP & Alan Plummer, MD, FCCP				
Specialty(s):	American College of Chest Physicians & American Thoracic Society				
CPT Code:	94453				
Sample Size:	1794	Resp n:	37	Resp %:	2.1
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	25.00	0.40	0.63	2.00	3.00
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	5.00	6.00	20.00	40.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	<u>12.00</u>	
Critical Care time/visit(s):	<u>0.00</u>	99291x 0 99292x 0
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0 99232x 0 99233x 0
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00

To calculate above and below time recommendations, tab here

**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	Global	Work RVU
94450	XXX	0.40

CPT Descriptor Breathing response to hypoxia (hypoxia response curve)

Other Reference CPT Code	Global	Work RVU
94010	XXX	0.17

CPT Descriptor Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 94453	Key Reference CPT Code: 94450
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	6.00	21.00
Median Immediate Post-service Time	12.00	0.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	23.00	21.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Calculate total
reference time
tab here

Mental Effort and Judgement (Mean)

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

Urgency of medical decision making	3.00	3.00
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.00
--------------------------	------	------

Physical effort required	2.00	2.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.00
---	------	------

Outcome depends on the skill and judgement of physician	3.00	3.00
---	------	------

Estimated risk of malpractice suit with poor outcome	3.00	3.00
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.00	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.*

An electronic 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 member of the practice management committees of the two societies who agreed to the recommendations. The representatives from the committees were 10 in number. Additionally, there wer 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? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

94450, 94620, 94761, and 94799.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonary Medicine

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1962

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency	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?

1,462 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

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

CPT Long Descriptor: High altitude simulation test (HAST) with physician interpretation and report.
(For obtaining arterial blood gases, see 36600) (Do not report 94452 in conjunction with 94760, 94761)

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

Geographic Practice Setting %: Rural 0% _____ Suburban 46% _____ Urban 54% _____

Type of Practice %: _____ Solo Practice
_____ 46% _____ Single Specialty Group
_____ Multispecialty Group
_____ 54% _____ 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:

ACCP and ATS utilized a consensus panel to develop the recommendations regarding the practice expense inputs. There were 24 members of the panel consisting of 20 Pulmonologists, 1 Respiratory Care Practitioner, 2 Practice Administrators, and 1 Registered Nurse. Ten of the pulmonologists were from single specialty groups practicing in a suburban setting, and the other ten pulmonologists were medical school faculty practicing in an urban setting. One practice administrator was from a suburban setting, and the other practice administrator and RN were from urban settings.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review the chart(s). Obtain vital signs, provide pre-service education, and obtain consent. Prepare room, equipment and supplies. Prepare and position patient.

Intra-Service Clinical Labor Activities:

Nasal cannula is placed on the patient without supplemental oxygen flowing unless baseline is <88%. A non-breather mask with reservoir bag attached to a certified BOC cylinder containing a mixture of 15% oxygen and 85% N₂ is securely (air tight) fitted to the patient's face over the nasal cannula. The patient breathes the hypoxic mixture and oxyhemoglobin saturations, heart rate, and clinical signs and symptoms are monitored.

Post-Service Clinical Labor Activities:

Clean room and equipment. Collate all the applicable data and format it for physician review.

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

CPT Long Descriptor: High altitude simulation test (HAST) with physician interpretation and report; with supplemental oxygen titration (For obtaining arterial blood gases, see 36600) (Do not report 94452 in conjunction with 94760, 94761)

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

Geographic Practice Setting %: Rural 0% _____ Suburban 46% _____ Urban 54% _____

Type of Practice %: _____ Solo Practice
_____ 46% _____ Single Specialty Group
_____ Multispecialty Group
_____ 54% _____ 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:

ACCP and ATS utilized a consensus panel to develop the recommendations regarding the practice expense inputs. There were 24 members of the panel consisting of 20 Pulmonologists, 1 Respiratory Care Practitioner, 2 Practice Administrators, and 1 Registered Nurse. Ten of the pulmonologists were from single specialty groups practicing in a suburban setting, and the other ten pulmonologists were medical school faculty practicing in an urban setting. One practice administrator was from a suburban setting, and the other practice administrator and RN were from urban settings.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review the chart(s). Obtain vital signs, provide pre-service education, and obtain consent. Prepare room, equipment and supplies. Prepare and position patient.

Intra-Service Clinical Labor Activities:

Nasal cannula is placed on the patient without supplemental oxygen flowing unless baseline is <88%. A non-breather mask with reservoir bag attached to a certified BOC cylinder containing a mixture of 15% oxygen and 85% N2 is securely (air tight) fitted to the patient's face over the nasal cannula. The patient breathes the hypoxic gas mixture and oxyhemoglobin saturations, heart rate, and clinical signs and symptoms are monitored. After observing oxygen desaturation below 88% while breathing the hypoxic

gas mixture, the nasal cannula is used to supply supplemental oxygen which is titrated to ensure stable oxyhemoglobin saturations for a minimum of 10 minutes.

Post-Service Clinical Labor Activities:

Clean room and equipment. Collate all the applicable data and format it for physician review.

	A	B	C	D	E	F
1						
2			94452		94453	
3	RUC January 2004	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	HAST TESTING with interpretation & report		HAST TESTING, including O2 Titration, with interpretation & report	
4	LOCATION		Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD					
6	TOTAL CLINICAL LABOR TIME	RT	43.0	0.0	53.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	RT	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	RT	43.0	0.0	53.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	RT	0.0	0.0	0.0	0.0
10	PRE-SERVICE					
11	Start: Following visit when decision for surgery or procedure made			N/A		N/A
12	Complete pre-service diagnostic & referral forms	RT				
13	Coordinate pre-surgery services	RT				
14	Schedule space and equipment in facility					
15	Provide pre-service education/obtain consent	RT				
16	Follow-up phone calls & prescriptions	RT				
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	RT	2		2	
23	Greet patient and provide gowning					
24	Obtain vital signs	RT	5		5	
25	Provide pre-service education/obtain consent	RT	3		3	
26	Prepare room, equipment, supplies	RT	2		2	
27						
28	Prepare and position patient/ monitor patient/ set up IV		8		8	
29	Sedate/apply anesthesia					
30	Intra-service					
31	Perform Procedure	RT	15		25	
32	Post-Service					
33	Monitor pt following service/check tubes, monitors, drains					
34	Clean room/equipment by physician staff	RT	3		3	
35	Clean Scope					
36	Clean Surgical Instrument Package					
37	Complete Report and Rx	RT	5		5	
38	Review/read X-ray, lab, and pathology reports					
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
40	Discharge day management 99238 –12 minutes 99239 –15 minutes					
41	Other Clinical Activity (please specify)					
42	End: Patient leaves office					
43	POST-SERVICE Period					
44	Start: Patient leaves office/facility					
45	Conduct phone calls/call in prescriptions	RT				
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					
49	99212 27 minutes					
50	99213 36 minutes					
51	99214 53 minutes					
52	99215 63 minutes					
53	Other					
54						
55	Total Office Visit Time			0	0	0
56	Other Activity (please specify)					
57	End: with last office visit before end of global period					

	A	B	C	D	E	F
2			94452		94453	
3	RUC January 2004	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	HAST TESTING with interpretation & report		HAST TESTING, including O2 Titration, with interpretation & report	
4	LOCATION		Non Facility	Facility	Non Facility	Facility
58	MEDICAL SUPPLIES					
59	15% O2/N2 Tank	No code	225 Liters		375 Liters	
60	Nonrebreather Mask	93804	1		1	
61	Nasal Cannula	SD100	1		1	
62	Oxygen 6ltr/min	SD084	0		150 Liters	
63						
64						
65						
66						
67						
68						
69						
70						
71						
72	Equipment					
73	Pulse Oximeter \$1295 00	E5503	1		1	
74	Recliner	CMS-No code	\$829 03		\$829 03	
75	Oxygen Tank	CMS-No code	0		1	
76	Gas test mixture tank	CMS-No code	1		1	
77						
78						

pH ambulatory recorder (Digitrapper)

Medtronic (5143G0202)	\$	6,900
-----------------------	----	-------

pH ambulatory recording workstation w-software (Digitrapper)

Medtronic (9043A0161 and 9043S0421)	\$	11,490
-------------------------------------	----	--------

pH ambulatory recorder (Bravo)

Medtronic (9043K0102)		6900
-----------------------	--	------

pH ambulatory recording workstation w-software (Bravo)

Medtronic (9043A0161 and 9043S0421)	\$	11,490
-------------------------------------	----	--------

vacuum pump, for Bravo system

Medtronic	\$	990
-----------	----	-----

catheter, multi-channel, with impedance sensors

Sandhill (Konigsberg)	\$	13,465
-----------------------	----	--------

impedance recording workstation w-software

Sandhill (InSight)	\$	36,805
--------------------	----	--------

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2004

Central Motor Evoked Potential Study

The CPT Editorial Panel created two new codes 95928 *Central motor evoked potential study (transcranial motor stimulation); upper limbs* and 59529 *Central motor evoked potential study (transcranial motor stimulation); lower limbs* to describe the procedure of transcranial electrical motor stimulation. The RUC understands that these services would not typically be performed on the same day. The RUC reviewed survey data from over 30 physicians who perform this procedure, who indicated that these new services described in 95928 and 59529 are more intense and complex than the selected reference service, 95860 *Needle electromyography; one extremity with or without related paraspinal areas* (Work RVU=0.96). In addition, while 95928 and 59529 had an intra-service time of 60 minutes and 55 minutes respectively, the reference services code, 95860, had an intra-service time of 34 minutes. Due to the greater intensity and extensively longer intra-service time of the two surveyed codes, the RUC agreed with the specialty societies' recommendation of the survey median for both of these new procedures. **The RUC recommends a work relative value of 1.50 for both 95928 and 59529.**

Practice Expense Inputs:

The RUC reviewed in great detail the practice expense inputs of 95928 and 59529. When reviewing the clinical labor time, there was some concern expressed by the RUC about coil and electrode placement. The societies informed the RUC that while the physician applies head coils to the brain to stimulate the hand region of the cortex or the leg region of the cortex, the technologist is applying electrodes to the head and peripheral locations including the hand or the leg. The RUC also questioned the intra-service times of the clinical labor. The specialty society explained that the clinical labor is assisting the physician for the entirety of the physician intra service time (60 minutes for 95928 and 55 minutes for 59529). However, in addition to these times, the specialty society has recommended an additional 8 minutes for 95928 and 23 minutes for 59529 to initiate a baseline nerve conduction study. The RUC agreed with this rationale and determined that it was best to separate this baseline nerve conduction study from the intra-service time. In addition the RUC modified the specialty societies' recommended medical supplies to reflect the addition of a multi-specialty supply package and a laser printer. The RUC approved the revised practice expense inputs, which are attached to the recommendation for these codes.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
+95920		<p>Intraoperative neurophysiology testing, per hour (List separately in addition to code for primary procedure)</p> <p>(Use code 95920 in conjunction with the study performed, 92585, 95822, 95860, 95861, 95867, 95868, <u>95870</u>, 95900, 95904, <u>95928</u>, <u>59529</u>, 95925, 95926, 95927, 95930, 95933, 95934, 95936, 95937)</p> <p>(Code 95920 describes ongoing electrophysiologic testing and monitoring performed during surgical procedures. Code 95920 is reported per hour of service, and includes only the ongoing electrophysiologic monitoring time distinct from performance of specific type(s) of baseline electrophysiologic study(ies) (95860, 95861, 95867, 95868, <u>95870</u>, 95900, 95904, <u>95928</u>, <u>95929</u>, 95933, 95934, 95936, 95937) or interpretation of specific type(s) of baseline electrophysiologic study(ies) (92585, 95822, <u>95870</u>, 95925, 95926, 95927, <u>95928</u>, <u>95929</u>, 95930). The time spent performing or interpreting the baseline electrophysiologic study(ies) should not be counted as intraoperative monitoring, but represents separately reportable procedures. Code 95920 should be used once per hour even if multiple electrophysiologic studies are performed. The baseline electrophysiologic study(ies) should be used once per operative session.)</p> <p>(For electrocorticography, use 95829)</p>	ZZZ	<p>2.11</p> <p>(No Change)</p>

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(For intraoperative EEG during nonintracranial surgery, use 95955) (For intraoperative functional cortical or subcortical mapping, see 95961-95962) (For intraoperative neurostimulator programming and analysis, see 95970-95975)		
•95928	R1	Central motor evoked potential study (transcranial motor stimulation); upper limbs	XXX	1.50
•59529	R2	lower limbs	XXX	1.50

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

CPT Code:95928 Tracking Number: R1 Global Period:XXX **Recommended RVW: 1.50**

CPT Descriptor: Central motor evoked potential study (transcranial motor stimulation); upper limbs

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: This 47-year-old man presented with subacute arm and leg weakness without sensory disturbances. Imaging shows spondylotic cervical myelopathy. After examination, EMG and other testing, his diagnosis remains uncertain. The differential includes cervical myelopathy, amyotrophic lateral sclerosis (ALS), and several peripheral neuromuscular disorders. He is referred for central motor evoked potential testing to assess whether his disorder includes central motor pathway impairment and to provide a baseline for measurement of progression.

Percentage of Survey Respondents who found Vignette to be Typical: 65%

Description of Pre-Service Work: Review request to determine which muscles to evaluate and special needs to be met during testing. Consult with referring physicians to establish patient testing plan.

Description of Intra-Service Work: Apply silver-silver chloride electrodes over the biceps, triceps, abductor pollicis brevis and abductor digiti minimi muscles in belly-tendon recording derivation. Apply gel. Secure electrodes. Check impedances, and reapply electrodes as needed. Prior to performing transcranial magnetic stimulation, routine motor nerve conduction studies of the ulnar and/or median nerves are performed in order to establish baseline compound muscle action potentials (CMAP). This should include stimulation at Erb's point and distal segments of the nerve. Determine the optimal scalp location for head coil using stepwise stimulus location changes and adjustments of intensity. At the optimal location for the first muscle tested, usually abductor digiti minimi, determine the resting motor evoked potential (MEP) threshold using in 5% increments of maximal stimulator output. After determining the threshold, record MEPs during modest tonic isometric contraction using stimulation 25% of maximum output above threshold. Measure the transcranial MEP amplitude and onset latency and compare to baseline nerve conduction studies.

Measure the abductor digiti minimi CMAP obtained with supramaximal electrical stimulation of the ulnar nerve. Calculate the relative abductor digiti minimi MEP amplitude as a percentage of the CMAP amplitude. Measure the MEP to cervical stimulation. Calculate central motor conduction time (CMCT) by subtracting latencies for scalp and cervical stimulation tests. Measure the dissociation between MEP threshold and the cortical stimulation silent period (CSSP) by reducing the stimulator output in 5% increments until stimulation no longer altered the appearance of the average rectified abductor digiti minimi EMG. Measure the dissociation between excitatory and inhibitory effects of transcranial stimulation (MEP facilitation failure) as EMG inhibition without a preceding MEP at 2 or more stimulus intensities.

Replicate data. Store the signals for later review and analysis.

Repeat this procedure for 3- 4 selected muscles on the same limb. Repeat this procedure on the other upper extremity.

Description of Post-Service Work: Review data, eliminate unreliable data, compare patient results to predetermined limits of normality using three criteria: (1) abnormal excitation using MEP threshold and MEP/CMAP ratio; (2) failure of MEP facilitation; (3) abnormal CMCT; and (4) CSSP. Determine appropriate clinical comments based on the patient's presenting problem and test results. Dictate, review and verify report. Verbal interpretation to referring physician if applicable. Respond to any questions from referring physician, or any patient problems.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		01/2004			
Presenter(s):	James Anthony, MD and Jaime Lopez, MD				
Specialty(s):	American Academy of Neurology, American Clinical Neurophysiology Society, and American Association of Electrodiagnostic Medicine				
CPT Code:	95928				
Sample Size:	53	Resp n:	34	Resp %:	64.1%
Sample Type:	Panel				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.54	0.94	1.50	2.07	4.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	10.00	30.00	60.00	120.00	130.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	<u>15.00</u>				
Critical Care time/visit(s):	<u>0.00</u>	99291x 0 99292x 0			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0			
Office time/visit(s):	<u>0.00</u>	99211x 0.0 12x 0.00 13x 0.00 14x 0.00 15x 0.0			

To calculate above and below time recommendations, tab here

**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>
95860	XXX	0.96

CPT Descriptor Needle electromyography; one extremity with or without related paraspinal areas

<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: 17**TIME ESTIMATES (Median)**

New/Revised	Key Reference
CPT Code:	CPT Code:
95928	95860

Median Pre-Service Time	15.00	0.00
-------------------------	-------	------

Median Intra-Service Time	60.00	34.00
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	90.00	34.00

Calculate total
reference time
tab here

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.41	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.24	3.18
Urgency of medical decision making	2.94	2.59

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.71
Physical effort required	3.59	3.12

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.94	2.65
Outcome depends on the skill and judgement of physician	4.12	3.94
Estimated risk of malpractice suit with poor outcome	2.94	2.41

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.88	2.47
Intra-Service intensity/complexity	4.24	3.53
Post-Service intensity/complexity	3.06	2.59

ADDITIONAL RATIONALE

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

A consensus panel reviewed the survey results and felt the median survey RVUs were reasonable for both codes, especially considering the intra-service times for the codes. The IWPUT for 95928 is 0.0138 and 95929 is 0.0151 (see attached worksheet for calculations). The low IWPUT values reinforce that the RVUs are fair. The intensity and complexity measures for the new codes were higher in almost every case than for the reference services code, and support a higher RVU value than 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? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) No billable code

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology

How often? Rarely

Specialty Physical Medicine & Rehabilitation

How often? Rarely

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3188

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Neurology

Frequency 3029

Percentage

95.01 %

Specialty PM&R

Frequency 160

Percentage

5.02 %

Specialty

Frequency

CPT Code:95928
Percentage

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

Specialty Neurology

Frequency 757

Percentage 94.98%

Specialty PM&R

Frequency 40

Percentage 5.02%

Specialty

Frequency

Percentage

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

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

CPT Code:95929 Tracking Number: R2 Global Period:XXX **Recommended RVW: 1.50**

CPT Descriptor: Central motor evoked potential study (transcranial motor stimulation); lower limbs

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: This 63-year-old female presented with subacute leg weakness without sensory disturbances. Imaging shows lumbar stenosis with myelopathy. After examination, EMG, and other testing, her diagnosis remains uncertain. The differential includes lumbar myelopathy, lumbar stenosis with secondary code compression, and several peripheral neuromuscular disorders. She is referred for central motor evoked potential testing to assess whether her disorder includes central motor pathway impairment and to provide a baseline for measurement of progression.

