

RUC Recommendations for  
CPT 2006  
Volume I

*RUC Meetings*  
*September 2004, February 2005,*  
*April 2005*

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
RUC RECOMMENDATIONS FOR CPT 2006**

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# American Medical Association

Physicians dedicated to the health of America



William L. Rich III, MD, FACS    515 North State Street    312 464-5604  
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AMA/Specialty Society RVS  
Update Committee

May 26, 2005

Stephen M. Phillips  
Director, Division of Practitioner Services  
Hospital and Ambulatory Policy Group  
Center for Medicare Management, C4-03-06  
7500 Security Blvd.  
Baltimore, MD 21244

Dear Mr. Phillips:

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 2006. Also included in this submission are the practice expense refinement recommendations for existing CPT 2005 codes. The RUC is also formally submitting recommendations related to the Professional Liability Insurance (PLI) methodology. These recommendations were informally shared with your staff immediately following our April 28-May 1, 2005 meeting. The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board is separately forwarding its recommendations to CMS.

## CPT 2006 New and Revised Codes

Enclosed are two binders of RUC recommendations for new and revised codes. The total number of coding changes for CPT 2006 is 447, including 221 additions, 129 revisions, and 97 deletions. Forty-Three of these new and revised codes are not payable on the RBRVS (eg, laboratory services and vaccines), and accordingly, the RUC does not submit any information on these codes. In addition, 14 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 293 new and revised codes, the RUC submits 283 recommendations at this time.

The RUC is recommending that five codes be carrier-priced in 2006. The RUC will not be submitting relative value recommendations for new CPT codes 15431 *Acellular xenograft implant; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof* and 88384 *Array-based evaluation of multiple molecular probes; 11 through 50 probes* and understands that these services will be infrequently performed. Three unlisted codes (45499, 51999, and 90779) will also be carrier priced. In addition, the RUC is unable to provide recommendations for five drug administration codes (90773, 96420, 96422, 96423, and 96425) performed through an

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intra-arterial route as survey data for these services was not available. The summary table in the attached binder, and in the enclosed CD, specifically identifies CPT code 33548 *Surgical ventricular restoration procedure, includes prosthetic patch, when performed (ventricular remodeling, SVR, SAVER, DOR procedures)* to be re-reviewed at the September 2005 RUC meeting. We will send any new information related to this service 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 2004, February 2005, and April 2005 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 Review Committee (PERC) over the past year. The RUC is submitting recommendations on the direct practice expense inputs for more than 200 existing CPT codes. We understand that the practice expense direct inputs for all existing CPT codes have been reviewed. If CMS identifies any services that have not been refined, please contact AMA staff so that we may schedule those codes for review at an upcoming RUC meeting.

Cost estimates for medical supplies and equipment not listed on "CMS's Labor, Supply, and Equipment List for the Year 2005" 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.

In the course of reviewing new and revised congenital cardiac procedures, the RUC identified an error in the database of direct practice expense inputs for cardiothoracic surgery. The RUC had previously recommended that all clinical staff time for cardiothoracic surgery be assigned a staff type of RN, rather than the traditional RN/LPN/MTA blend. Unfortunately, our submission only included a spreadsheet with all of the cardiothoracic surgery high volume codes and, therefore, it appears that the application of this standard to all cardiothoracic surgery services was not implemented. We have attached a list of all cardiothoracic services. The RUC recommends that the staff type be modified to RN only for each of these identified codes.

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### Professional Liability Insurance

The RUC continues to be concerned regarding the Medicare utilization data and its use in the PLI relative value methodology. As we have stated in past comment letters to CMS, we believe that the dominant specialty should be utilized to determine which risk factor to apply to a CPT code. The RUC will continue to advocate that this is preferable to the case mix approach that is currently utilized by CMS. The RUC understands that to date CMS has determined that the dominant approach will not be utilized. However, CMS has offered a number of other solutions to remove anomalous data from the utilization database. The RUC appreciates this consideration.