Percentage of Survey Respondents who found Vignette to be Typical: 63.00%

Description of Pre-Service Work: Review request to determine which muscles to evaluate and special needs to be met during testing. Consult with referring physicians to establish patient testing plan.

Description of Intra-Service Work: Apply electrodes over appropriate muscles and check impedances. Obtain motor nerve conduction studies and establish baseline compound muscle action potentials (CMAP). Determine optimal scalp location for head coil. Determine the resting motor evoked potential (MEP) threshold and record MEP during modest tonic isometric contraction. Also measure the transcranial MEP amplitude and onset latency and compare to baseline nerve conduction studies. Measure CMAP obtained with supramaximal electrical stimulation and calculate the relative MEP amplitude. Measure the MEP to lumbar stimulation and calculate the relative MEP amplitude. Measure the dissociation between MEP threshold and the cortical stimulation silent period (CSSP). Measure the dissociation between excitatory and inhibitory effects of transcranial stimulation (MEP facilitation failure). Replicate data and store signals for later review and analysis. Repeat procedure for selected muscles on same limb. Repeat this procedure for other lower extremity.

Description of Post-Service Work: Review data, eliminate unreliable data, compare patient results to predetermined limits of normality using three criteria: (1) abnormal excitation using MEP threshold and MEP/CMAP ratio; (2) failure of MEP facilitation; (3) abnormal CMCT; and (4) CSSP. Determine appropriate clinical comments based on the patient's presenting problem and test results. Dictate, review and verify report. Verbal interpretation to referring physician if applicable. Respond to any questions from referring physician, or any patient problems.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2004
Presenter(s):	James Anthony, MD and Jaime Lopez, MD
Specialty(s):	American Academy of Neurology, American Clinical Neurophysiology Society, and American Association of Electrodiagnostic Medicine
CPT Code:	95929

Sample Size: 53		Resp n: 35	Resp %: 66.0%			
Sample Type: Panel						
		Low	25 th pctl	Median*	75th pctl	High
Survey RVW:		0.54	0.75	1.50	2.00	4.00
Pre-Service Evaluation Time:				15.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		10.00	30.00	55.00	120.00	130.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		15.00				
Critical Care time/visit(s):		0.00	99291x 0 99292x 0			
Other Hospital time/visit(s):		0.00	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:		0.00	99238x 0.0 99239x 0.0			
Office time/visit(s):		0.00	99211x 0.0 12x 0.00 13x 0.00 14x 0.00 15x 0.0			

To calculate above and below time recommendations, tab here

**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>
95860	XXX	0.96

CPT Descriptor Needle electromyography; one extremity with or without related paraspinal areas

<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: 17

TIME ESTIMATES (Median)

	New/Revised CPT Code: 95929	Key Reference CPT Code: 95860
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	55.00	34
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	85.00	34.00

Calculate total
reference time
tab here**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.41	3.59
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.24	3.18
--	------	------

Urgency of medical decision making	2.94	2.59
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.76
--------------------------	------	------

Physical effort required	3.59	3.12
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.94	2.65
---	------	------

Outcome depends on the skill and judgement of physician	4.12	3.94
---	------	------

Estimated risk of malpractice suit with poor outcome	2.94	2.53
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.88	2.47
----------------------------------	------	------

Intra-Service intensity/complexity	4.24	3.53
------------------------------------	------	------

Post-Service intensity/complexity	3.06	2.59
-----------------------------------	------	------

ADDITIONAL RATIONALE

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

A consensus panel reviewed the survey results and felt the median survey RVUs were reasonable for both codes, especially considering the intra-service times for the codes. The IWPUT for 95928 is 0.0138 and 95929 is 0.0151 (see attached worksheet for calculations). The low IWPUT values reinforce that the RVUs are fair. The intensity and complexity measures for the new codes were higher in almost every case than for the reference services code, and support a higher RVU value than for the reference service.

Specialty Neurology	Frequency 2271	Percentage	94.98 %
---------------------	----------------	------------	---------

Specialty PM&R

Frequency 120

CPT Code:95929
Percentage 5.02%

Specialty

Frequency

Percentage

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

	A	B	C	D	E	F	G	H
1								
2			95928		95929		95927	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Central motor evoked potential study (transcranial motor stimulation); upper limbs		Central motor evoked potential study (transcranial motor stimulation); lower limbs		Short-latency somatosensory evoked potential study, .. in the trunk or head	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		XXX		XXX		XXX	
6	TOTAL CLINICAL LABOR TIME	L047B REEGT	119.0	0.0	129.0	0.0	109.0	0 0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		14.0	0.0	14.0	0.0	14 0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		105.0	0.0	115.0	0.0	92.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	0.0	0.0	0.0	3.0	0.0
10	PRE-SERVICE							
11	Start: Following visit when decision for surgery or procedure made							
12	Complete pre-service diagnostic & referral forms		2		2			
13	Coordinate pre-surgery services		2		2			
14	Schedule space and equipment in facility							
15	Provide pre-service education/obtain consent		7		7			
16	Follow-up phone calls & prescriptions		3		3			
17	Other clinical activity							
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		3		3			
23	Greet patient and provide gowning		3		3			
24	Obtain vital signs		3		3			
25	Provide pre-service education/obtain consent							
26	Prepare room, equipment, supplies		2		2			
27	Setup scope (non facility setting only)							
28	Prepare and position patient/ monitor patient/ set up IV		2		2			
29	Sedate/apply anesthesia							
30	Measure and mark head and penpheral locations for electrode Apply and secure electrodes		12		12			
31	Initiate Baseline Nerve Conduction Study		8		23			
32	Intra-service							
33	Assist physician in determining optimal scalp location for head coil, determining resting MEP threshold, recording MEP during isometric contraction, measuring amplitude and onset latencies to cortical stimulation, calculating relative MEP amplitude, measuring MEP to spinal stimulation, calculating relative MEP amplitude, measuring the dissociation between MEP threshold and MSSP, and measuring dissociation between excitatory and inhibitory effects of transcranial stimulation Assist physician in collecting patient data Replicate data Troubleshoot Store data Mark waveforms Assist physician in collecting additional data if needed Repeat procedure for other extremity		60		55			
34	Remove electrodes and clean up patient		4		4			
35	Post-Service							
36	Monitor pt following service/check tubes, monitors, drains		5		5			
37	Clean room/equipment by physician staff		3		3			
38	Clean Scope							
39	Clean Surgical Instrument Package							
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	Discharge day management 99238 --12 minutes 99239 --15 minutes							
44	Other Clinical Activity (please specify)							
45	End: Patient leaves office							
46	POST-SERVICE Period							
47	Start: Patient leaves office/facility							
48	Conduct phone calls/call in prescriptions							
49	Office visits Greet patient,escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results,assist physician duning 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	AMA Specialty Society First Number and Level of Office Visits Recommendation	16						Page 1
51	99211 --15 minutes							

	A	B	C	D	E	F	G	H
2			95928		95929		95927	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Central-motor evoked potential study (transcranial motor stimulation); upper limbs		Central motor evoked potential study (transcranial motor stimulation); lower limbs		Short-latency somatosensory evoked potential study, .. in the trunk or head	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
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
59	Other Activity (please specify)							
60	End. with last office visit before end of global period							
61	MEDICAL SUPPLIES							
62	PEAC multispecialty supply package		1		1			
63	Post-op incision care kit							
65	emery board	SK021	1		1			
67	disposable NCV electrode		8		8			
68	measuring tape, paper	SK048	1		1		1	
69	drape, non-sterile, sheet 40in x 60in	SB006	1		1		1	
71	paper, laser printing (each sheet)	SK057	15		15			
72	swab-pad, alcohol	SJ053	1		1		2	
73	omni prep		1		1		0.1	
74	disposable EMG/NCV ground electrode		1		1		1	
75	gauze, non-sterile 4in x 4in	SG051	1		1		1	
77	tape, porous-hypoallergenic 2in (Scanpore)	SG077	48		48		24	
80	electrode conductive gel	SJ020	1		1		1	
82								
83	EQUIPMENT							
84	Basic Surgical Instrument Package \$500							
85	Medium Surgical Instrument Package \$1,500							
86	EMG-EP machine	E54004	1		1		1	
89	reclining exam chair with headrest	E11011	1		1			
90	Jali mag-stim BiStim		1		1			
91	head coil to stimulate hand region of cortex		1					
92	head coil to stimulate leg region of cortex				1			
93	Dedicated laser printer		1		1			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2004

Complex Deep Brain Neurostimulator Generator – Transmitter Electronic Analysis

Codes 95978 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour* and 95979 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)* describe initial or subsequent electronic analysis of an implanted brain neurostimulator pulse generator system, with programming. The RUC concluded that these codes represent new technology that was not available when the other neurostimulator codes (95971-95973) were developed and therefore complex deep brain stimulation was not included in the original valuation or vignette. **The RUC therefore recommends that the changes to codes 95971-95973 do not change the physician work and recommends 0.78 work RVUs for code 95971, 1.50 RVUs for 95972, and 0.92 RVUs for 95973.**

The presenters provided a rationale for a value of 3.50 RVUs, which is between the median and 75th percentile survey values. The most frequent reference code listed by survey respondents was 95974, *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour* (work RVU = 3.00). This reference code and code 95978 are for the first 60 minutes of service. Survey respondents evaluated the 95978 as more complex and more intense than the reference code but the median RVU was 2.75, which was less than the reference code. The presenters concluded that the respondents incorrectly assumed that they could only allot a total of 60 minutes of time rather than 60 minutes of intra-service time and the median survey value of 2.75 RVUs would create a rank order anomaly in this family of codes, as would the 75th percentile of 5.0 RVUs. The RUC compared 95978 to several other codes such as 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU = 3.52 and intra-service time of 60 minutes, pre-service time of 15 minutes, and post-service time of 20 minutes). Therefore, the RUC concluded that an RVU of 3.50 for

95978 would be appropriate and would fit well in comparison to 95810 as 95978 has the same 60 minutes of intra-service time but at a higher intensity, but also has lower pre and post-service time at 5 minutes each. **The RUC recommends a work RVU of 3.50 for code 95978.**

95979

The work value for this add on code was developed by comparing the additional intra-service time to the value recommended for 95978. Since 95978 has 10 minutes of pre and post service time, the RUC felt that this time should be omitted from 95979 and only 30 minutes of intra-service work should determine the value. Therefore the value for 95979 was determined by using the recommended value of 3.50 for 95978 and reducing the value by the 10 minutes of pre/post service $(10 \times .0224) = .224$ $3.50 - .224 = 3.28$. The value of 3.28 represents the 60 minutes intra-service work of 95978. This value is then cut in half to represent only the 30 minutes of intra-service work for 95979 for a total RVU of 1.64. **The RUC recommends a work RVU of 1.64 for code 95979.**

Practice Expense

The RUC accepted the proposed practice expense inputs without modification. The presenters clarified that clinical staff employed by the physician are involved in programming the neurostimulator and this work is not performed by equipment manufacturer representatives. The clinical staff time to assist the physician was set at 2/3rds of the physician intra-service time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
95970		<i>Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming</i>	XXX	0.45 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲95971	BB1	simple brain , spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	XXX	0.78 (No Change)
▲95972	BB2	complex brain , spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour	XXX	1.50 (No Change)
✚▲95973	BB3	complex brain , spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure) <i>(Use 95973 in conjunction with 95972)</i>	ZZZ	0.92 (No Change)
95974		<i>complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour</i>	XXX	3.0 (No Change)
✚95975		<i>complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)</i> <i>(Use 95975 in conjunction with 95974)</i>	ZZZ	1.70 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●95978	BB4	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour	XXX	3.50
+●95979	BB5	each additional 30 minutes after first hour (List separately in addition to code for primary procedure) <u>(Use 95979 in conjunction with 95978)</u>	ZZZ	1.64

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

Recommended Work Relative Value

CPT Code:95978 Tracking Number: BB4 Global Period: XXX Specialty Society RVU: **3.50** RUC RVU: **3.50**

CPT Descriptor: Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71 year old woman with a 15 year history of idiopathic Parkinson's disease with disability for many activities of daily living returns for follow-up programming of implanted deep brain neurostimulator devices and on her usual doses of medications.

(In responding to the questions on this survey, please consider only the work you perform with respect to the electronic analysis and programming of the neurostimulator FOR THE FIRST HOUR of the session.)

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: THE FOLLOWING INFORMATION WAS NOT INCLUDED ON THE SURVEY:

Review the patient's history concerning Parkinson's disease symptoms including, levodopa associated dyskinesias, rigidity, tremor, bradykinesia, speech difficulties, and gait/balance disorders. Review the anti-Parkinson medication regimen and the response of individual symptoms to the various medications being administered. Review the response of individual symptoms to the current stimulation settings. Confirm that the patient is off levodopa for the initial programming session.

Description of Intra-Service Work: Check the programming system to insure proper functioning. Perform device and lead diagnostic testing, as needed. Each side of the brain has a lead with four contacts. The integrity of all eight contacts (four on each side of the brain) is evaluated by testing impedance. Interrogate the device and determine the percent time the device has been in use since the last programming session to evaluate patient compliance and determine if the device may have been unintentionally inactivated.

Evaluate the patient's experience to date with the device. Review the action/interaction of individual anti-Parkinson medications and deep brain stimulation and their combined effect on individual Parkinsonian symptoms. During a programming session, the physician considers each contact along both electrode leads, stimulation amplitude, pulse width, rate, cathode / anode effects on current, gradual stimulator parameters on a case by case basis, symptom benefit or worsening, and side effects. The physician then considers 200 of a possible one million combinations of the different parameters for an individual patient with a deep brain stimulator. The physician decides which of the 200 combinations to test for an optimal effect while minimizing adverse side effects.

Description of Post-Service Work: At the end of each programming visit, the physician provides the patient and family members with detailed instructions regarding stimulator operations, use of the patient control device to activate or inactivate the stimulator(s) and evaluate battery performance. Document in patient's medical record the results stimulation combinations for each contact including impedance, symptom benefit, and side effects. Document final programming settings and instructions to the patient and family regarding use of the devices, actions to take in case of emergency, and instructions for routine follow-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	James Anthony, MD; Michael Rezak, MD; Frederick Boop, MD; John Wilson, MD				
Specialty(s):	American Academy of Neurology, American Association of Neurological Surgeons/Congress of Neurological Surgeons				
CPT Code:	95978				
Sample Size:	96	Resp n:	32	Response: 33.33 %	
Sample Type:	Panel				
		Low	25 th pctl	Median*	75th pctl
Survey RVW:		1.50	2.15	2.75	5.00
Pre-Service Evaluation Time:				5	
Pre-Service Positioning Time:				0.0	
Pre-Service Scrub, Dress, Wait Time:				0.0	
Intra-Service Time:		15.00	40.00	60	60.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	5				
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).

Society Recommended Time Inputs

Pre: 5 minutes
Intra: 60 minutes
Post: 5 minutes

Additional Rationale

The specialty societies requested pre-facilitation to help us reconcile anomalies identified in the survey. The most frequent reference code listed by survey respondents was 95974, cranial nerve stimulation. Both this code and the survey code are time-based codes for the first 60 minutes of service. Survey respondents uniformly evaluated the 9597x1 as significantly more complex and more intense than the reference code. Yet, the median RVU value suggested by the survey respondents was 2.75, which was less than the reference code. Upon review of the survey responses, we identified numerous responses that gave 40 minutes of intra-service time, with 10 minutes of pre and 10 minutes of post time. We felt that these respondents incorrectly assumed that they could only allot a total of 60 minutes of time rather than 60 minutes of intra-service time. Going with the 50th percentile RVU of 2.75 would create a rank order anomaly in this family of codes. In pre-facilitation, it was clear that the 75th percentile of 5.0 was too high of a value.

In looking at 99291, it is also a time-based code for the first hour of critical care, with a value of 4.0. We felt that 9597x1 was of less intensity, and therefore would necessitate a value of less than 4.0. We identified another code of similar work intensity and times to 9597x1, which was polysomnography, code 95810, with intra-service time of 60 minutes, pre-service time of 15 minutes, and post-service time of 20 minutes. This code was RUC surveyed with a work RVU of 3.52. Therefore we decided upon a recommended work RVU of 3.5 for 9597x1.

This new recommended value corresponds well to the 50th percentile response for the add-on code, 9597x2, at 1.75.

KEY REFERENCE SERVICE:

Key CPT Code
95974

Global
XXX

Work RVU
3.00

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour

Other Reference CPT Code

Global

Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 43.7 %

TIME ESTIMATES (Median)

New/Revised
CPT Code:
9597x
Key
Reference
CPT Code:
95974

Median Pre-Service Time	5	30.00
Median Intra-Service Time	60	60.00
Median Immediate Post-service Time	5	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	20.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	70.00	130.00

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	4.57	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.57	3.14
Urgency of medical decision making	4.14	2.93

Technical Skill/Physical Effort (Mean)

Technical skill required	4.57	3.14
Physical effort required	3.71	2.36

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.36	3.29
Outcome depends on the skill and judgment of physician	4.86	3.79
Estimated risk of malpractice suit with poor outcome	3.57	3.14

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.07	2.64
Intra-Service intensity/complexity	4.93	3.50
Post-Service intensity/complexity	3.86	2.64

ADDITIONAL RATIONALE

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

The complexity and intensity measures for the deep brain stimulation programming codes are significantly greater compared to the other codes in the family. The intensity is higher because of the increased risk of adverse clinical events secondary to electrical stimulation of deep brain structures. The complexity is higher due to the intricacies of the multiple brain stimulation programs.

Upon review of the survey responses, there are numerous responses that gave 40 minutes intra-service time and 10 pre-time and 10 post-time. It's clear that the responders felt that they could only allot a total of 60 minutes time, rather than 60 minutes of intra-service time. We feel it is appropriate to recommend the 75th percentile RVU of 5.0.

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) 95972

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Rarely

Specialty Neurosurgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Neurology Frequency 4250 Percentage 85.00 %

Specialty Neurosurgery Frequency 750 Percentage 15.00 %

Specialty Frequency Percentage %

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

4,250 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Neurology Frequency 3613 Percentage 85.01 %

Specialty Neurosurgery Frequency 637 Percentage 15.00 %

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: 95979 Tracking Number: BB5 Global Period: ZZZ Specialty Society RVU: **1.75** RUC RVU: **1.64**

CPT Descriptor: Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure.)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71 year old woman with a 15 year history of idiopathic Parkinson's disease with disability for many activities of daily living returns for follow-up programming of implanted deep brain neurostimulator devices and on her usual doses of medications.

(In responding to the questions on this survey, please consider only the work you perform with respect to the electronic analysis and programming of the neurostimulator FOR EACH ADDITIONAL 30 MINUTES AFTER THE FIRST HOUR of the session.)

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? 3%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: Continue to review the action/interaction of individual anti-Parkinson medications and deep brain stimulation and their combined effect on individual Parkinsonian symptoms. During a programming session, the physician considers each contact along both electrode leads, stimulation amplitude, pulse width, rate, cathode / anode effects on current, gradual stimulator parameters on a case by case basis, symptom benefit or worsening, and side effects. The physician then considers 200 of a possible one million combinations of the different parameters for an individual patient with a deep brain stimulator. The physician decides which of the 200 combinations to test for an optimal effect while minimizing adverse side effects.

Description of Post-Service Work:

SURVEY DATA

CONFIDENTIAL

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):		James Anthony, MD; Michael Rezak, MD; Frederick Boop, MD; John Wilson, MD				
Specialty(s):		American Academy of Neurology, American Association of Neurological Surgeons/Congress of Neurological Surgeons				
CPT Code:		95979				
Sample Size: 96		Resp n: 31		Response: 32.29 %		
Sample Type: Panel						
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:		0.92	1.50	1.75	2.50	9.00
Pre-Service Evaluation Time:				0.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		

Intra-Service Time:		15.00	30.00	30.00	30.00	180.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	0.00					
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).

Additional Rationale

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
95973	ZZZ	0.92

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

<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: 45.2 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 9597x	Key Reference CPT Code: 95973
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	30.00	30.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	30.00	30.00

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	4.07	3.57
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.50
--	------	------

Urgency of medical decision making	4.07	3.57
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.64	4.14
--------------------------	------	------

Physical effort required	3.64	3.21
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.74	3.29
---	------	------

Outcome depends on the skill and judgment of physician	4.71	4.14
--	------	------

Estimated risk of malpractice suit with poor outcome	3.21	3.07
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

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

Intra-Service intensity/complexity	4.43	4.00
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

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 feel it is appropriate to assign an RVU that is half the value of the per hour code, therefore we recommend the 75th percentile RVU of 2.50. The complexity and intensity measured higher than 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: 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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95973

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Rarely

Specialty Neurosurgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Neurology Frequency 425 Percentage 85.00 %

Specialty Neurosurgery Frequency 75 Percentage 9.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 425

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

Specialty Neurology Frequency 361 Percentage 84.94 %

Specialty Neurosurgery Frequency 64 Percentage 15.00 %

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

AMTA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor. Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour

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 composed of neurologists and neurosurgeons from across the country and varying practice settings developed the inputs. Since the code is for one hour, the consensus panel assigned two-thirds of the physician work time for the nurse assisting the physician with the procedure. Additional activities are standard RUC times.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic and referral forms. Coordinate pre-testing services. Provide pre-service education/obtain consent. Follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Review charts. Greet patient and provide gowning. Obtain vital signs. Prepare room, equipment, supplies. Prepare and position patient/ monitor patient. Assist physician with procedure.

Post-Service Clinical Labor Activities:

None

Total Staff Time In Office:

Visits in Global Period:

CMS'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)
L042A	RN/LPN	6	53	0	

* 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	Units Used for Purchase	Cost Estimate and Source (if applicable)
	PEAC Multispecialty Supply Package	1		

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	Cost Estimate and Source (if applicable)
	N'Vision Complete Programmer Package	\$1975.00
E11001	Exam table	

AMA/Specialty Society Update Process
PEAC Summary of Recommendation
ZZZ Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure.)

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

A consensus panel composed of neurologists and neurosurgeons from across the country and varying practice settings developed the inputs. Since the code is for 30 minutes, the consensus panel assigned two-thirds of the physician work time for the nurse assisting the physician with the procedure.

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities:

Assist physician with procedure.

Total Staff Time Non Facility:

Visits in Global Period:

CMS's Staff Type Code*	Clinical Labor	Service Period	Cost Estimate and Source (if applicable)
L042A	RN/LPN	20	

*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	Units Used for Purchase	Cost Estimate and Source (if applicable)

*From CMS's 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'Vision Complete Programmer Package	\$1975.00
E11001	Exam table	

*From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed provide full description, estimated cost, and cost source

	A	B	C	D	E	F
1						
2			95978		95979	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration; battery status,		implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status,	
4	LOCATION		Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		XXX		ZZZ	
6	TOTAL CLINICAL LABOR TIME	L042A RN/LPN	59.0	0.0	20.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		6.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		53.0	0.0	20.0	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		3			
13	Coordinate pre-surgery services		3			
14	Schedule space and equipment in facility					
15	Provide pre-service education/obtain consent					
16	Follow-up phone calls & prescriptions					
17	Other Clinical Activity (please specify)					
18	End: When patient enters office/facility for surgery/procedure					
19	SERVICE PERIOD					
20	Start: When patient enters office/facility for surgery/procedure					
21	Pre-service services					
22	Review charts		3			
23	Greet patient and provide gowning		3			
24	Obtain vital signs		3			
25	Provide pre-service education/obtain consent					
26	Prepare room, equipment, supplies		2			
27	Setup scope (non facility setting only)					
28	Prepare and position patient/ monitor patient/ set up IV		2			
29	Sedate/apply anesthesia					
30	Intra-service					
31	Assist physician in performing procedure 2/3 physician time		40		20	
32	Post-Service					
33	Monitor pt following service/check tubes, monitors, drains					
34	Clean room/equipment by physician staff					
35	Clean Scope					
36	Clean Surgical Instrument Package					
37	Complete diagnostic forms, lab & X-ray requisitions					
38	Review/read X-ray, lab, and pathology reports					
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
40	Discharge day management 99238 --12 minutes 99239 --15 minutes					
41	Other Clinical Activity (please specify)					
42	End: Patient leaves office					
43	POST-SERVICE Period					
44	Start: Patient leaves office/facility					
45	Conduct phone calls/call in prescriptions					
46	Office visits Greet patient, escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results, assist physician during exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care					
47	List Number and Level of Office Visits					
48	99211 16 minutes	16				
49	99212 27 minutes	27				
50	99213 36 minutes	36				
51	99214 53 minutes	53				
52	99215 63 minutes	63				
53	Other					
54						
55	Total Office Visit Time		0	0	0	0
56	Other Activity (please specify)					
57	End: with last office visit before end of global period					

	A	B	C	D	E	F
2			95978		95979	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status,		implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status,	
4	LOCATION		Non Facility	Facility	Non Facility	Facility
58	MEDICAL SUPPLIES					
59	PEAC multispecialty supply package		1			
60	Post-op incision care kit					
61						
62						
63						
64						
65						
66	Equipment					
67	Basic Surgical Instrument Package \$500					
68	Medium Surgical Instrument Package \$1,500					
69	NVision Complete Programmer Package \$1,975		1		1	
70	exam table	E11001	1		1	
71						
72						
73						
74						
75						

HCPAC Recommendations

For CPT 2005

RUC Meetings:

September 2003, February 2004 and
April 2004

American Medical Association

Physicians dedicated to the health of America



AMA/Specialty Society RVS Update Process 515 North State Street 312 464-4736
Chicago, Illinois 60610 312 464-5849 Fax

May 27, 2004

Terry Kay
Deputy Director
Hospital and Ambulatory Policy Group
Center for Medicare Management
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 2005.

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

- Acupuncture/Electroacupuncture
- Comprehensive Tinnitus Assessment
- Evaluation of Central Auditory Function
- Negative Pressure Wound Therapy
- Wound Care-Removal of Devitalized Tissue

In addition, the Practice Expense Advisory Committee (PEAC) practice expense refinement recommendations are included in the practice expense binder.

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,

A handwritten signature in black ink, appearing to read "R. Whitten".

Richard W. Whitten, MD

A handwritten signature in black ink, appearing to read "Mary Foto, OTR".

Mary Foto, OTR

cc: Ken Simon, MD
 Edith L. Hambrick, MD
 Carolyn Mullen
 Pam West, PT
 Rick Ensor
 Sherry Smith
 Patrick Gallagher

CPT 2005 RUC HCPAC Review Board Recommendations

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
92589	XXX	D	Feb04	C1	Evaluation of Central Auditory Function		HCPAC	N	ASHA				Yes	
92620	XXX	N	Feb04	C1	Evaluation of Central Auditory Function	AY1	HCPAC	N	ASHA				Yes	No Physician Work - Practice Expense Inputs Only
92621	XXX	N	Feb04	C1	Evaluation of Central Auditory Function	AY2	HCPAC	N	ASHA				Yes	No Physician Work - Practice Expense Inputs Only
92625	XXX	N	Feb04	C1	Comprehensive Tinnitus Assessment	AZ1	HCPAC	N	ASHA				Yes	No Physician Work - Practice Expense Inputs Only
97597	XXX	N	Aug03	30	Wound Care-Removal of Devitalized Tissue	F1	HCPAC	30	APTA, AOTA	0.69	0.58		Yes	
97598	XXX	N	Aug03	S	Wound Care-Removal of Devitalized Tissue	F2	HCPAC	30	APTA, AOTA	0.80	0.80		Yes	
97601	XXX	D	Nov03	S	Wound Care-Removal of Devitalized Tissue		HCPAC	30					Yes	
97605	XXX	N	Aug03	T	Negative Pressure Wound Therapy	G1	HCPAC	30	APTA	0.55	0.55		Yes	
97606	XXX	N	Aug03	T	Negative Pressure Wound Therapy	G2	HCPAC	30	APTA	0.60	0.60		Yes	
97780	XXX	D	Nov03	H	Acupuncture/Electroacupuncture		HCPAC	N					Yes	
97781	XXX	D	Nov03	H	Acupuncture/Electroacupuncture		HCPAC	N					Yes	

Wednesday, May 26, 2004 Page 1 of 2

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
97810	XXX	N	Nov03	H	Acupuncture/Electroacupuncture	S1	HCPAC	N	ACA		0.70	0.60		Yes	
97811	ZZZ	N	Nov03	H	Acupuncture/Electroacupuncture	S2	HCPAC	N	ACA		0.65	0.50		Yes	
97813	XXX	N	Nov03	H	Acupuncture/Electroacupuncture	S3	HCPAC	N	ACA		0.75	0.65		Yes	
97814	ZZZ	N	Nov03	H	Acupuncture/Electroacupuncture	S4	HCPAC	N	ACA		0.70	0.55		Yes	

AMA/Specialty Society RVS Update Committee
Health Care Professional Advisory Committee
Summary of Recommendations

April 2004

Evaluation of Central Auditory Function

The CPT Editorial Panel created two new codes to describe the appropriate time and additional time used to perform a blended battery of evaluations for auditory functions associated with a comprehensive language evaluation. Previous CPT codes were generic and did not allow for the repeated use of the code for multiple individual tests. Therefore, the codes were created specifically describe multiple tests comprised in a clinic visit.

92620 & 92621

No physician work values were presented for these two codes.

Practice Expense

In the extensive discussion of the practice expense for 92620 *Evaluation of central auditory function, with report; initial 60 minutes* and 92621 *each additional 15 minutes*, the HCPAC determined that some clinical services (i.e., gowning the patient and cleaning the room) are below PEAC standards because a gown is not usually worn by the patient for these services and there is little to clean. Additionally, the intra-service for 92621 was dropped from 23 minutes to 15 minutes to appropriately represent the work specified in the descriptor. **The HCPAC deemed this was appropriate and recommends the attached Practice Expense inputs.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
92589		Central Auditory Function test(s) (specify) (92589 has been deleted. To report, see 92620, 92621)	XXX	N/A
●92620	AZ1	Evaluation of central auditory function, with report; initial 60 minutes	XXX	No Physician Work- See Practice Expense Inputs
●92621	AZ2	each additional 15 minutes (Do not report 92620, 92621 in conjunction with 92506)	ZZZ	No Physician Work- See Practice Expense Inputs

AMTA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Evaluation of central auditory function, with report; initial 60 minutes

Sample Size: 7 Response Rate: (%): 1 Global Period: XXX

Geographic Practice Setting %: Rural 14% Suburban 29% Urban 43% Multiple 14%

Type of Practice %: 14% Solo Practice
14% Single Specialty Group
14% Multispecialty Group
57% Medical School Faculty Practice Plan

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

A survey was sent to a sample of audiologists targeted for participation because of their noted area of expertise or participation in Special Interest Divisions. The data were then reviewed and refined by a consensus panel of six audiologists representing the American Speech-Language-Hearing Association and the American Academy of Audiology.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The audiologist reviews all pertinent auditory and academic history and central auditory questionnaire responses.

Intra-Service Clinical Labor Activities:

After greeting the family and bringing them to the audiometric booth, a history was taken to obtain information on developmental, familial, and medical factors that may have impacted the child's auditory processing abilities. The child was then seated in the sound treated room and earphones were positioned. The child was initially instructed to listen carefully to words that may be hard to understand. His task was to repeat the word or sentence to the best of his abilities and guess at individual responses when he is not sure. The audiologist leaves the child in the patient side of the audiometric booth and takes a seat behind the diagnostic audiometer, while maintaining eye contact with the child. Each test is played via CD or cassette tape and routed through the diagnostic audiometer. The audiologist records the child's responses on respective scoring forms for each test. After administration of each test, the audiologist determines the raw and standard scores and plots the standard scores for a visual representation of the child's performance. Before the administration of each new test, the child receives instructions through the earphones with regard to the nature of the task and the child's required responses. The audiologist must not only record the child's responses, but must also monitor the child's

performance to ensure that the child can continue to tend to the task at hand and is not beginning to fatigue. After administering all necessary tests, the audiologist compiles the respective scores to derive an interpretation of the age-equivalent performance level and types of stimuli and environments that will cause difficulties for the child. The results, interpretation, and recommendations are then conveyed to the accompanying family members. For interdisciplinary evaluations, representatives of the other professional disciplines are notified of the test results and interpretation in the event that these findings influence the conclusions and recommendations generated by their respective test results.

Post-Service Clinical Labor Activities:

A report is prepared and forwarded to the referring physician and to the other members of the interdisciplinary team.

CPT Code: 92620
Specialty Society('s) ASHA

Total Staff Time In Office:

Visits in Global Period:

CMS'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)
L052A	Audiologist	3	73	8	

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	Units Used for Purchase	Cost Estimate and Source (if applicable)
SK008	Audiology forms	4	Each	0.088

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	Cost Estimate and Source (if applicable)
E71029	Audiometer	
Need update	Sound proof booth – double walled	\$46,400 TELE-ACOUSTICS, Florida a Trilogy Audiometrics company www.trilogyaudiometrics.com

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period

SITE OF SERVICE: NON FACILITY

Clinical Services

Minutes

Staff Type – Circle

Pre-Service Period

Start: When appointment for service is made

Review/read X-ray, lab, and pathology reports

Audiologist

Other Clinical Activity (please specify)

Review case history, CAP questionnaires, reports

3

Audiologist

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

2

Audiologist

Obtain vital signs

Audiologist

Prep and position patient

2

Audiologist

Prepare room, equipment, supplies

2

Audiologist

Perform Procedure

60

Audiologist

Education/instruction/ counseling

5

Audiologist

Coordinate home or outpatient care

Audiologist

Clean room/equipment

2

Audiologist

Other Clinical Activity (please specify)

Audiologist

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family pharmacy

3

Audiologist

Other Activity (please specify)

Write report

Audiologist

5

End: When appointment for next office visit is made.

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

CPT Long Descriptor: Evaluation of central auditory function, with report; each additional 15 minutes

Sample Size: 7 Response Rate: (%): 1 Global Period: ZZZ

Geographic Practice Setting %: Rural 14% Suburban 29% Urban 43% Multiple 14%

Type of Practice %: 14% Solo Practice
14% Single Specialty Group
14% Multispecialty Group
57% Medical School Faculty Practice Plan

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

A survey was sent to a sample of audiologists targeted for participation because of their noted area of expertise or participation in Special Interest Divisions. The data were then reviewed and refined by a consensus panel of six audiologists representing the American Speech-Language-Hearing Association and the American Academy of Audiology.

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities:

After greeting the family and bringing them to the audiometric booth, a history was taken to obtain information on developmental, familial, and medical factors that may have impacted the child's auditory processing abilities. The child was then seated in the sound treated room and earphones were positioned. The child was initially instructed to listen carefully to words that may be hard to understand. His task was to repeat the word or sentence to the best of his abilities and guess at individual responses when he is not sure. The audiologist leaves the child in the patient side of the audiometric booth and takes a seat behind the diagnostic audiometer, while maintaining eye contact with the child. Each test is played via CD or cassette tape and routed through the diagnostic audiometer. The audiologist records the child's responses on respective scoring forms for each test. After administration of each test, the audiologist determines the raw and standard scores and plots the standard scores for a visual representation of the child's performance. Before the administration of each new test, the child receives instructions through the earphones with regard to the nature of the task and the child's required responses. The audiologist must not only record the child's responses, but must also monitor the child's performance to ensure that the child can continue to tend to the task at hand and is not beginning to fatigue. After administering all necessary tests, the audiologist compiles the respective scores to derive an interpretation of the age-equivalent performance level and types of stimuli and environments that will cause difficulties for the child. The results, interpretation, and recommendations are then conveyed to the accompanying family members. For interdisciplinary evaluations, representatives of the other professional disciplines are

notified of the test results and interpretation in the event that these findings influence the conclusions and recommendations generated by their respective test results.