The first CMS suggestion to improve the data is to remove specialties from the methodology if the specialties represent less than a certain percentage threshold (1%, 3%, or 5%) of the utilization. **The RUC has reviewed the CMS request to consider the various threshold levels and the RUC recommends that a 5% level be utilized as it most closely reflects the dominant approach.** The RUC considers the recommendation to implement a threshold as an interim step and will continue to advocate the dominant approach.

In addition, CMS has considered a review of anomalous data within low volume codes. The RUC engaged in a project to review CPT codes with Medicare utilization of fewer than 100 services reported. A review of 1,844 CPT codes with total volume less than 100 per year, yielded 240 CPT codes where the specialty who would be expected to be the dominant provider is not indicated as the most frequent provider of the service. In addition, 152 CPT codes have zero Medicare utilization and in this case, the RUC has indicated an expected dominant specialty for each service. The RUC recommends that CMS use the attached spreadsheet on low volume codes for consideration in their 2006 rulemaking process. **The RUC strongly recommends that CMS utilize these recommended specialties for low volume codes (ie, fewer than 100 claims per year), rather than rely on claims data.**

On March 4, 2005, the RUC submitted a letter to CMS with several recommendations related to the PLI methodology, including a recommendation to crosswalk gynecologist/oncologist to surgical oncology and colorectal surgery to general surgery. In April 2005, hand surgery also identified themselves as having been assigned an inappropriate risk factor. **The RUC recommends that hand surgery be crosswalked to orthopaedic surgery (without spine).** The American Society for Hand Surgery has provided additional support in the attached letter to verify that the majority of hand surgeons are orthopaedic surgeons and incur the same PLI premiums as orthopaedic surgeons.

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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 black ink that reads "William Rich, MD FACS". The signature is written in a cursive style with a large initial 'W'.

William Rich, MD

cc: Ken Simon, MD  
Rick Ensor  
Edith L Hambrick MD  
Carolyn Mullen  
Pam West, PT  
RUC Participants

# CPT 2006 RUC Recommendations

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
01964	XXX	D	May04	13	Incomplete or Missed Abortion Anesthesia		Oct04	10					Yes	
01965	XXX	N	May04	13	Incomplete or Missed Abortion Anesthesia	A1	Oct04	10	ASA	4.00	4.00		Yes	
01966	XXX	N	May04	13	Incomplete or Missed Abortion Anesthesia	A2	Oct04	10	ASA	4.00	4.00		Yes	
15000	000	R	Feb05	24	Free Skin Grafts	FF1	Apr05	06	ASPS, ABA	3.99	3.99	Yes	Yes	
15001	ZZZ	R	Feb05	24	Free Skin Grafts	FF2	Apr05	06	ASPS, ABA	1.00	1.00	Yes	Yes	
15040	000	N	Feb05	24	Free Skin Grafts	FF3	Apr05	06	ASPS, ABA	2.00	2.00		Yes	
15100	090	R	Feb05	24	Free Skin Grafts		Apr05	06		9.04	9.04	Yes	Yes	
15101	ZZZ	R	Feb05	24	Free Skin Grafts		Apr05	06		1.72	1.72	Yes	Yes	
15110	090	N	Feb05	24	Free Skin Grafts	FF4	Apr05	06	ASPS, ABA	9.50	9.50		Yes	
15111	ZZZ	N	Feb05	24	Free Skin Grafts	FF5	Apr05	06	ASPS, ABA	1.85	1.85		Yes	
15115	090	N	Feb05	24	Free Skin Grafts	FF6	Apr05	06	ASPS, ABA	9.81	9.81		Yes	
15116	ZZZ	N	Feb05	24	Free Skin Grafts	FF7	Apr05	06	ASPS, ABA	2.50	2.50		Yes	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	MFS	Comments
15120	090	R	Feb05	24	Free Skin Grafts		Apr05	06		9.81	9.81	Yes	Yes	
15121	ZZZ	R	Feb05	24	Free Skin Grafts		Apr05	06		2.67	2.67	Yes	Yes	
15130	090	N	Feb05	24	Free Skin Grafts	FF8	Apr05	06	ASPS, ABA	7.00	7.00		Yes	
15131	ZZZ	N	Feb05	24	Free Skin Grafts	FF9	Apr05	06	ASPS, ABA	1.50	1.50		Yes	
15135	090	N	Feb05	24	Free Skin Grafts	FF10	Apr05	06	ASPS, ABA	10.50	10.50		Yes	
15136	ZZZ	N	Feb05	24	Free Skin Grafts	FF11	Apr05	06	ASPS, ABA	1.50	1.50		Yes	
15150	090	N	Feb05	24	Free Skin Grafts	FF12	Apr05	06	ASPS, ABA	8.25	8.25		Yes	
15151	ZZZ	N	Feb05	24	Free Skin Grafts	FF13	Apr05	06	ASPS, ABA	2.00	2.00		Yes	
15152	ZZZ	N	Feb05	24	Free Skin Grafts	FF14	Apr05	06	ASPS, ABA	2.50	2.50		Yes	
15155	090	N	Feb05	24	Free Skin Grafts	FF15	Apr05	06	ASPS, ABA	9.00	9.00		Yes	
15156	ZZZ	N	Feb05	24	Free Skin Grafts	FF16	Apr05	06	ASPS, ABA	2.75	2.75		Yes	
15157	ZZZ	N	Feb05	24	Free Skin Grafts	FF17	Apr05	06	ASPS, ABA	3.00	3.00		Yes	
15170	090	N	Feb05	24	Free Skin Grafts	FF18	Apr05	06	ASPS, ABA	5.00	5.00		Yes	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
15171	ZZZ	N	Feb05	24	Free Skin Grafts	FF19	Apr05	06	ASPS, ABA	1.55	1.55	Yes	
15175	090	N	Feb05	24	Free Skin Grafts	FF20	Apr05	06	ASPS, ABA	7.00	7.00	Yes	
15176	ZZZ	N	Feb05	24	Free Skin Grafts	FF21	Apr05	06	ASPS, ABA	2.45	2.45	Yes	
15300	090	N	Feb05	24	Free Skin Grafts	FF22	Apr05	06	ASPS, ABA	3.99	3.99	Yes	
15301	ZZZ	N	Feb05	24	Free Skin Grafts	FF23	Apr05	06	ASPS, ABA	1.00	1.00	Yes	
15320	090	N	Feb05	24	Free Skin Grafts	FF24	Apr05	06	ASPS, ABA	4.70	4.70	Yes	
15321	ZZZ	N	Feb05	24	Free Skin Grafts	FF25	Apr05	06	ASPS, ABA	1.50	1.50	Yes	
15330	090	N	Feb05	24	Free Skin Grafts	FF26	Apr05	06	ASPS, ABA	3.99	3.99	Yes	
15331	ZZZ	N	Feb05	24	Free Skin Grafts	FF27	Apr05	06	ASPS, ABA	1.00	1.00	Yes	
15335	090	N	Feb05	24	Free Skin Grafts	FF28	Apr05	06	ASPS, ABA	4.50	4.50	Yes	
15336	ZZZ	N	Feb05	24	Free Skin Grafts	FF29	Apr05	06	ASPS, ABA	1.43	1.43	Yes	
15340	010	N	Feb05	24	Free Skin Grafts	FF30	Apr05	06	ASPS, ABA, APMA	3.72	3.72	Yes	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC S.S. Tab	Specialty	RUC Rec	Same RVU as last year?	MFS	Comments
15341	ZZZ	N	Feb05	24	Free Skin Grafts	FF31	Apr05	06 ASPS, ABA, APMA	0.50	0.50		Yes
15342	010	D	Feb05	24	Free Skin Grafts		Apr05	06				Yes
15343	ZZZ	D	Feb05	24	Free Skin Grafts		Apr05	06				Yes
15350	090	D	Feb05	24	Free Skin Grafts		Apr05	06				Yes
15351	ZZZ	D	Feb05	24	Free Skin Grafts		Apr05	06				Yes
15360	090	N	Feb05	24	Free Skin Grafts	FF32	Apr05	06 ASPS, ABA	3.87	3.87		Yes
15361	ZZZ	N	Feb05	24	Free Skin Grafts	FF33	Apr05	06 ASPS, ABA	1.15	1.15		Yes
15365	090	N	Feb05	24	Free Skin Grafts	FF34	Apr05	06 ASPS, ABA	4.15	4.15		Yes
15366	ZZZ	N	Feb05	24	Free Skin Grafts	FF35	Apr05	06 ASPS, ABA	1.45	1.45		Yes
15400	090	R	Feb05	24	Free Skin Grafts	FF36	Apr05	06 ASPS, ABA	3.99	3.99	Yes	Yes
15401	ZZZ	R	Feb05	24	Free Skin Grafts	FF37	Apr05	06 ASPS, ABA	1.00	1.00	Yes	Yes
15420	090	N	Feb05	24	Free Skin Grafts	FF38	Apr05	06 ASPS, ABA	4.50	4.50		Yes
15421	ZZZ	N	Feb05	24	Free Skin Grafts	FF39	Apr05	06 ASPS, ABA	1.50	1.50		Yes