Total Staff Time Non Facility:

Visits in Global Period:

CMS's Staff Type Code*	Clinical Labor	Service Period	Cost Estimate and Source (if applicable)
L052A	Audiologist	26	

*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	Units Used for Purchase	Cost Estimate and Source (if applicable)
SK008	Audiology forms	2	Each	0.088

*From CMS's 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)
E71029	Audiometer	
Need update	Sound proof booth – double walled	\$46,400 TELE-ACOUSTICS, Florida a Trilogy Audiometrics company www.trilogyaudiometrics.com

*From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed provide full description, estimated cost, and cost source.

SITE OF SERVICE: Non Facility
Clinical Services

Minutes **Staff Type – Circle**

Pre-Service Period

Start: Following visit when decision for surgery or procedure made

Pre-service time (If applicable) Please specify activities _____

Audiologist

Other Activity (please specify)

Review questionnaires and reports _____

Audiologist

Service Period

Start: When patient enters office for surgery/procedure
Pre-service services

Pre-service time (If applicable) Prepare room _____

1

Audiologist

Intra-service

Perform procedure _____

23

Audiologist

Post-service (if applicable)

Please specify activities _____

1

Audiologist

Education/instruction/counseling

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Conduct phone calls/call in prescriptions _____

Audiologist

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

Audiologist

A _____

B _____

List total number of office visits

Total office visit time (A * B)

Other Activity (please specify) _____

Write report _____

1

Audiologist

End: With last office visit before end of global period

	A	B	C	D	E	F	G	H
1								
2			92625		92620		92621	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Assessment of tinnitus (includes pitch, loudness matching and masking)		Evaluation of central auditory function, with report; initial 60 minutes		Evaluation of central auditory function, with report, each additional 15 minutes	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		XXX	NA	XXX	NA	ZZZ	NA
6	TOTAL CLINICAL LABOR TIME	L052A	83.0		84.0		18.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0		0.0		0.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L052A	74.0		76.0		17.0	
9	TOTAL POST-SERV CLINICAL LABOR TIME	L052A	9.0		8.0		1.0	
10	PRE-SERVICE							
11	Start: Following visit when decision for surgery or procedure made							
12	Complete pre-service diagnostic & referral forms							
13	Coordinate pre-surgery services							
14	Schedule space and equipment in facility							
15	Provide pre-service education/obtain consent							
16	Follow-up phone calls & prescriptions							
17	Other Clinical Activity (please specify) Review case history, questionnaires, reports							
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	L052A	3		3			
23	Greet patient and provide gowning	L052A	2		2			
24	Obtain vital signs							
25	Provide pre-service education/obtain consent							
26	Prepare room, equipment, supplies	L052A	2		2		1	
27	Setup scope (non facility setting only)							
28	Prepare and position patient/ monitor patient/ set up IV	L052A			2			
29	Sedate/apply anesthesia							
30	Intra-service							
31	Perform procedure	L052A	60		60		15	
32	Post-Service							
33	Education/instruction/counseling	L052A	5		5		1	
34	Monitor pt following service/check tubes, monitors, drains							
35	Clean room/equipment by physician staff	L052A	2		2			
36	Clean Scope							
37	Clean Surgical Instrument Package							
38	Complete diagnostic forms, lab & X-ray requisitions							
39	Review/read X-ray, lab, and pathology reports							
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions							
41	Discharge day management 99238 –12 minutes 99239 –15 minutes							
42	Other Clinical Activity (please specify)							
43	End: Patient leaves office							
44	POST-SERVICE Period							
45	Start: Patient leaves office/facility							
46	Conduct phone calls/call in prescriptions	L052A	3		3			
47	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							
48	List Number and Level of Office Visits							
49	99211 16 minutes	16						
50	99212 27 minutes	27						
51	99213 36 minutes	36						
52	99214 53 minutes	53						
53	99215 63 minutes	63						
54								
55								
56	Total Office Visit Time		0	0	0	0	0	0
57	Other Activity (please specify) Write report	L052A	6		5		1	
58	End: with last office visit before end of global period							

	A	B	C	D	E	F	G	H
2			92625		92620		92621	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Assessment of tinnitus (includes pitch, loudness matching and masking)		Evaluation of central auditory function, with report; initial 60 minutes		Evaluation of central auditory function, with report; each additional 15 minutes	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
59	MEDICAL SUPPLIES							
60	Audiology forms		3		4		2	
61								
62								
63								
64								
65								
66								
67	EQUIPMENT							
68	Audiometer	E71029	1		1		1	
69	Sound proof booth - double walled	d updated inform	1		1		1	
70								
71								
72								
73								
74								
75								
76								

AMA/Specialty Society RVS Update Committee
Health Care Professional Advisory Committee
Summary of Recommendations

April 2004

Comprehensive Tinnitus Assessment

The CPT Editorial Panel created a new code to describe the comprehensive components of assessing tinnitus, which includes assessing pitch, loudness matching and masking noises in the ear(s).

92625

No physician work values were presented for this code, only practice expense inputs.

Practice Expense

In the discussion of the practice expense for 92625 *Assessment of tinnitus (includes pitch, loudness matching, and masking)*, the HCPAC determined that audiology forms needed to be added to the supplies for this code. **With this revision, the HCPAC recommends the clinical labor time, supplies and equipment for 92625 on the attached Practice Expense Summary.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•92625	BA1	Assessment of tinnitus (includes pitch, loudness matching, and masking) (Do not report 92625 in conjunction with 92562) For unilateral assessment, use modifier 52)	XXX	No Physician Work-See Practice Expense Inputs

AMTA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Assessment of tinnitus (includes pitch, loudness matching and masking)

Sample Size: 8 Response Rate: (%): 1 Global Period: XXX

Geographic Practice Setting %: Rural 25% Suburban 13% Urban 62%

Type of Practice %: 0% Solo Practice
 25% Single Specialty Group
 50% Multispecialty Group
 12% Medical School Faculty Practice Plan

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

A survey was sent to a sample of audiologists targeted for participation through their noted area of expertise or participation in Special Interest Divisions. The data were then reviewed and refined by a consensus panel of six audiologists representing the American Speech-Language-Hearing Association and the American Academy of Audiology.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The audiologist reviews pertinent case history and audiometric results.

Intra-Service Clinical Labor Activities:

The audiologist greets the patient and accompanies her to the testing suite. The audiologist prepares the patient by inserting earphones into each ear canal after otoscopic inspection. The audiologist then sits at the diagnostic audiometer in the control booth facing the patient in the test booth. Pitch (frequency) matching is accomplished by individually presenting nine frequencies (500, 750, 1000, 1500, 2000, 3000, 4000, 6000 and 8000 Hz) using a two-alternative forced-choice procedure (2AFC) whereby the patient must choose which tone is closest in pitch to her self-perceived tone. The audiometric tones are presented at intensity levels slightly above the patient's auditory threshold at each frequency. The patient describes the pitch of the stimulus as higher, lower, or similar to her perceived sound. This pitch bracketing process continues until the patient states that the stimulus is the same as or very similar to her perceived sound or is fully bracketed between adjacent half-octave frequencies. This procedure is then performed on the patient's other ear. Loudness matching testing is then performed by presenting a series of pure tones and the patient is asked to report if each presented tone is louder, softer or equal in loudness to the self-perceived sound. Typically, octave and mid-octave frequencies from 500 Hz to 8000 Hz are presented at intensity levels slightly above the patient's auditory threshold at each frequency. The intensity level of the stimulus is increased or decreased in 1 dB steps by the audiologist. When the patient

reports the external stimulus as being equal in loudness to her self-perceived sound, this level is recorded as the loudness match (in dB) for that frequency. Equal loudness estimates are calculated in dB SL (loudness match in dB HL minus the auditory threshold in dB HL at that frequency). This loudness matching procedure is performed for each ear separately, resulting in eighteen (nine matches per ear) loudness matches between the stimulus and the patient's self-perceived sound. Instructions regarding the masking procedure are then given to the patient and masking stimuli are presented to the same earphone as the perceived tone. Ten individual masking stimuli (nine frequencies of narrow band noise at octave and mid-octave frequencies from 500 - 8000 Hz as well as wide band noise) are individually increased in intensity from threshold in 1-2 dB steps until masking of the tinnitus is accomplished. The Minimum Masking Level (MML) is recorded in dB SL (SL=Sensation Level, e.g., the effective tinnitus masking level in dB HL minus the auditory threshold for the masking stimulus) for each masking stimulus. Comparative measurements between the various forms of maskers are needed to select the masker with the greatest efficiency in providing the most effective masking stimulus. This procedure is performed for each ear independently and for binaural stimulation for those patients with bilateral tinnitus. The audiologist then presents the most effective masking stimulus at +10 to +15 dB SL (above the MML) continuously for 60 seconds. The patient is asked to report if her perceived tinnitus increased, decreased or was unchanged after cessation of the masking stimulus. The length of time the patient is without perception of the tinnitus is determined and the duration of tinnitus suppression ("residual inhibition") is calculated. The patient is informed of the outcome of the evaluation and the potential for remediation.

Post-Service Clinical Labor Activities:

The referring physician is notified by telephone and a report is written concerning the outcome of the evaluation and recommendations for masking therapy.

CPT Code: 92625
Specialty Society('s) ASHA

Total Staff Time In Office:

Visits in Global Period:

CMS'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)
L052A	Audiologist	3	72	9	

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	Units Used for Purchase	Cost Estimate and Source (if applicable)
SK008	Audiometric forms	3	Each	0.088

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	Cost Estimate and Source (if applicable)
E71029	Audiometer	
	Sound proof booth – double walled	\$46,400 TELE-ACOUSTICS, Florida a Trilogy Audiometrics company www.trilogyaudiometrics.com

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period

SITE OF SERVICE: NON FACILITY

Clinical Services

Minutes

Staff Type – Circle

Pre-Service Period

Start: When appointment for service is made

Review/read X-ray, lab, and pathology reports

Audiologist

Other Clinical Activity (please specify)

Review case history and audiometric information

_____ 3 _____

Audiologist

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

_____ 2 _____

Audiologist

Obtain vital signs

Prep and position patient

Prepare room, equipment, supplies

_____ 2 _____

Audiologist

Perform procedure

_____ 60 _____

Audiologist

Education/instruction/ counseling

_____ 5 _____

Audiologist

Coordinate home or outpatient care

Clean room/equipment

_____ 3 _____

Audiologist

Other Clinical Activity (please specify)

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family pharmacy

_____ 3 _____

Audiologist

Other Activity (please specify)

Write report

_____ 6 _____

Audiologist

End: When appointment for next office visit is made.

	A	B	C	D	E	F	G	H
1								
2			92625		92620		92621	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Assessment of tinnitus (includes pitch, loudness matching and masking)		Evaluation of central auditory function, with report, initial 60 minutes		Evaluation of central auditory function, with report; each additional 15 minutes	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		XXX	NA	XXX	NA	ZZZ	NA
6	TOTAL CLINICAL LABOR TIME	L052A	83.0		84.0		18.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0		0.0		0.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L052A	74.0		76.0		17.0	
9	TOTAL POST-SERV CLINICAL LABOR TIME	L052A	9.0		8.0		1.0	
10	PRE-SERVICE							
11	Start: Following visit when decision for surgery or procedure made							
12	Complete pre-service diagnostic & referral forms							
13	Coordinate pre-surgery services							
14	Schedule space and equipment in facility							
15	Provide pre-service education/obtain consent							
16	Follow-up phone calls & prescriptions							
17	Other Clinical Activity (please specify) Review case history, questionnaires, reports							
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	L052A	3		3			
23	Greet patient and provide gowning	L052A	2		2			
24	Obtain vital signs							
25	Provide pre-service education/obtain consent							
26	Prepare room, equipment, supplies	L052A	2		2		1	
27	Setup scope (non facility setting only)							
28	Prepare and position patient/ monitor patient/ set up IV	L052A			2			
29	Sedate/apply anesthesia							
30	Intra-service							
31	Perform procedure	L052A	60		60		15	
32	Post-Service							
33	Education/instruction/counseling	L052A	5		5		1	
34	Monitor pt following service/check tubes, monitors, drains							
35	Clean room/equipment by physician staff	L052A	2		2			
36	Clean Scope							
37	Clean Surgical Instrument Package							
38	Complete diagnostic forms, lab & X-ray requisitions							
39	Review/read X-ray, lab, and pathology reports							
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions							
41	Discharge day management 99238 –12 minutes 99239 –15 minutes							
42	Other Clinical Activity (please specify)							
43	End: Patient leaves office							
44	POST-SERVICE Period							
45	Start: Patient leaves office/facility							
46	Conduct phone calls/call in prescriptions	L052A	3		3			
47	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							
48	List Number and Level of Office Visits							
49	99211 16 minutes	16						
50	99212 27 minutes	27						
51	99213 36 minutes	36						
52	99214 53 minutes	53						
53	99215 63 minutes	63						
54								
55								
56	Total Office Visit Time		0	0	0	0	0	0
57	Other Activity (please specify) Write report	L052A	6		5		1	
58	End: with last office visit before end of global period							

	A	B	C	D	E	F	G	H
2			92625		92620		92621	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Assessment of tinnitus (includes pitch, loudness matching and masking)		Evaluation of central auditory function, with report; initial 60 minutes		Evaluation of central auditory function, with report, each additional 15 minutes	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
59	MEDICAL SUPPLIES							
60	Audiology forms		3		4		2	
61								
62								
63								
64								
65								
66								
67	Equipment							
68	Audiometer	E71029	1		1		1	
69	Sound proof booth - double walled	and updated inform	1		1		1	
70								
71								
72								
73								
74								
75								
76								

AMA/Specialty RVS Update Committee
HCPAC Review Board
Summary of Recommendations

February 2004

Wound Care-Removal of Devitalized Tissue

The CPT Editorial Panel revised an existing code and created a new code to describe the work for selective debridement based on total surface area of wound sizes(s) with possible use of a whirlpool.

97597

The HCPAC reviewed the survey results of 97597 *Removal of devitalized tissue from wound(s), selective debridement without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters*. The survey respondents indicated the work associated with 97597 was more intense than 11040 *Debridement; skin, partial thickness* (Work RVU=0.50). In addition, the HCPAC noted that the intra-service time for the revised code (30 minutes) is longer than the intra-service time for the reference code 11040 (14 minutes). However, during deliberation the HCPAC discussed the different modalities of debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps) and determined that a whirlpool would be utilized in approximately 75 percent of patients. Therefore, by using a building block approach, the HCPAC discussed a recommendation of 0.58 for 97597 by adding the work of 11040 and half of the work associated with 97022 *Application of a modality to one or more areas; whirlpool* (Work RVU = 0.17). **The HCPAC recommends a work value of 0.58 for 97597.**

97598

The HCPAC reviewed the survey results of this code and the survey respondents indicated it required more mental effort, technical skill and psychological stress than its reference service code, 97530 *Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes* (Work RVU=0.44). In addition, the HCPAC noted that the intra-service time for the new code (40 minutes) is longer than the intra service time for the reference code 97530 (14 minutes). Therefore, the HCPAC approved the society recommended 0.80 work RVU recommendation for 97598. **The HCPAC recommends 0.80 work RVUs for 97598.**

The HCPAC felt these values were appropriate because they maintain work neutrality. The HCPAC discussed the total frequency of the existing code 97597, which is 82,119 claims. The specialty society forecasted that approximately 75 percent of the existing claims for 97597(61,589 claims) would be maintained in the base code and 25 percent of the existing claims for the 97597 (20,530 claims) would now be billed as 97598. The following calculations describe how these values and forecasted frequency information would maintain the work neutrality of these codes.

Total RVUs with HCPAC Recommended Values for New Codes:

97597: $61,589 \times 0.58 = 35,721.62$

97598: $20,530 \times 0.80 = 16,424$

Total RVUs for Both Codes = 52,145.62

Total RVUs with CMS Values for Existing Code:

97597: $82,119 \times 0.50 = 41,059.5$

97022: $82,119 \times 0.75 \times 0.17 = 10,470.17$ (75% of 97597 is billed with use of a whirlpool which was originally billed separately)

Total RVUs = 51,529.67

Practice Expense

The RUC reviewed the practice expense inputs for 97598. These inputs were assessed and modified to PEAC accepted standards of clinical labor time, supplies and equipment. The RUC recommends the practice expense inputs as defined in the attached spreadsheets.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		Active wound care procedures are performed to remove devitalized and/or necrotic tissue and promote healing. and involve selective debridement and non-selective debridement techniques Provider is required to have direct (one-on-one) patient contact.		

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲97597	F1	Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet <u>with/without suction</u> , sharp selective debridement with scissors, scalpel and tweezers <u>forceps</u>), <u>with or without including</u> —topical application(s), wound assessment, and instruction(s) for ongoing care, <u>may include use of a whirlpool</u> , per session; <u>total wound(s) surface area less than or equal to 20 square centimeters</u>	XXX	0.58
●97598	F2	total wound(s) surface area greater than 20 square centimeters	XXX	0.80
97601		Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers) including topical application(s), wound assessment, and instruction(s) for ongoing care, per session (97601 has been deleted. To report, use 97597, 97598)	XXX	0.50

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

CPT Code:97597 Tracking Number: F1 Global Period:XXX **Recommended RVW: 0.69 0.58**

CPT Descriptor: Removal of devitalized tissue from wound(s), selective debridement without anesthesia (eg, high pressure waterjet with/without suction, sharp debridement with scissors, scalpel and forceps), with/without use of a whirlpool, topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 20 square centimeters

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 68 year old woman who has developed a pressure ulcer on the sacrum and reports pain from the ulcerated area. Examination reveals that the wound is covered with black eschar and is surrounded by chronic inflammation with dark pigmentation. It is determined that the patient is not a candidate for surgery due to several comorbidities, however would benefit from sharp debridement of the necrotic tissue. The wound is lightly cleansed and then measured. The sacral wound measures 6.5 cm x 2.0 cm, with 100% black wound bed and no obvious drainage. The surrounding tissue is palpated with the wound margin observed as being inflamed and indurated. The wound is wiped with an anti-microbial solution, followed by sharp debridement using scissors, scalpel and forceps to remove the devitalized tissue and facilitate subsequent wound healing. An enzymatic agent, saline gauze and a composite dressing are placed directly on the wound bed. The last component related to this intervention is instruction to the patient/caregiver regarding application of dressing, frequency of dressing change and signs of wound deterioration.