CPT Code	Global Coding Period	Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
15430	090	N	Feb05	24	Free Skin Grafts	FF40	Apr05	06 ASPS, ABA	5.75	5.75			Yes	
15431	ZZZ	N	Feb05	24	Free Skin Grafts	FF41	Apr05	06 ASPS, ABA					Yes	Carrier Priced
15810	090	D	Feb05	26	Salabrasion		Deleted						Yes	
15811	090	D	Feb05	26	Salabrasion		Deleted						Yes	
16010	000	D	Feb05	24	Free Skin Grafts		Apr05	06					Yes	
16015	000	D	Feb05	24	Free Skin Grafts		Apr05	06					Yes	
16020	000	R	Feb05	24	Free Skin Grafts	FF42	Apr05	06 ASPS, ABA	0.80	0.80	Yes		Yes	
16025	000	R	Feb05	24	Free Skin Grafts	FF43	Apr05	06 ASPS, ABA	1.85	1.85	Yes		Yes	
16030	000	R	Feb05	24	Free Skin Grafts	FF44	Apr05	06 ASPS, ABA	2.08	2.08	Yes		Yes	
19260	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE1	Apr05	07 STS	15.42	15.42	Yes		Yes	
19271	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE2	Apr05	07 STS	18.87	18.87	Yes		Yes	
19272	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE3	Apr05	07 STS	21.52	21.52	Yes		Yes	
21493	090	D	Aug04	12	Hyoid Larynx Fracture		Deleted						Yes	
21494	090	D	Aug04	12	Hyoid Larynx Fracture		Deleted						Yes	

CPT Code	Global Coding Period	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
22010	090	N	Feb05	27	Incision and Drainage Spinal Deep Abscess	HH1	Apr05	08	NASS, AANS/C, NS, AAOS	11.05	11.05		Yes	
22015	090	N	Feb05	27	Incision and Drainage Spinal Deep Abscess	HH2	Apr05	08	NASS, AANS/C, NS, AAOS	10.94	10.94		Yes	
22520	010	R	Feb05	110	Vertebral Augmentation - Kyphoplasty		Apr05	09	NASS, AAPM, AANS/C, NS, SIR, ACR, ASA, ASNR, AAOS	8.90	8.90	Yes	Yes	Under Review-Five Year Review
22521	010	R	Feb05	110	Vertebral Augmentation - Kyphoplasty		Apr05	09	NASS, AAPM, AANS/C, NS, SIR, ACR, ASA, ASNR, AAOS	8.33	8.33	Yes	Yes	Under Review-Five Year Review