Percentage of Survey Respondents who found Vignette to be Typical: 26.52%

Description of Pre-Service Work: Review chart /referral; remove existing dressings.

Description of Intra-Service Work: Measure and cleanse the wound; palpate surrounding tissue; perform thorough cleaning and debridement as described in above vignette.

Description of Post-Service Work: Instruct patient and/or caregiver on proper care, dressing change schedule, proper positioning of body area containing wound.

SURVEY DATA

RUC Meeting Date (mm/yyyy)			
Presenter(s):	Jonathan Cooperman, PT and Mary Foto, OT		
Specialty(s):	American Physical Therapy Assoc. and American Occupational Therapy Assoc.		
CPT Code:	97597		
Sample Size:	2505	Resp n:	181
		Resp %:	7.2%
Sample Type:	Panel		

	<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:	0.17	0.50	0.69	1.00	2.16
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	20.00	30.00	40.00	75.00
Post-Service	Total Min** CPT code / # of visits				
Immed. Post-time:	10.00				
Critical Care time/visit(s):	0.00	99291x 0 99292x 0			
Other Hospital time/visit(s):	0.00	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			

To calculate above and below time recommendations, tab here

**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
97530

Global

Work RVU
0.44

CPT Descriptor therapeutic activities, direct one-on-one patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Other Reference CPT Code

Global

Work RVU

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 42

TIME ESTIMATES (Median)

	New/Revised CPT Code: 97597	Key Reference CPT Code: 97530
Median Pre-Service Time	10.00	2.00
Median Intra-Service Time	30.00	14.00
Median Immediate Post-service Time	10.00	2.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	50.00	18.00

Calculate total
reference time
tab here**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.08	3.98
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.64
--	------	------

Urgency of medical decision making	4.23	3.32
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.67	3.87
--------------------------	------	------

Physical effort required	3.55	3.39
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.02	2.98
---	------	------

Outcome depends on the skill and judgement of physician	4.38	2.61
---	------	------

Estimated risk of malpractice suit with poor outcome	4.58	3.89
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.90	2.61
----------------------------------	------	------

Intra-Service intensity/complexity	4.58	3.89
------------------------------------	------	------

Post-Service intensity/complexity	3.26	2.92
-----------------------------------	------	------

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.*

APTA and AOTA met via conference call, discussed the results of the survey, and reached a consensus on the recommended values.

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

- A typical scenario for services that might be delivered with wound services would depend on the reason for the skin breakdown. For an amputee, additional prosthetic training (97520) may be appropriate; for an incontinent patient, neuromuscular reeducation (97112) or electrical stimulation (97014 or G028X for Medicare) may be appropriate; therapeutic activities (97530) may be appropriate for patients with bed sores to help them to shift and re-position.

Other	Global	Work RVU	Pre Svc Time	Intra Svc Time	Post Svc Time
97520	XXX	0.45	2 minutes	14 minutes	2 minutes
97112	XXX	0.45	2	14	2
97014	XXX	0.18	1	11	1
97530	XXX	0.44	2	14	2

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.

Estimate the number of times this service might be provided nationally in a one-year period? 120,000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty PT	Frequency 30,000	Percentage
Specialty OT	Frequency 10,000	Percentage
Specialty	Frequency	Percentage

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
61,589 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty PT	Frequency 46192	Percentage
Specialty OT	Frequency 15397	Percentage
Specialty	Frequency	Percentage

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

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

CPT Code:97598 Tracking Number: F2 Global Period:XXX **Recommended RVW: 0.80**

CPT Descriptor: Removal of devitalized tissue from wound(s), selective debridement without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with/without use of whirlpool, topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 20 sq cm.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 72 year old male who developed a pressure ulcer on the left hip and a venous ulcer of the left medial lower leg just proximal to the ankle. The wounds are lightly cleansed and then measured.

Examination of the left hip wound reveals a stage III ulcer measuring 5.0cm x 4.4 cm x 3.2cm. The wound bed is obscured with semi-adherent, yellow necrotic tissue. The wound margin is indurated with non-blanchable redness noted. Moderate amounts of serosanguineous drainage is noted.

The left lower leg wound measures 10.0cm x 6.8 cm x 1.5 cm. This is a full thickness wound. Seventy-five percent is covered with adherent yellow necrotic tissue. Twenty-five percent is dull pink tissue. The wound margins are irregular and macerated. Copious serosanguineous drainage is evident. Circumferential measurements taken at the calf and ankle reveals 2 centimeters of measurable edema on the left compared to the right lower extremity.

A more thorough cleansing of the left hip wound is performed utilizing high pressure waterjet with suction in order to facilitate loosening of the tissue. The wound is then wiped with an antimicrobial solution followed by sharp debridement with scissors, scalpel and forceps to remove devitalized tissue. The wound is then dressed with saline moistened gauze, lightly packed and a composite dressing applied.

The ankle wound is wiped with an antimicrobial solution followed by sharp debridement utilizing scissors, scalpel and forceps to remove the devitalized tissue. A barrier cream is applied to protect the tissue around the wound and prevent further breakdown. The wound is dressed with an absorbent dressing that promotes further autolytic debridement and covered with a composite dressing.

The last component related to this intervention is instruction to the patient/caregiver regarding appropriate exercise and limb elevation.

Percentage of Survey Respondents who found Vignette to be Typical: 27.33%

Description of Pre-Service Work: Review chart/referral; remove existing dressings.

Description of Intra-Service Work: Measure and cleanse wound; palpate surrounding tissue; perform thorough cleaning and debridement as described in above vignette.

Description of Post-Service Work: Instruct patient and/or caregiver on proper care, dressing change schedule, proper positioning of body area containing wound, and exercise.

SURVEY DATA

RUC Meeting Date (mm/yyyy)					
Presenter(s):	Jonathan Cooperman, PT and Mary Foto, OT				
Specialty(s):	American Physical Therapy Assoc. and American Occupational Therapy Assoc.				
CPT Code:	97598				
Sample Size:	2505	Resp n:	161	Resp %:	6.4%
Sample Type: Panel					
		Low	25th pctl	Median*	75th pctl
Survey RVW:		0.25	0.60	0.80	1.20
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		4.00	30.00	40.00	50.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	15.00				
Critical Care time/visit(s):	0.00	99291x 0 99292x 0			
Other Hospital time/visit(s):	0.00	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			

To calculate above and below time recommendations, tab here

**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>
97530	XXX	0.44

CPT Descriptor therapeutic activities, direct one-on-one patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

<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: 38

TIME ESTIMATES (Median)

	New/Revised CPT Code: 97598	Key Reference CPT Code: 97530
Median Pre-Service Time	15.00	2.00
Median Intra-Service Time	40.00	14.00

Median Immediate Post-service Time	15.00	2.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00
Median Office Visit Time	0.00	0.00
Median Total Time	70.00	18.00

Calculate total
reference time
tab here

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.33	3.81
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	3.45
--	------	------

Urgency of medical decision making	4.39	3.42
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.72	3.90
--------------------------	------	------

Physical effort required	3.86	3.42
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.31	3.14
---	------	------

Outcome depends on the skill and judgement of physician	4.56	3.82
---	------	------

Estimated risk of malpractice suit with poor outcome	4.09	3.10
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.18	2.70
----------------------------------	------	------

Intra-Service intensity/complexity	4.68	3.88
------------------------------------	------	------

Post-Service intensity/complexity	3.46	2.94
-----------------------------------	------	------

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.*

APTA and AOTA met via conference call, discussed the results of the survey, and reached a consensus on the recommended 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: Yes

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

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

The procedure is not reported using multiple codes, but several procedures (CPT codes) are typically reported on the same date. Codes in the Physical Medicine section of the CPT manual (97000 series) are developed with the knowledge that multiple services (codes) such as therapeutic exercise (97110) and gait training (97116) may be delivered at the same visit.

A typical scenario for services that might be delivered with wound services would depend on the reason for the skin breakdown. For an amputee, additional prosthetic training (97520) may be appropriate; for an incontinent patient, neuromuscular reeducation (97112) or electrical stimulation (97014 or G028X for Medicare) may be appropriate; therapeutic activities (97530) may be appropriate for patients with bed sores to help them to shift and re-position.

Other Codes	Global	Work RVU	Pre Svc Time	Intra Svc Time	Post Svc Time
97520	XXX	0.45	2 minutes	14 minutes	2 minutes
97112	XXX	0.45	2 minutes	14 minutes	2 minutes
97014	XXX	0.18	1 minute	11 minutes	1 minute
97530	XXX	0.44	2 minutes	14 minutes	2 minute

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) 97597

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

Specialty PT How often? Sometimes

Specialty OT How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 120000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty PT	Frequency 30000	Percentage
--------------	-----------------	------------

Specialty OT	Frequency 10000	Percentage
--------------	-----------------	------------

Specialty	Frequency 0	Percentage
-----------	-------------	------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20,530 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty PT	Frequency 15,398	Percentage
--------------	------------------	------------

Specialty OT	Frequency 5132	Percentage
--------------	----------------	------------

Specialty	Frequency 0	Percentage
-----------	-------------	------------

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

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

CPT Long Descriptor: Removal of devitalized tissue from wound(s), selective debridement without anesthesia (eg, high pressure waterjet with/without suction, sharp debridement with scissors, scalpel and forceps), with/without use of a whirlpool, topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 20 square centimeters

Sample Size: 2505 Response Rate: (%): 7% Global Period: XXX

Geographic Practice Setting %: Rural 19 Suburban 43 Urban 37

Type of Practice %: 15 Solo Practice
 22 Single Specialty Group
 26 Multispecialty Group
 37 Medical School Faculty Practice Plan

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

A panel of experts was convened via conference call to develop practice expenses for the current series of wound care codes. This panel represented several treatment sites and included both physical therapists and occupational therapists. Using the practice expenses for the current code 97597 (Removal of devitalized tissue) as a starting point, the panel further refined the values for the new codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Includes reviewing the chart, greeting and providing the patient with gowning, obtaining vital signs, preparing the room and equipment and preparing and positioning patient.

Intra-Service Clinical Labor Activities:

Includes assisting the physical or occupational therapist in performing the procedure.

Post-Service Clinical Labor Activities:

Includes cleaning the room and equipment and delivering post treatment assistance to the patient, as well as phone calls to family and care-givers.

Total Staff Time In Office:

Visits in Global Period:

CMS'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)
	RN/LPN/MTA				
	PTA		14		
	Aide		24		

* 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	Units Used for Purchase	Cost Estimate and Source (if applicable)
	From Whirlpool, 97022			
52304	silver nitrate stick	1		0.65
11306	mask, surgical	1		0.30
11107	patient gown, disp	1		0.57
31514	tape	12		0.03
31509	Kling roller bandage	1		0.38
32014	stockinette	1		0.45
	Sterilizing chem (chorozene)	1		2.50
31505	Guaze, Sterile 4X4	5		1.10
14005	Gloves, sterile	1		0.89
	For Current Code			
31514	Tape	6		
31526	Kling, Sterile 4"	1		
14005	glove, sterile	1		
11107	patient gown, disp	2		
11111	exam table paper	7		
11306	mask, surgical	0		
31508	guaze, sterile, 4x4 (10 pack)	1		
11112	pillow case	1		
14004	towel, sterile	1		
11102	Chux	1		
From 97597	Debridement Kit, sharp	1		
From 97597	biohazard cannister	1		
	Emzematic Agent (thermazine)	one sixth of \$15		
	Antimicrobial solution (betadine)	\$0.50		
	Saline	\$2.30		
	Specialty dressing (composites, Iodosorb, Iodoflex)	1 unit \$16		
	Face Shield	1		

CPT Code: 97597

	Barrier Cream	1 un \$0.45		

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	Cost Estimate and Source (if applicable)
E92005	whirlpool	\$3,700
From current 97597	Suction machine for debridement	942
From current 97597	low mat table	5,000

**Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period**

(Please see attached spreadsheet)

SITE OF SERVICE: NON FACILITY**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)

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
PEAC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs**

CPT Long Descriptor: Removal of devitalized tissue from wound(s), selective debridement without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with/without use of whirlpool, topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 20 sq cm.

Sample Size: 2505 Response Rate: (%): 6% Global Period: XXX

Geographic Practice Setting %: Rural 22 Suburban 43 Urban 36

Type of Practice %: 16 Solo Practice
 23 Single Specialty Group
 24 Multispecialty Group
 37 Medical School Faculty Practice Plan

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

A panel of experts was convened via conference call to develop practice expenses for the current series of wound care codes. This panel represented several treatment sites and included both physical therapists and occupational therapists. Using the practice expenses for the current code 97597 (Removal of devitalized tissue) as a starting point, the panel further refined the values for the new codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Includes reviewing the chart, greeting and providing the patient with gowning, obtaining vital signs, preparing the room and equipment and preparing and positioning patient.

Intra-Service Clinical Labor Activities:

Includes assisting the physical or occupational therapist in performing the procedure.

Post-Service Clinical Labor Activities:

Includes cleaning the room and equipment and delivering post treatment assistance to the patient, as well as phone calls to family and care-givers.

Total Staff Time In Office:

Visits in Global Period:

CMS'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)
	RN/LPN/MTA				
	PTA		14		
	Aide		24		

* 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	Units Used for Purchase	Cost Estimate and Source (if applicable)
	From Whirlpool, 97022			
52304	silver nitrate stick	1		0.65
11306	mask, surgical	1		0.30
11107	patient gown, disp	1		0.57
31514	tape	12		0.03
31509	Kling roller bandage	1		0.38
32014	stockinette	1		0.45
	Sterilizing chem (chorozene)	1		2.50
31505	Guaze, Sterile 4X4	5		1.10
14005	Gloves, sterile	1		0.89
	For Current Code			
31514	Tape	6		
31526	Kling, Sterile 4"	0, see below		
14005	glove, sterile	1		
11107	patient gown, disp	2		
11111	exam table paper	7		
11306	mask, surgical	0		
31508	guaze, sterile, 4x4 (10 pack)	1		
11112	pillow case	1		
14004	towel, sterile	1		
11102	Chux	1		
From 97597	Debridement Kit, sharp	1		
From 97597	biohazard cannister	1		
	Emzematic Agent (thermazine)	one sixth of \$15		
	Antimicrobial solution (betadine)	\$0.50		
	Saline	\$2.30		
	Specialty dressing (composites, Iodosorb, Iodoflex)	1 unit \$16		
	Face Shield	1		

CPT Code: 97598

	Barrier Cream	1 un \$0.45		
	Kurlex dressing	1		

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	Cost Estimate and Source (if applicable)
E92005	whirlpool	\$3,700
From current 97597	Suction machine for debridement	942
From current 97597	low mat table	5,000

**Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period**

(Please see attached spreadsheet)

**SITE OF SERVICE: NON FACILITY
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)

_____ 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.

	A	B	C	D	E	F	G	H
1								
2			97597		Revised 97597		97598	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	ANCHOR CODE - Current Code - Removal of Devascularized Tissue		Removal of devitalized tissue, w/w/o whirlpool, 20 sq cm or less		Removal of devitalized tissue, w/w/o whirlpool, more than 20 sq cm	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD							
6	TOTAL CLINICAL LABOR TIME		38	0	35	0	35	0
7	Phy Ther or Occ Ther Assistant		14		14		14	
8	Aide		24		21		21	
9	TOTAL PRE-SERV CLINICAL LABOR TIME		0	0	0	0	0	0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		36	0	32	0	32	0
11	TOTAL POST-SERV CLINICAL LABOR TIME		2	0	3	0	3	0
12	PRE-SERVICE							
13	Start: Following visit when decision for surgery or procedure made							
14	Complete pre-service diagnostic & referral forms							
15	Coordinate pre-surgery services							
16	Schedule space and equipment in facility							
17	Provide pre-service education/obtain consent							
18	Follow-up phone calls & prescriptions							
19	Other Clinical Activity (please specify)							
20	End:When patient enters office/facility for surgery/procedure							
21	SERVICE PERIOD							
22	Start: When patient enters office/facility for surgery/procedure							
23	Pre-service services							
24	Review charts	Assistant	3		3		3	
25	Greet patient and provide gowning	Aide	3		3	(standard)	3	
26	Obtain vital signs	Assistant	2		2	(standard)	2	
27	Provide pre-service education/obtain consent							
28	Prepare room, equipment, supplies	Aide	6		3		3	
29	Setup scope (non facility setting only)							
30	Prepare and position patient/ monitor patient/ set up IV	Aide	3		2	(2 is std)	2	
31	Sedate/apply anesthesia							
32	Intra-service							
33	Assist physician in performing procedure	Assistant	5		5		5	
34	Post-Service							
35	Monitor pt following service/check tubes, monitors, drains							
36	Clean room/equipment by physician staff	Aide	10		10	(3 is std)	10	
37	Clean Scope							
38	Clean Surgical Instrument Package							
39	Complete diagnostic forms, lab & X-ray requisitions							
40	Review/read X-ray, lab, and pathology reports							
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	Assistant	2		2		2	
42	Discharge day management 99238 --12 minutes 99239 --15 minutes							
43	Other -Post treatment Assistance	Aide	2		2		2	
44	End: Patient leaves office							
45	POST-SERVICE Period							
46	Start. Patient leaves office/facility							
47	Conduct phone calls/call in prescriptions	PTA	2		3	(standard)	3	
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 36 minutes	36						
53	99214 53 minutes	53						
54	99215 63 minutes	63						
55	Other							
57	Total Office Visit Time		0	0	0	0	0	0
58	Other Activity (please specify)							
59	End. with last office visit before end of global period							

	A	B	C	D	E	F	G	H
2			97597		Revised 97597		97598	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	ANCHOR CODE - Current Code - Removal of Devitalized Tissue		Removal of devitalized tissue, w/w/o whirlpool, 20 sq cm or less		Removal of devitalized tissue, w/w/o whirlpool, more than 20 sq cm	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
60	MEDICAL SUPPLIES							
61	PEAC multispecialty supply package							
62	Post-op incision care kit							
64	Tape	31514	6		18		18	
65	Kling, Sterile 4"	31526	1		2		1	
66	glove, sterile	14005	1		2		2	
67	patient gown, disp	11107	2		2		2	
68	exam table paper	11111	7		7		7	
69	mask, surgical	11306	1					
70	gauze, sterile, 4x4 (10 pack)	31508	1		2		2	
71	pillow case	11112	1		1		1	
72	towel, sterile	14004	1		1		1	
73	Chux	11102	1		1		1	
74	Debridement Kit, sharp	SA029	1		1		1	
75	biohazard cannister/bag	SM004	1		1		1	
76	From Whirlpool - silver nitrate stick	52304			1		1	
77	From Whirlpool - stockinette	32014			1		1	
78	From Whirlpool - Sterilizing chem (chorozene)	(ong 97022)			1		1	
79	biohazard glass disp Box	SM005						
80	Emzematic Agent (thermazine)/accuzyne				\$2 04		\$2 04	
81	Antimicrobial solution (betadine)	SJ041			1		1	
82	Saline	SH069			1		1	
83	Specialty dressing (composites, Iodosorb, Iodoflex), acticoat				\$15 87		\$31 74	
84	Face/eye Shield	SM016			1		1	
85	Barners Cream/zinc oxide	SJ064			1		1	
86	Kerlex dressing	SG016					1	
87	Skin Prep lotion				\$0 35		\$0 35	
88	Adaptex (non adherent gauze/mesh)	SG040			1		1	
89	Dressing set for neg pressure wound therapy pump	A6550						
90	"Y" connector							
92	Equipment							
93	Basic Surgical Instrument Package \$500							
94	Medium Surgical Instrument Package \$1,500							
95	Suction machine for debridement		36		32		32	
96	low mat table	E11001	36		32		32	
97	whirlpool	E92005			24		24	
98	Canister set for neg pressure wound therapy pump	A6551						
99	Neg pressure wound therapy elec pump	E2402						

	A	B	C	D	I	J	K	L
1								
2			97597		97773		97774	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	ANCHOR CODE - Current Code - Removal of Devitalized Tissue		Negative pressure wound therapy, 50 sq cm or less		Negative pressure wound therapy, more than 50 sq cm	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD							
6	TOTAL CLINICAL LABOR TIME		38	0	24	0	24	0
7	Phy Ther or Occ Ther Assistant		14		11		11	
8	Aide		24		13		13	
9	TOTAL PRE-SERV CLINICAL LABOR TIME		0	0	0	0	0	0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		36	0	22	0	22	0
11	TOTAL POST-SERV CLINICAL LABOR TIME		2	0	2	0	2	0
12	PRE-SERVICE							
13	Start: Following visit when decision for surgery or procedure made							
14	Complete pre-service diagnostic & referral forms							
15	Coordinate pre-surgery services							
16	Schedule space and equipment in facility							
17	Provide pre-service education/obtain consent							
18	Follow-up phone calls & prescriptions							
19	Other Clinical Activity (please specify)							
20	End: When patient enters office/facility for surgery/procedure							
21	SERVICE PERIOD							
22	Start: When patient enters office/facility for surgery/procedure							
23	Pre-service services							
24	Review charts	Assistant	3		3		3	
25	Greet patient and provide gowning	Aide	3		3		3	
26	Obtain vital signs	Assistant	2		2		2	
27	Provide pre-service education/obtain consent							
28	Prepare room, equipment, supplies	Aide	6		2		2	
29	Setup scope (non facility setting only)							
30	Prepare and position patient/ monitor patient/ set up IV	Aide	3		2		2	
31	Sedate/apply anesthesia							
32	Intra-service							
33	Assist physician in performing procedure	Assistant	5		5		5	
34	Post-Service							
35	Monitor pt following service/check tubes, monitors, drains							
36	Clean room/equipment by physician staff	Aide	10		3		3	
37	Clean Scope							
38	Clean Surgical Instrument Package							
39	Complete diagnostic forms, lab & X-ray requisitions							
40	Review/read X-ray, lab, and pathology reports							
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	Assistant	2					
42	Discharge day management 99238 -12 minutes 99239 -15 minutes							
43	Other -Post treatment Assistance	Aide	2		2		2	
44	End: Patient leaves office							
45	POST-SERVICE PERIOD							
46	Start: Patient leaves office/facility							
47	Conduct phone calls/call in prescriptions	PTA	2		2		2	
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 36 minutes	36						
53	99214 53 minutes	53						
54	99215 63 minutes	63						
55	Other							
57	Total Office Visit Time		0	0	0	0	0	0
58	Other Activity (please specify)							
59	End. with last office visit before end of global period							

	A	B	C	D	I	J	K	L
2			97597		97773		97774	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	ANCHOR CODE - Current Code - Removal of Devitalized Tissue		Negative pressure wound therapy, 50 sq cm or less		Negative pressure wound therapy, more than 50 sq cm	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
60	MEDICAL SUPPLIES							
61	PEAC multispecialty supply package							
62	Post-op incision care kit							
64	Tape	31514	6		6		6	
65	Kling, Sterile 4"	31526	1					
66	glove, sterile	14005	1		1		1	
67	patient gown, disp	11107	2		2		2	
68	exam table paper	11111	7		7		7	
69	mask, surgical	11306	1		1		1	
70	gauze, sterile, 4x4 (10 pack)	31508	1		1		1	
71	pillow case	11112	1		1		1	
72	towel, sterile	14004	1		1		1	
73	Chux	11102	1		1		1	
74	Debridement Kit, sharp	SA029	1		1			
75	biohazard cannister/bag	SM004	1		1		1	
76	From Whirlpool - silver nitrate stick	52304						
77	From Whirlpool - stockinette	32014						
78	From Whirlpool - Sterilizing chem (chorozene)	(ong 97022)						
79	biohazard glass disp Box	SM005						
80	Emzematic Agent (thermazine)/accuzyme							
81	Antimicrobial solution (betadine)	SJ041						
82	Saline	SH069						
83	Specialty dressing (composites, Iodosorb, Iodoflex), acticoat							
84	Face/eye Shield	SM016						
85	Bamer Cream/zinc oxide	SJ064						
86	Kerlex dressing	SG016						
87	Skin Prep lotion				1		1	
88	Adaptac (non adherent gauze/mesh)	SG040			2		4	
89	Dressing set for neg pressure wound therapy pump	A6550			1		1	
90	"Y" connector				\$2.00		\$2.00	
92	Equipment							
93	Basic Surgical Instrument Package \$500							
94	Medium Surgical Instrument Package \$1,500							
95	Suction machine for debridement		36					
96	low mat table	E11001	36					
97	whirlpool	E92005						
98	Canister set for neg pressure wound therapy pump	A6551			22		22	
99	Neg pressure wound therapy elec pump	E2402			22		22	

AMA Specialty Society RVS Update Committee
HCPAC Review Board
Summary of Recommendations

February 2004

Negative Pressure Wound Therapy

The CPT Editorial Panel created two new codes to describe negative pressure wound therapy, a procedure that manages wound exudates and promotes wound closure. It is a distinctive selective debridement procedure utilizing vacuum assisted drainage collection systems.

97605

The HCPAC reviewed the survey results for 97605 *Negative pressure wound therapy (e.g. vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters*. The survey respondents indicated that 97605 is more intense and requires more mental effort, technical skill and psychological stress than the reference service code 97002 *Physical therapy re-evaluation* (Work RVU= 0.60). The HCPAC also discussed other codes that are similar to the services performed in the new codes such as 97601 *Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session* (Work RVU=0.50). The HCPAC was informed by the specialty society that 97601 accounts for the selective debridement portion of the 97605, however, it does not include the suction and drainage collection which are performed in the new code. Therefore the HCPAC agreed with the specialty society's recommendation of their survey median which appropriately places this new service in between the two discussed reference services. **Therefore, the HCPAC recommends 0.55 work RVU for 97605.**

97606

The HCPAC reviewed the survey results for 97606 *total wound(s) surface area greater than 50 square centimeters*. The survey respondents indicated that 97606 is more intense and requires more mental effort, technical skill and psychological stress than the reference service code 97110 *Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* (Work RVU=0.45). In addition, the median intra-service time for 97606 is 30 minutes, which is more than 14 minutes for the reference code 97110. Again, the HCPAC also discussed another potential reference code such as 97601 *Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet, sharp*

selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session (Work RVU=0.50). The HCPAC agreed with the previous rationale that not only the work associated with the new codes incorporated suction and drainage collection whereas the 97601 does not, it also agreed that proper rank order must be maintained between 97605 and 97606. Therefore the HCPAC agreed with the specialty society's median RVU recommendation of 0.60 for the new code because it properly places it between the discussed reference code and the newly created base code. **Therefore, the HCPAC recommends 0.60 work RVU for 97606.**

Practice Expense

The HCPAC reviewed the practice expense inputs for 97605 and 97606. These inputs were assessed and modified to accurately reflect of clinical labor time, supplies and equipment associated with these new codes. The HCPAC recommends no practice expense inputs in the facility setting. The RUC recommends the practice expense inputs as defined in the attached spreadsheets.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Active wound care procedures are performed to remove devitalized and/or necrotic tissue and promote healing. and involve selective debridement and non-selective debridement techniques Provider is required to have direct (one-on-one) patient contact.				
•97605	G1	Negative pressure wound therapy (e.g. vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	XXX	0.55
•97606	G2	total wound(s) surface area greater than 50 square centimeters	XXX	0.60

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

CPT Code:97605 Tracking Number: Global Period:XXX **Recommended RVW: 0.55**

CPT Descriptor: Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 sq cm.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 73 yr old male with a stage III pressure ulcer of the sacrum. The base of the wound is clean and red and presents with heavy amount of serous drainage. There is also significant induration of the entire wound periphery with 1.5 cm of undermining proximally. The wound measures 8.5 x 5.0 x 3.2 centimeters.

Prior to application of the negative pressure therapy, the wound is thoroughly cleansed. The wound is assessed to assure no sinus tracts and/or fistulas are present. The skin around the wound is cleansed thoroughly and prepared for the application of transparent film. The foam sponge is cut to fit the size and depth of the wound as well as the undermined areas.

The foam is secured in the wound using an adhesive transparent film. The film is applied with ample border to assure a tight seal. The suction feet and tubing are then inserted into the foam. Additional transparent film is placed around the suction feet to secure the seal. The tubing is then connected to the negative pressure therapy pump. The negative pressure parameters are set on intermittent application at 100mm/Hg. The pump is activated and the dressing is inspected for appropriate negative pressure suction and no evidence of leaks.

Percentage of Survey Respondents who found Vignette to be Typical: 70.59%

Description of Pre-Service Work: Review chart/referral; remove existing dressings.

Description of Intra-Service Work: Thoroughly clean the wound and assess the wound to assure no sinus tracts and/or fistulas are present. Clean skin around the wound and prepare for the application of transparent film. Insert tubing and connect to the negative pressure therapy pump. Set pump parameters and activate. Inspect for leaks and clogs, and the need for canister replacement.

Description of Post-Service Work: The patient/caregiver is instructed in the maintenance of the pump, technique for canister replacement, proper inspection of the dressing and signs or symptoms of wound deterioration.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	February 2004
Presenter(s).	Jonathan Cooperman, PT
Specialty(s):	American Physical Therapy Assoc.
CPT Code:	97605

Sample Size:	207	Resp n:	17	Resp %:	8%
Sample Type:	Panel				
		Low	25th pctl	Median*	75th pctl
Survey RVW:		0.35	0.45	0.55	0.75
Pre-Service Evaluation Time:				10.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		12.00	20.00	30.00	30.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	10.00				
Critical Care time/visit(s):	0.00	99291x 0 99292x 0			
Other Hospital time/visit(s):	0.00	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			

To calculate above and below time recommendations, tab here

**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

Global

Work RVU

97002

0.60

CPT Descriptor physical therapy reevaluation

Other Reference CPT Code

Global

Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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/Revised
CPT Code:
97605

Key Reference
CPT Code:
97002

Median Pre-Service Time	10.00	2.00
Median Intra-Service Time	30.00	18.00
Median Immediate Post-service Time	10.00	5.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0 00
Median Discharge Day Management Time	0.00	0 00
Median Office Visit Time	0.00	0.00
Median Total Time	50.00	25.00

Calculate total
reference time
tab here**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.06	3.94
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	3.75
--	------	------

Urgency of medical decision making	3.94	3.25
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.18	3.94
--------------------------	------	------

Physical effort required	3.24	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.71	2.94
---	------	------

Outcome depends on the skill and judgement of physician	4.18	3.94
---	------	------

Estimated risk of malpractice suit with poor outcome	3.88	3.12
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	2.76
----------------------------------	------	------

Intra-Service intensity/complexity	4.18	3.88
------------------------------------	------	------

Post-Service intensity/complexity	3.41	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.*

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)

The procedure is not reported using multiple codes, but several procedures (CPT codes) are typically reported on the same date. Codes in the Physical Medicine section of the CPT manual (97000 series) are developed with the knowledge that multiple services (codes) such as therapeutic exercise (97110) and gait training (97116) may be delivered at the same visit.

A typical scenario for services that might be delivered with wound services would depend on the reason for the skin breakdown. For an amputee, additional prosthetic training (97520) may be appropriate; for an incontinent patient, neuromuscular reeducation (97112) or electrical stimulation (97014 or G028X for Medicare) may be appropriate; therapeutic activities (97530) may be appropriate for patients with bed sores to help them to shift and re-position.

Other Codes	Global	Work RVU	Pre Svc Time	Intra Svc Time	Post Svc Time
97520	XXX	0.45	2 minutes	14 minutes	2 minutes
97112	XXX	0.45	2 minutes	14 minutes	2 minutes
97014	XXX	0.18	1 minute	11 minutes	1 minute
97530	XXX	0.44	2 minutes	14 minutes	2 minutes

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) 97601

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

Specialty PT	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? 5000

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?
1,000 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

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

CPT Code:97606 Tracking Number: Global Period:XXX **Recommended RVW: 0.60**

CPT Descriptor: Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 sq cm.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 68 year old woman who underwent gastric surgery. Four days after surgery, the abdominal post-op site dehiscd revealing a proximal wound measuring 4.0 cm x 6.2 cm x 2.5 cm and a distal wound measuring 8.4 cm x 4.6 cm x 3.5 cm. The proximal wound has a 100% red granulating wound bed with indurated wound margins and moderate amounts of serosanguineous drainage. The distal wound presents with a 25% yellow necrotic wound bed, indurated wound margins, localized redness and copious amounts of purulent drainage.

The wounds are cleansed. The wounds are then assessed to assure no sinus tracts and/or fistulas are present. The skin around the wound is cleansed thoroughly and prepared for the application of transparent film. The foam sponges are cut to fit the size and depth of each wound.

The foam is secured in the wounds using an adhesive, transparent film. The film must be applied with ample border to assure a tight seal. The suction feet and tubing are then inserted into the foam at each site. Additional transparent film is placed around the suction feet to secure the seal. The tubing of both wounds is joined to the negative pressure therapy pump by a "Y" connector. The pump parameters are set at continuous pressure of 125 mm/Hg. The pump is activated and the dressing is inspected for appropriate negative pressure suction and no evidence of leaks.

The patient continues to be monitored for tolerance, and the tubing and film monitored for leaks, clogs, and the need for canister replacement.

Percentage of Survey Respondents who found Vignette to be Typical: 56.25%

Description of Pre-Service Work: Review chart/referral; remove existing dressings.

Description of Intra-Service Work: Thoroughly clean the wound and assess the wound to assure no sinus tracts and/or fistulas are present. Clean skin around the wound and prepare for the application of transparent film. Insert tubing and connect to the negative pressure therapy pump. Set pump parameters and activate. Inspect for leaks and clogs, and the need for canister replacement.

Description of Post-Service Work: The patient/caregiver is instructed in the maintenance of the pump, technique for canister replacement, proper inspection of the dressing and signs or symptoms of wound deterioration.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	February 2004
Presenter(s):	Jonathan Cooperman, PT

Specialty(s):	American Physical Therapy Assoc.				
CPT Code:	97606				
Sample Size:	207	Resp n:	16	Resp %:	8%
Sample Type:	Panel				
		Low	25th pctl	Median*	75th pctl
Survey RVW:		0.36	0.48	0.60	0.70
Pre-Service Evaluation Time:				10.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		14.00	25.00	30.00	40.00
Post-Service	Total Min**	CPT code / # of visits			
Immed. Post-time:	10.00				
Critical Care time/visit(s):	0.00	99291x 0 99292x 0			
Other Hospital time/visit(s):	0.00	99231x 0 99232x 0 99233x 0			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			

To calculate above and below time recommendations, tab here

**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>
97110		0.45

CPT Descriptor Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
97002		0.60

CPT Descriptor physical therapy reevaluation

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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

TIME ESTIMATES (Median)

	New/Revised CPT Code: 97606	Key Reference CPT Code: 97110
Median Pre-Service Time	10.00	2.00
Median Intra-Service Time	30.00	14.00
Median Immediate Post-service Time	10.00	2.00
Median Critical Care Time	0.00	0.00
Median Other Hospital Visit Time	0.00	0.00
Median Discharge Day Management Time	0.00	0.00

Median Office Visit Time	0.00	0.00
Median Total Time	50.00	18.00

Calculate total
reference time
tab here

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.81	3.73
--	------	------

Urgency of medical decision making	4.00	3.00
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.44	3.67
--------------------------	------	------

Physical effort required	3.38	2.87
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.88	2.60
---	------	------

Outcome depends on the skill and judgement of physician	4.31	3.93
---	------	------

Estimated risk of malpractice suit with poor outcome	3.88	3.13
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.13	2.63
----------------------------------	------	------

Intra-Service intensity/complexity	4.38	3.81
------------------------------------	------	------

Post-Service intensity/complexity	3.50	3.06
-----------------------------------	------	------

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.*

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	Frequency 0	Percentage	20.00%
Specialty	Frequency 0	Percentage	0.00%
Specialty	Frequency 0	Percentage	0.00%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
1,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

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

CPT Code: 97605

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

CPT Long Descriptor: Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 sq cm.