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
22522	ZZZ	R	Feb05	110	Vertebral Augmentation - Kyphoplasty		Apr05	09	NASS, AAPM, AANS/CNS, SIR, ACR, ASA, ASNR, AAOS	4.30	4.30	Yes	Yes	Yes	Under Review-Five Year Review
22523	010	N	Feb05	110	Vertebral Augmentation - Kyphoplasty	M1	Apr05	09	NASS, AAPM, AANS/CNS, SIR, ACR, ASA, ASNR, AAOS	8.94	8.94			Yes	
22524	010	N	Feb05	110	Vertebral Augmentation - Kyphoplasty	M2	Apr05	09	NASS, AAPM, AANS/CNS, SIR, ACR, ASA, ASNR, AAOS	8.54	8.54			Yes	

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
22525	ZZZ	N	Feb05	110	Vertebral Augmentation - Kyphoplasty	M3	Apr05	09	NASS, AAPM, AANS/CNS, SIR, ACR, ASA, ASNR, AAOS	4.67	4.47		Yes	
28890	090	N	Nov04	04	High Energy Extracorporeal Shock Wave Therapy	N1	Feb05	08	APMA, AOFAS, AAOS	4.50	3.30		Yes	
29866	090	R	Feb05	28	Osteochondral Procedures		Feb05		Editorial	13.88	13.88	Yes	Yes	
29867	090	R	Feb05	28	Osteochondral Procedures		Feb05		Editorial	17.00	17.00	Yes	Yes	
29868	090	R	Feb05	28	Osteochondral Procedures		Feb05		Editorial	23.59	23.59	Yes	Yes	
30130	090	R	Nov04	10	Inferior Turbinate Procedures	O1	Feb05	09	AAO-HNS	3.37	3.37	Yes	Yes	
30140	090	R	Nov04	10	Inferior Turbinate Procedures	O2	Feb05	09	AAO-HNS	3.42	3.42	Yes	Yes	
30801	010	R	Nov04	10	Inferior Turbinate Procedures	O3	Feb05	09	AAO-HNS	1.09	1.09	Yes	Yes	
30802	010	R	Nov04	10	Inferior Turbinate Procedures	O4	Feb05	09	AAO-HNS	2.03	2.03	Yes	Yes	
30930	010	R	Nov04	10	Inferior Turbinate Procedures	O5	Feb05	09	AAO-HNS	1.26	1.26	Yes	Yes	
31526	000	R	Feb05	05	Laryngeal Telescope		Feb05		Editorial	2.57	2.57	Yes	Yes	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
31531	000	R	Feb05	05	Laryngeal Telescope					3.58	3.58	Yes	Yes	
31536	000	R	Feb05	05	Laryngeal Telescope					3.55	3.55	Yes	Yes	
31541	000	R	Feb05	05	Laryngeal Telescope					4.52	4.52	Yes	Yes	
31561	000	R	Feb05	05	Laryngeal Telescope					5.99	5.99	Yes	Yes	
31571	000	R	Feb05	05	Laryngeal Telescope					4.26	4.26	Yes	Yes	
31585	090	D	Aug04	12	Hyoid Larynx Fracture								Yes	
31586	090	D	Aug04	12	Hyoid Larynx Fracture								Yes	
32002	000	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07 STS		2.19	2.19	Yes	Yes	
32020	000	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07 STS		3.97	3.97	Yes	Yes	
32100	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07 STS		15.22	15.22	Yes	Yes	
32440	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE4	Apr05	07 STS		24.96	24.96	Yes	Yes	
32442	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE5	Apr05	07 STS		26.20	26.20	Yes	Yes	
32445	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE6	Apr05	07 STS		25.05	25.05	Yes	Yes	
32480	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE7	Apr05	07 STS		23.71	23.71	Yes	Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
32482	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE8	Apr05	07	STS	24.96	24.96	Yes	Yes	Yes	
32484	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE9	Apr05	07	STS	20.66	20.66	Yes	Yes	Yes	
32486	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE10	Apr05	07	STS	23.88	23.88	Yes	Yes	Yes	
32488	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE11	Apr05	07	STS	25.67	25.67	Yes	Yes	Yes	
32491	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE12	Apr05	07	STS	21.22	21.22	Yes	Yes	Yes	
32500	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE13	Apr05	07	STS	21.97	21.97	Yes	Yes	Yes	
32503	090	N	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE14	Apr05	07	STS	30.00	30.00			Yes	
32504	090	N	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE15	Apr05	07	STS	34.80	34.80			Yes	
32520	090	D	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07						Yes	
32522	090	D	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07						Yes	
32525	090	D	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07						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 as last year?	RVU	MFS	Comments
33478	090	R	Aug04	17	Cavopulmonary Shunting		Apr05	12 STS	26.70	26.70	Yes	Yes	
33502	090	R	Aug04	15	Coronary Artery Anomaly Unroofing		Apr05	10	21.01	21.01	Yes	Yes	
33503	090	R	Aug04	15	Coronary Artery Anomaly Unroofing		Apr05	10	21.75	21.75	Yes	Yes	
33504	090	R	Aug04	15	Coronary Artery Anomaly Unroofing		Apr05	10	24.62	24.62	Yes	Yes	
33505	090	R	Aug04	15	Coronary Artery Anomaly Unroofing		Apr05	10	26.80	26.80	Yes	Yes	
33506	090	R	Aug04	15	Coronary Artery Anomaly Unroofing		Apr05	10	35.45	35.45	Yes	Yes	
33507	090	N	Aug04	15	Coronary Artery Anomaly Unroofing	D1	Apr05	10 STS	30.00	30.00		Yes	
33548	090	N	Aug04	16	Ventricular Restoration	E1	Apr05	11 STS	37.97	37.97		Yes	Interim - to be reviewed Sept05
33617	090	R	Aug04	17	Cavopulmonary Shunting		Apr05	12 STS	36.94	36.94	Yes	Yes	
33767	090	R	Aug04	17	Cavopulmonary Shunting		Apr05	12 STS	24.46	24.46	Yes	Yes	
33768	090	N	Aug04	17	Cavopulmonary Shunting	F1	Apr05	12 STS	8.00	8.00	Yes	Yes	
33880	090	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II1	Apr05	14 SVS, SIR, ACR	33.00	33.00		Yes	
33881	090	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II2	Apr05	14 SVS, SIR, ACR	28.00	28.00		Yes	
33883	090	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II3	Apr05	14 SVS, SIR, ACR	20.00	20.00		Yes	

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33884	ZZZ	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II4	Apr05	14	SVS, SIR, ACR	8.20	8.20			Yes	
33886	090	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II5	Apr05	14	SVS, SIR, ACR	17.00	17.00			Yes	
33889	000	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II6	Apr05	14	SVS, SIR, ACR	15.92	15.92			Yes	
33891	000	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II7	Apr05	14	SVS, SIR, ACR	20.00	20.00			Yes	
33918	090	D	Aug04	19	Repair of Pulmonary Artery Arborization Anomaly		Apr05	13						Yes	
33919	090	D	Aug04	19	Repair of Pulmonary Artery Arborization Anomaly		Apr05	13						Yes	
33925	090	N	Aug04	19	Repair of Pulmonary Artery Arborization Anomaly	G1	Apr05	13	STS	29.50	29.50			Yes	
33926	090	N	Aug04	19	Repair of Pulmonary Artery Arborization Anomaly	G2	Apr05	13	STS	42.00	42.00			Yes	
34833	000	R	Feb05	33	Descending Thoracic Aorta Endovascular Repair		Apr05	14	SVS, SIR, ACR	11.98	11.98	Yes		Yes	
34834	000	R	Feb05	33	Descending Thoracic Aorta Endovascular Repair		Apr05	14	SVS, SIR, ACR	5.34	5.34	Yes		Yes	