Sample Size: 207 Response Rate: (%): 8% Global Period: XXX

Geographic Practice Setting %: Rural 20% Suburban 40% Urban 30%

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

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

A panel of experts was convened via conference call to develop practice expenses for the current series of wound care codes. This panel represented several treatment sites and included both physical therapists and occupational therapists. Using the practice expenses for the current code 97601 (Removal of devitalized tissue) as a starting point, the panel further refined the values for the new codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Includes reviewing the chart, greeting and providing the patient with gowning, obtaining vital signs, preparing the room and equipment and preparing and positioning patient.

Intra-Service Clinical Labor Activities:

Includes assisting the physical or occupational therapist in performing the procedure.

Post-Service Clinical Labor Activities:

Includes cleaning the room and equipment and delivering post treatment assistance to the patient, as well as phone calls to family and care-givers.

CPT Code: 97605

Total Staff Time In Office:

Visits in Global Period:

CMS'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)
	RN/LPN/MTA				
	PTA		14		
	Aide		24		

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

[illegible]

CPT Code: 97605

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	Cost Estimate and Source (if applicable)
from 97601	low mat table	5,000
A6551	Canister set for neg pressure wound therapy pump	
E2402	Neg pressure wound therapy elec pump	

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period

(Please see attached spreadsheet)

SITE OF SERVICE: NON FACILITY

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)

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 made¹

CPT Code: 97606

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

CPT Long Descriptor: Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 sq cm.

Sample Size: 207 Response Rate: (%): 8% Global Period: XXX

Geographic Practice Setting %: Rural 27% Suburban 40 Urban 34

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

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

A panel of experts was convened via conference call to develop practice expenses for the current series of wound care codes. This panel represented several treatment sites and included both physical therapists and occupational therapists. Using the practice expenses for the current code 97601 (Removal of devitalized tissue) as a starting point, the panel further refined the values for the new codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Includes reviewing the chart, greeting and providing the patient with gowning, obtaining vital signs, preparing the room and equipment and preparing and positioning patient.

Intra-Service Clinical Labor Activities:

Includes assisting the physical or occupational therapist in performing the procedure.

Post-Service Clinical Labor Activities:

Includes cleaning the room and equipment and delivering post treatment assistance to the patient, as well as phone calls to family and care-givers.

CPT Code: 97606

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	Cost Estimate and Source (if applicable)
from 97601	low mat table	5,000
A6551	Canister set for neg pressure wound therapy pump	
E2402	Neg pressure wound therapy elec pump	

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period

(Please see attached spreadsheet)

SITE OF SERVICE: NON FACILITY**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)

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

	A	B	C	D	E	F	G	H
1								
2			97601		Revised 97601		97603	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	ANCHOR CODE - Current Code - Removal of Devitalized Tissue		Removal of devitalized tissue, w/w/o whirlpool, 20 sq cm or less		Removal of devitalized tissue, w/w/o whirlpool, more than 20 sq cm	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD							
6	TOTAL CLINICAL LABOR TIME		38	0	35	0	35	0
7	Phy Ther or Occ Ther Assistant		14		14		14	
8	Aide		24		21		21	
9	TOTAL PRE-SERV CLINICAL LABOR TIME		0	0	0	0	0	0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		36	0	32	0	32	0
11	TOTAL POST-SERV CLINICAL LABOR TIME		2	0	3	0	3	0
12	PRE-SERVICE							
13	Start: Following visit when decision for surgery or procedure made							
14	Complete pre-service diagnostic & referral forms							
15	Coordinate pre-surgery services							
16	Schedule space and equipment in facility							
17	Provide pre-service education/obtain consent							
18	Follow-up phone calls & prescriptions							
19	Other Clinical Activity (please specify)							
20	End: When patient enters office/facility for surgery/procedure							
21	SERVICE PERIOD							
22	Start: When patient enters office/facility for surgery/procedure							
23	Pre-service services							
24	Review charts	Assistant	3		3		3	
25	Greet patient and provide gowning	Aide	3		3	(standard)	3	
26	Obtain vital signs	Assistant	2		2	(standard)	2	
27	Provide pre-service education/obtain consent							
28	Prepare room, equipment, supplies	Aide	6		3		3	
29	Setup scope (non facility setting only)							
30	Prepare and position patient/ monitor patient/ set up IV	Aide	3		2	(2 is std)	2	
31	Sedate/apply anesthesia							
32	Intra-service							
33	Assist physician in performing procedure	Assistant	5		5		5	
34	Post-Service							
35	Monitor pt following service/check tubes, monitors, drains							
36	Clean room/equipment by physician staff	Aide	10		10	(3 is std)	10	
37	Clean Scope							
38	Clean Surgical Instrument Package							
39	Complete diagnostic forms, lab & X-ray requisitions							
40	Review/read X-ray, lab, and pathology reports							
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	Assistant	2		2		2	
42	Discharge day management 99238 --12 minutes 99239 --15 minutes							
43	Other -Post treatment Assistance	Aide	2		2		2	
44	End: Patient leaves office							
45	POST-SERVICE Period							
46	Start: Patient leaves office/facility							
47	Conduct phone calls/call in prescriptions	PTA	2		3	(standard)	3	
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 36 minutes	36						
53	99214 53 minutes	53						
54	99215 63 minutes	63						
55	Other							
57	Total Office Visit Time		0	0	0	0	0	0
58	Other Activity (please specify)							
59	End: with last office visit before end of global period							

	A	B	C	D	E	F	G	H
2			97601		Revised 97601		97603	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	ANCHOR CODE - Current Code - Removal of Devitalized Tissue		Removal of devitalized tissue, w/w/o whirlpool, 20 sq cm or less		Removal of devitalized tissue, w/w/o whirlpool, more than 20 sq cm	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
60	MEDICAL SUPPLIES							
61	PEAC multispecialty supply package							
62	Post-op incision care kit							
64	Tape	31514	6		18		18	
65	Kling, Sterile 4"	31526	1		2		1	
66	glove, sterile	14005	1		2		2	
67	patient gown, disp	11107	2		2		2	
68	exam table paper	11111	7		7		7	
69	mask, surgical	11306	1					
70	gauze, sterile, 4x4 (10 pack)	31508	1		2		2	
71	pillow case	11112	1		1		1	
72	towel, sterile	14004	1		1		1	
73	Chux	11102	1		1		1	
74	Debridement Kit, sharp	SA029	1		1		1	
75	biohazard cannister/bag	SM004	1		1		1	
76	From Whirlpool - silver nitrate stick	52304			1		1	
77	From Whirlpool - stockinette	32014			1		1	
78	From Whirlpool - Sterilizing chem (chorozene)	(ong 97022)			1		1	
79	biohazard glass disp Box	SM005						
80	Emzematic Agent (thermazine)/accuzyme				\$2 04		\$2 04	
81	Antimicrobial solution (betadine)	SJ041			1		1	
82	Saline	SH069			1		1	
83	Specialty dressing (composites, Iodosorb, Iodoflex), acticoat				\$15 87		\$31 74	
84	Face/eye Shield	SM016			1		1	
85	Barrier Cream/zinc oxide	SJ064			1		1	
86	Kerlex dressing	SG016					1	
87	Skin Prep lotion				\$0 35		\$0 35	
88	Adaptex (non adherent gauze/mesh)	SG040			1		1	
89	Dressing set for neg pressure wound therapy pump	A6550						
90	"Y" connector							
92	Equipment							
93	Basic Surgical Instrument Package \$500							
94	Medium Surgical Instrument Package \$1,500							
95	Suction machine for debridement		36		32		32	
96	low mat table	E11001	36		32		32	
97	whirlpool	E92005			24		24	
98	Canister set for neg pressure wound therapy pump	A6551						
99	Neg pressure wound therapy elec pump	E2402						

	A	B	C	D	I	J	K	L
1								
2			97601		97605		97606	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	ANCHOR CODE - Current Code - Removal of Devitalized Tissue		Negative pressure wound therapy, 50 sq cm or less		Negative pressure wound therapy, more than 50 sq cm	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD							
6	TOTAL CLINICAL LABOR TIME		38	0	24	0	24	0
7	Phy Ther or Occ Ther Assistant		14		11		11	
8	Aide		24		13		13	
9	TOTAL PRE-SERV CLINICAL LABOR TIME		0	0	0	0	0	0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		36	0	22	0	22	0
11	TOTAL POST-SERV CLINICAL LABOR TIME		2	0	2	0	2	0
12	PRE-SERVICE							
13	Start: Following visit when decision for surgery or procedure made							
14	Complete pre-service diagnostic & referral forms							
15	Coordinate pre-surgery services							
16	Schedule space and equipment in facility							
17	Provide pre-service education/obtain consent							
18	Follow-up phone calls & prescriptions							
19	Other Clinical Activity (please specify)							
20	End: When patient enters office/facility for surgery/procedure							
21	SERVICE PERIOD							
22	Start: When patient enters office/facility for surgery/procedure							
23	Pre-service services							
24	Review charts	Assistant	3		3		3	
25	Greet patient and provide gowning	Aide	3		3		3	
26	Obtain vital signs	Assistant	2		2		2	
27	Provide pre-service education/obtain consent							
28	Prepare room, equipment, supplies	Aide	6		2		2	
29	Setup scope (non facility setting only)							
30	Prepare and position patient/ monitor patient/ set up IV	Aide	3		2		2	
31	Sedate/apply anesthesia							
32	Intra-service							
33	Assist physician in performing procedure	Assistant	5		5		5	
34	Post-Service							
35	Monitor pt following service/check tubes, monitors, drains							
36	Clean room/equipment by physician staff	Aide	10		3		3	
37	Clean Scope							
38	Clean Surgical Instrument Package							
39	Complete diagnostic forms, lab & X-ray requisitions							
40	Review/read X-ray, lab, and pathology reports							
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	Assistant	2					
42	Discharge day management 99238 -12 minutes 99239 -15 minutes							
43	Other -Post treatment Assistance	Aide	2		2		2	
44	End: Patient leaves office							
45	POST-SERVICE Period							
46	Start: Patient leaves office/facility							
47	Conduct phone calls/call in prescriptions	PTA	2		2		2	
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 36 minutes	36						
53	99214 53 minutes	53						
54	99215 63 minutes	63						
55	Other							
57	Total Office Visit Time		0	0	0	0	0	0
58	Other Activity (please specify)							
59	End: with last office visit before end of global period							

	A	B	C	D	I	J	K	L
2			97601		97605		97606	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	ANCHOR CODE - Current Code - Removal of Devitalized Tissue		Negative pressure wound therapy, 50 sq cm or less		Negative pressure wound therapy, more than 50 sq cm	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
60	MEDICAL SUPPLIES							
61	PEAC multispecialty supply package							
62	Post-op incision care kit							
64	Tape	31514	6		6		6	
65	Kling, Sterile 4"	31526	1					
66	glove, sterile	14005	1		1		1	
67	patient gown, disp	11107	2		2		2	
68	exam table paper	11111	7		7		7	
69	mask, surgical	11306	1		1		1	
70	gauze, sterile, 4x4 (10 pack)	31508	1		1		1	
71	pillow case	11112	1		1		1	
72	towel, sterile	14004	1		1		1	
73	Chux	11102	1		1		1	
74	Debridement Kit, sharp	SA029	1		1			
75	biohazard cannister/bag	SM004	1		1		1	
76	From Whirlpool - silver nitrate stick	52304						
77	From Whirlpool - stockinette	32014						
78	From Whirlpool - Sterilizing chem (chorozene)	(ong 97022)						
79	biohazard glass disp Box	SM005						
80	Emzematic Agent (thermazine)/accuzyme							
81	Antimicrobial solution (betadine)	SJ041						
82	Saline	SH069						
83	Specialty dressing (composites, Iodosorb, Iodoflex), acticoat							
84	Face/eye Shield	SM016						
85	Barner Cream/zinc oxide	SJ064						
86	Kerlex dressing	SG016						
87	Skin Prep lotion				1		1	
88	Adaptac (non adherent gauze/mesh)	SG040			2		4	
89	Dressing set for neg pressure wound therapy pump	A6550			1		1	
90	"Y" connector				\$2.00		\$2.00	
92	Equipment							
93	Basic Surgical Instrument Package \$500							
94	Medium Surgical Instrument Package \$1,500							
95	Suction machine for debridement		36					
96	low mat table	E11001	36					
97	whirlpool	E92005						
98	Canister set for neg pressure wound therapy pump	A6551			22		22	
99	Neg pressure wound therapy elec pump	E2402			22		22	

AMA/Specialty Society RVS Update Committee
Health Care Professional Advisory Committee
Summary of Recommendations

April 2004

Acupuncture/Electroacupuncture

The CPT Editorial Panel created two new codes and two new add-on codes to describe the appropriate time or additional time and levels of service that can be performed using acupuncture and electroacupuncture, acupuncture therapy with electrical stimulation.

97810 – 97814

The HCPAC reviewed the survey results for 97810 *Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of direct one-on-one contact with the patient*, 97811 *each additional 15 minutes of direct one-on-one contact with the patient (List separately in addition to code for primary procedure)*, 97813 *Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes of direct one-on-one contact with the patient*, and 97814 *each additional 15 minutes of direct one-on-one contact with the patient (List separately in addition to code for primary procedure)*. After an extensive discussion of the specialty's initial relative value recommendations, the HCPAC selected an alternate methodology. The key reference code 98941 *Chiropractic manipulative treatment (CMT); spinal, three to four regions* (Work RVU = 0.65), was used to support the recommendation for 97813 and the surveyed rank order was applied to the remaining codes. Service times for 97810 and 97813 are recommended by the HCPAC to include 3 minutes pre-service, 15 minutes intra-service and 3 minutes post-service. 97811 and 97814 service times are recommended to only capture the 15 minutes of intra-service time. The HCPAC understands that a patient is typically in the office 35 minutes for 15 minutes of face-to-face time. The HCPAC recommends the RVUs based on the assumption that the CPT descriptor will include the clarification that the 97811 and 97814 codes are only applied when new needles are inserted. **The HCPAC recommends 0.60 work RVU for 97810, 0.50 work RVU recommendation for 97811, 0.65 work RVU recommendation for 97813 and 0.55 work RVU recommended for 97814.**

HCPAC Recommendations

CPT Code	Pre-Service	Intra-Service	Post-Service	Recommended RVU
97810	3 minutes	15 minutes	3 minutes	0.60
97811		15 minutes		0.50
97813	3 minutes	15 minutes	3 minutes	0.65
97814		15 minutes		0.55

Practice Expense

The HCPAC reviewed the practice expense inputs for 97810-97814. These inputs were assessed, modified and approved by the HCPAC to accurately reflect the supplies and equipment associated with these new codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<u>Acupuncture is reported based on 15 minute increments of personal (face-to-face) contact with the patient, not the duration of acupuncture needle(s) placement.</u> <u>If no electrical stimulation is used during a 15 minute increment, use 97810, 97811. If electrical stimulation of any needle is used during a 15 minute increment, use 97813, 97814</u>				
97780		Acupuncture, one or more needles; without electrical stimulation <i>(97780 has been deleted. To report, see 97810, 97811)</i>		N/A
•97810	S1	Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of <u>personal direct</u> one-on-one contact with the patient	XXX	0.60
+•97811	S2	each additional 15 minutes of <u>personal direct</u> one-on-one contact with the patient, <u>with re-insertion of needle(s)</u> (List separately in addition to code for primary procedure) <i>(Use 97811 in conjunction with 97810)</i>	ZZZ	0.50

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p><u>(Evaluation and Management services may be reported separately, using the modifier 25, if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the acupuncture services. The time of the E/M service is not included in the time of the acupuncture service.)</u></p> <p><u>(Do not report 97810, 97811 in conjunction with 97813 or 97814)</u></p>		
97781		<p>Acupuncture, one or more needles; with electrical stimulation</p> <p>(97781 has been deleted. To report, see 97813, 97814)</p>		N/A
●97813	S3	Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes of <u>direct personal</u> one-on-one contact with the patient	XXX	0.65
+●97814	S4	<p>each additional 15 minutes of <u>direct personal</u> one-on-one contact with the patient, <u>with re-insertion of needle(s)</u> (List separately in addition to code for primary procedure)</p> <p><u>(Use 97814 in conjunction with 97813)</u></p> <p><u>(Evaluation and Management services may be reported separately, using the modifier 25, if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the acupuncture services. The time of the E/M service is not included in the time of the acupuncture service.)</u></p> <p><u>(Do not report 97813, 97814 in conjunction with 97810 or 97811)</u></p>	ZZZ	0.55

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

CPT Code:97810 Tracking Number: Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: .70
RUC RVU: **0.60**

CPT Descriptor: Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17 year old male presents for repeat treatment of non-traumatic cervicgia of three days duration. The patient reports cervical pain and limited range of motion.

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The practitioner reviews the chart, greets the patient and obtains a brief account of the results of the previous treatment and any significant changes that have occurred since the last visit. Points are selected for today's treatment.

Description of Intra-Service Work: The practitioner locates three points and selects the appropriate needle lengths and gauges for this treatment. The practitioner then inserts and mildly stimulates the needles. The patient is instructed to rest for 20 minutes while the needles are retained. The practitioner returns periodically to monitor the patient and to restimulate the needles and to inquire about patient comfort and treatment response. When the desired effect is achieved, the practitioner removes the needles and presses on the points with a cotton ball to prevent bruising or bleeding.

Description of Post-Service Work: The needles are disposed in accordance with OSHA guidelines. The practitioner then assists the patient to an upright position, making sure that the patient does not feel faint. Follow-up instructions are given to the patient. Final documentation is recorded in the patient chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004				
Presenter(s):	Anthony Hamm, DC					
Specialty(s):	American Chiropractic Association					
CPT Code:	97810					
Sample Size:	280	Resp n:	101	Response: 36.07 %		
Sample Type:	Random					
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:		0.30	0.52	0.70	0.87	4.00
Pre-Service Evaluation Time:				3.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		3.00	6.00	15.00	15.00	35.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	3.00					

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>
99213	XXX	0.67

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: 1) a problem focused history; 2) a problem focused examination; 3) straightforward medical decision making.

<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: 47 % of respondents: 46.5 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 97810	Key Reference CPT Code: 99213
Median Pre-Service Time	3.00	0.00
Median Intra-Service Time	15.00	23.00
Median Immediate Post-service Time	3.00	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	21.00	23.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.42	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.09	3.03
Urgency of medical decision making	2.76	2.66

Technical Skill/Physical Effort (Mean)

Technical skill required	3.86	3.27
--------------------------	------	------

Physical effort required	2.96	2.79
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.56	2.62
Outcome depends on the skill and judgment of physician	3.67	3.25
Estimated risk of malpractice suit with poor outcome	2.37	2.52

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.10	2.89
Intra-Service intensity/complexity	3.38	3.03
Post-Service intensity/complexity	2.74	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.*

The final recommendation was reached based on the mean/median responses from a random survey.

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: Yes

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

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

- Please provide a table listing the typical scenario where this 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	Global	RVU	Pre	Intra	Post	Sum	Sum
Total	97810	XXX		.70	10	10	5	25
	97811	ZZZ	.65	5	10	5	20	45

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 97780

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

Specialty American Chiropractic Association How often? Sometimes

Specialty American Academy of Medical Acupuncture How often? Commonly

Specialty American Association of Oriental Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 5377000

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 %
Specialty	Frequency 0	Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0

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

Specialty	Frequency 0	Percentage %
Specialty	Frequency 0	Percentage %
Specialty	Frequency 0	Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 98941

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

CPT Descriptor: Acupuncture, one or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure) (Use 97811 in conjunction with 97810)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26 year-old female with a diagnosis of migraine presents for a return office visit. The patient is currently symptomatic, presenting with a unilateral headache of one day's duration.

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: A 977x1 has already been provided as an initial 15 minute service. Following removal of needles from the initial acupuncture service provided, the practitioner instructs the patient to turn to the prone position. New points are selected to complete the treatment.

Description of Intra-Service Work: After palpating to locate these points, they are marked and cleaned with alcohol swabs, bilaterally. Six needles are selected, inserted and manipulated to obtain the desired effect. The patient is instructed to rest for 20 minutes while these needles are retained. Periodically, the practitioner returns to manipulate these needles. When the treatment is complete, the practitioner removes the needles and presses cotton on the points to prevent bleeding or bruising.

Description of Post-Service Work: The needles are disposed in accordance with OSHA guidelines. The patient is assisted to an upright position. Follow-up instructions are given to the patient. Final documentation is recorded in the patient chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Anthony Hamm, DC				
Specialty(s):	American Chiropractic Association				
CPT Code:	97811				
Sample Size:	280	Resp n:	101	Response:	36.07 %
Sample Type:	Random				
		Low	25th pctl	Median*	75th pctl
Survey RVW:		0.18	0.45	0.65	0.87
Pre-Service Evaluation Time:			0.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:		1.00	5.00	15.00	45.00
Post-Service	Total Min**	CPT code / # of visits			

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>
99213	XXX	0.67

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: 1) a problem focused history; 2) a problem focused examination; 3) straightforward medical decision making.

<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: 0 % of respondents: 0.0 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 97811	Key Reference CPT Code: 99213
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	15.00	23.00
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	15.00	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	3.50	3.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.11	2.93
Urgency of medical decision making	2.90	2.84

Technical Skill/Physical Effort (Mean)

Technical skill required	3.83	3.27
--------------------------	------	------

Physical effort required	2.95	2.86
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.65	2.68
Outcome depends on the skill and judgment of physician	3.78	3.25
Estimated risk of malpractice suit with poor outcome	2.52	2.62

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.10	2.89
Intra-Service intensity/complexity	3.38	3.03
Post-Service intensity/complexity	2.74	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.*

The final recommendation was reached based on the mean/median responses from a random survey.

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.

	CPT Code	Global	RVU	Pre	Intra	Post	Sum	Sum
Total	97810	XXX		.70	10	10	5	25
	97811	ZZZ	.65	5	10	5	20	45

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 97780

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

Specialty American Chiropractic Association How often? Sometimes

Specialty American Academy of Medical Acupuncture How often? Commonly

Specialty American Association of Oriental Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 5377000

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 %
Specialty	Frequency 0	Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage %
Specialty	Frequency 0	Percentage %
Specialty	Frequency 0	Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 98941

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:97813 Tracking Number: Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: .75
RUC RVU: **0.65**

CPT Descriptor: Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 49 year old female receiving chemotherapy for breast cancer was previously referred for acupuncture to relieve post-chemo nausea. This treatment is part of an ongoing series of treatments for this condition. The patient is weak but not faint, and has not vomited since chemotherapy was received earlier in the day.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The practitioner reviews the chart, greets the patient and obtains a brief account of the results of the previous treatment and any significant changes that have occurred since the last visit. The appropriate four points are selected for today's treatment.

Description of Intra-Service Work: The patient is placed in the supine position and the points are located. The practitioner selects the appropriate needles before inserting and mildly stimulating them. Electrodes are then attached to the shafts of the needles and an appropriate frequency (Hz) and waveform is selected. The practitioner then slowly increases the amplitude of the signal until patient tolerance is reached. The patient is instructed to rest for 20 minutes while the needles are retained.

The practitioner returns periodically to monitor the patient, re-adjust the electrical stimulation and to inquire about patient comfort and treatment response. When the desired effect is achieved, the practitioner removes the electrodes and needles, and presses on the points with a cotton ball to prevent bruising or bleeding.

Description of Post-Service Work: The needles are disposed in accordance with OSHA guidelines. The practitioner then assists the patient to an upright position, making sure that the patient does not feel faint. Follow-up instructions are given to the patient. Final documentation is recorded in the patient chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Anthony Hamm, DC				
Specialty(s):	American Chiropractic Association				
CPT Code:	97813				
Sample Size:	280	Resp n:	101	Response: 36.07 %	
Sample Type:	Random				
	<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:	0.20	0.65	0.75	1.03	2.50
Pre-Service Evaluation Time:			3.0		
Pre-Service Positioning Time:			0.0		

Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		1.00	9.00	15.00	20.00	40.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	3.00					
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>
99213	XXX	0.67

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: 1) a problem focused history; 2) a problem focused examination; 3) straightforward medical decision making.

<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: 50 % of respondents: 49.5 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 97813	Key Reference CPT Code: 99213
Median Pre-Service Time	3.00	0.00
Median Intra-Service Time	15.00	23.00
Median Immediate Post-service Time	3.00	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	21.00	23.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.60	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.07
Urgency of medical decision making	3.16	2.99

Technical Skill/Physical Effort (Mean)

Technical skill required	3.92	3.36
--------------------------	------	------

Physical effort required	3.16	2.95
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.29	2.74
Outcome depends on the skill and judgment of physician	4.17	3.42
Estimated risk of malpractice suit with poor outcome	2.80	2.69

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.40	3.10
Intra-Service intensity/complexity	3.66	3.10
Post-Service intensity/complexity	3.08	2.82

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 final recommendation was reached based on the mean/median responses from a random survey.

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: Yes

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

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

- Please provide a table listing the typical scenario where this 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	Global	RVU	Pre	Intra	Post	Sum	Sum
Total	97813	XXX		.75	6	12	5	23
	97814	ZZZ	.70	5	15	5	25	48

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 97781

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

Specialty American Chiropractic Association How often? Sometimes

Specialty American Academy of Medical Acupuncture How often? Commonly

Specialty American Association of Oriental Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 5377000

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? 0

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?

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. 98941

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:97814 Tracking Number: Global Period: ZZZ **Recommended Work Relative Value**
Specialty Society RVU: .70
RUC RVU: **0.55**

CPT Descriptor: Acupuncture, one or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure) (Use 97814 in conjunction with 97813)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old male returns for a repeat visit to treat lumbalgia.

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: A 977813 has already been provided as an initial 15 minute service. Following removal of needles from the initial acupuncture service provided (97813), the practitioner assists the patient to his feet and asks him to walk around the room to test the effectiveness of treatment. The pain has reduced but is still significant, so the practitioner selects four additional points, palpates to locate, then marks and cleans those points.

Description of Intra-Service Work: The practitioner inserts the four additional needles, and they are manipulated to produce a deep, aching sensation. Electrodes are then attached to the shafts of the needles and an appropriate frequency (Hz) and waveform is selected. The practitioner then slowly increases the amplitude of the signal until patient tolerance is reached. The patient is instructed to rest. The practitioner remains in the room and continues to stimulate the needles during this phase of treatment by adjusting the electrical stimulation, until the pain and dysfunction are improved to an acceptable level. At the conclusion of this service the electrodes and needles are removed.

Description of Post-Service Work: Follow-up instructions are given to the patient. The needles are disposed in accordance with OHSA guidelines. Final documentation is recorded in the patient chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2004			
Presenter(s):	Anthony Hamm, DC				
Specialty(s):	American Chiropractic Association				
CPT Code:	97814				
Sample Size:	280	Resp n:	101	Response: 36.07 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.18	0.45	0.70	1.00	2.50
Pre-Service Evaluation Time:			0.0		
re-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	1.00	10.00	15.00	20.00	45.00
Post-Service	Total Min**	CPT code / # of visits			

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>
99213	XXX	0.67

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: 1) a problem focused history; 2) a problem focused examination; 3) straightforward medical decision making.

<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: 38 % of respondents: 37.6 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 97814	Key Reference CPT Code: 99213
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	15.00	23.00
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	15.00	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	3.46	3.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.12	2.95
Urgency of medical decision making	2.87	2.77

Technical Skill/Physical Effort (Mean)

Technical skill required	4.21	3.24
--------------------------	------	------

Physical effort required	3.15	2.99
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.83	2.71
Outcome depends on the skill and judgment of physician	3.69	3.26
Estimated risk of malpractice suit with poor outcome	2.63	2.70

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.93	2.83
Intra-Service intensity/complexity	3.63	3.11
Post-Service intensity/complexity	2.81	2.62

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 final recommendation was reached based on the mean/median responses from a random survey.

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.

	CPT Code	Global	RVU	Pre	Intra	Post	Sum	Sum
Total	97813	XXX	.75	6	12	5	23	
	97814	ZZZ	.70	5	15	5	25	48

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 97781

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

Specialty American Chiropractic Association How often? Sometimes

Specialty American Academy of Medical Acupuncture How often? Commonly

Specialty American Association of Oriental Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 5377000

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? 0

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?

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. 98941

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

AMTA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Acupuncture, one or more needles; without electrical stimulation,
initial 15 minutes of personal one-on-one contact with the patient.

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

Geographic Practice Setting %: N/A Rural Suburban Urban

Type of Practice %: N/A Solo Practice
 Single Specialty Group
 Multispecialty Group
 Medical School Faculty Practice Plan

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

The American Chiropractic Association (ACA) used a consensus panel processes to develop direct practice expense recommendations for acupuncture codes 97810-4. The doctors/ clinical staff on the Acupuncture Relative Value Update Committee (ARVUC) were representatives from the American Chiropractic Association, the American Academy of Medical Acupuncture and the American Association of Oriental Medicine, and were chosen to represent diversity in geographic location and practice type. The ARVUC utilized a consensus process to arrive at final recommendations, based upon PEAC approved inputs for similar procedures.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Staff Reviews Charts
Staff Prepares Room, Equipment and Supplies
Staff Greets Patient and Provides Gown
Staff Prepares and Positions Patient for Doctor

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

Staff Cleans Treatment Room and Equipment

CPT Code: 97810
American Chiropractic Association

Total Staff Time In Office:

Visits in Global Period:

CMS'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)
L037D	RN/LPN/MTA	3	0	3	

* 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	Units Used for Purchase	Cost Estimate and Source (if applicable)
SB026	Patient Gown	1		
SB036	Exam Table Paper	7 feet		
SB037	Pillow Case	1		
SB022	Gloves (non-sterile)	2 pair		
	Disposable Acupuncture Needles	12 needles		10 cents per needle www.omsmedical.com www.heliomed.com
SJ053	Alcohol Swabs	2 swabs		

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	Cost Estimate and Source (if applicable)
E11001	Examination Table	

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period

SITE OF SERVICE: NON FACILITY
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)

_____ 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.

**AMTA/Specialty Society Update Process
PEAC Summary of Recommendation
ZZZ Global Period
Non Facility Direct Inputs**

CPT Long Descriptor: Acupuncture, one or more needles; without electrical stimulation, **each additional 15 minutes** of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure) (Use 97811 in conjunction with 97810).

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

Geographic Practice Setting %: N/A Rural Suburban Urban

Type of Practice %: N/A Solo Practice
 Single Specialty Group
 Multispecialty Group
 Medical School Faculty Practice Plan

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

The American Chiropractic Association (ACA) used a consensus panel processes to develop direct practice expense recommendations for acupuncture codes 97810-4. The doctors/clinical staff on the Acupuncture Relative Value Update Committee (ARVUC) were representatives from the American Chiropractic Association, the American Academy of Medical Acupuncture and the American Association of Oriental Medicine, and were chosen to represent diversity in geographic location and practice type. The ARVUC utilized a consensus process to arrive at final recommendations, based upon PEAC approved inputs for similar procedures.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

CPT Code: 97811
American Chiropractic Association

Total Staff Time In Office:

Visits in Global Period:

CMS'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)

* 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	Units Used for Purchase	Cost Estimate and Source (if applicable)
SB036	Exam Table Paper	7 feet		
SB022	Gloves (non-sterile)	2 pair		
	Disposable Acupuncture Needles	12 needles		10 cents per needle www.omsmedical.com www.heliomed.com
SJ053	Alcohol Swabs	2 swabs		

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	Cost Estimate and Source (if applicable)
E11001	Examination Table	

Type of Service: Evaluation/Management Services or Diagnostic Tests
ZZZ Global Period

SITE OF SERVICE: NON FACILITY
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)

_____ 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.

**AMTA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs**

CPT Long Descriptor: Acupuncture, one or more needles; with electrical stimulation, **initial 15 minutes** of personal one-on-one contact with the patient.

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

Geographic Practice Setting %: N/A Rural Suburban Urban

Type of Practice %: N/A Solo Practice
 Single Specialty Group
 Multispecialty Group
 Medical School Faculty Practice Plan

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

The American Chiropractic Association (ACA) used a consensus panel processes to develop direct practice expense recommendations for acupuncture codes 97810-4. The doctors/clinical staff on the Acupuncture Relative Value Update Committee (ARVUC) were representatives from the American Chiropractic Association, the American Academy of Medical Acupuncture and the American Association of Oriental Medicine, and were chosen to represent diversity in geographic location and practice type. The ARVUC utilized a consensus process to arrive at final recommendations, based upon PEAC approved inputs for similar procedures.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Staff Reviews Charts
Staff Prepares Room, Equipment and Supplies
Staff Greets Patient and Provides Gown
Staff Prepares and Positions Patient for Doctor

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

Staff Cleans Treatment Room and Equipment

CPT Code: 97813
American Chiropractic Association

Total Staff Time In Office:

Visits in Global Period:

CMS'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)
L037D	RN/LPN/MTA	3	0	3	

* 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	Units Used for Purchase	Cost Estimate and Source (if applicable)
SA048	Minimum Supply Package	1		
	Disposable Acupuncture Needles	12 needles		10 cents per needle www.omsmedical.com www.heliomed.com
SJ0053	Alcohol Swabs	2 swabs		

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	Cost Estimate and Source (if applicable)
E11001	Examination Table	

**Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period**

**SITE OF SERVICE: NON FACILITY
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)

_____ 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.

**AMTA/Specialty Society Update Process
PEAC Summary of Recommendation
ZZZ Global Period
Non Facility Direct Inputs**

CPT Long Descriptor: Acupuncture, one or more needles; with electrical stimulation, **each additional 15 minutes** of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure) (Use 97814 in conjunction with 97813).

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

Geographic Practice Setting %: N/A Rural Suburban Urban

Type of Practice %: N/A Solo Practice
 Single Specialty Group
 Multispecialty Group
 Medical School Faculty Practice Plan

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

The American Chiropractic Association (ACA) used a consensus panel processes to develop direct practice expense recommendations for acupuncture codes 97810-4. The doctors/clinical staff on the Acupuncture Relative Value Update Committee (ARVUC) were representatives from the American Chiropractic Association, the American Academy of Medical Acupuncture and the American Association of Oriental Medicine, and were chosen to represent diversity in geographic location and practice type. The ARVUC utilized a consensus process to arrive at final recommendations, based upon PEAC approved inputs for similar procedures.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

CPT Code: 97814
American Chiropractic Association

Total Staff Time In Office:

Visits in Global Period:

CMS'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)

* 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	Units Used for Purchase	Cost Estimate and Source (if applicable)
SA048	Minimum Supply Package	1		
	Disposable Acupuncture Needles	12 needles		10 cents per needle www.omsmedical.com www.heliomed.com
SJ053	Alcohol Swabs	2 swabs		

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	Cost Estimate and Source (if applicable)
E11001	Examination Table	

Type of Service: Evaluation/Management Services or Diagnostic Tests
ZZZ Global Period

SITE OF SERVICE: NON FACILITY
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)

_____ 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.