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35601	090	R	Feb05	33	Descending Thoracic Aorta Endovascular Repair		Apr05	14	SVS, SIR, ACR	17.47	17.47	Yes	Yes	
35691	090	R	Feb05	33	Descending Thoracic Aorta Endovascular Repair		Apr05	14	SVS, SIR, ACR	18.02	18.02	Yes	Yes	
35694	090	R	Feb05	33	Descending Thoracic Aorta Endovascular Repair		Apr05	14	SVS, SIR, ACR	19.13	19.13	Yes	Yes	
36598	000	N	Nov04	16	Radiologic Venous Catheter Evaluation	P1	Feb05	06	SIR, ACR	0.88	0.74		Yes	
37184	000	N	Feb05	07	Mechanical Thrombectomy	KK1	Apr05	15	SVS, SIR, ACR	8.66	8.66		Yes	
37185	ZZZ	N	Feb05	07	Mechanical Thrombectomy	KK2	Apr05	15	SVS, SIR, ACR	3.28	3.28		Yes	
37186	ZZZ	N	Feb05	07	Mechanical Thrombectomy	KK3	Apr05	15	SVS, SIR, ACR	4.92	4.92		Yes	
37187	000	N	Feb05	07	Mechanical Thrombectomy	KK4	Apr05	15	SVS, SIR, ACR	8.03	8.03		Yes	
37188	000	N	Feb05	07	Mechanical Thrombectomy	KK5	Apr05	15	SVS, SIR, ACR	5.71	5.71		Yes	

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37209	000	R	Feb05	07	Mechanical Thrombectomy		Apr05	15 SVS, SIR, ACR	2.27	2.27	Yes	Yes	
37700	090	R	Feb05	34	Saphenous Vein Removal		Apr05	16 SVS	3.72	3.72	Yes	Yes	
37718	090	N	Feb05	34	Saphenous Vein Removal	JJ1	Apr05	16 SVS	6.76	6.76		Yes	
37720	090	D	Feb05	34	Saphenous Vein Removal		Apr05	16				Yes	
37722	090	N	Feb05	34	Saphenous Vein Removal	JJ2	Apr05	16 SVS	7.79	7.79		Yes	
37730	090	D	Feb05	34	Saphenous Vein Removal		Apr05	16				Yes	
37735	090	R	Feb05	34	Saphenous Vein Removal		Apr05	16 SVS	10.51	10.51	Yes	Yes	
42325	090	D	Feb05	35	Oral Procedure Code		Deleted					Yes	
42326	090	D	Feb05	35	Oral Procedure Code		Deleted					Yes	
43638	090	D	Nov04	17	Partial Gastrectomy		Deleted					Yes	
43639	090	D	Nov04	17	Partial Gastrectomy		Deleted					Yes	
43770	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R1	Apr05	17 SAGES	16.71	16.71		Yes	
43771	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R2	Apr05	17 SAGES	19.50	19.50		Yes	
43772	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R3	Apr05	17 SAGES	15.00	15.00		Yes	
43773	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R4	Apr05	17 SAGES	19.50	19.50		Yes	

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43774	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R5	Apr05	17	SAGES	15.00	15.00			Yes	
43845	090	N	Nov03	R	Gastric Restrictive Procedures	L1	Apr05	5	SAGES	31.00	31.00			Yes	CPT 2005 Issue
43848	090	R	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band		Apr05	17	SAGES	29.35	29.35	Yes	Yes		
43886	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R6	Apr05	17	SAGES	4.00	4.00			Yes	
43887	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R7	Apr05	17	SAGES	3.95	3.95			Yes	
43888	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R8	Apr05	17	SAGES	5.80	5.80			Yes	
44180	090	N	Nov04		Laparoscopic Enterolysis		Renumb			14.42	14.42			Yes	Renumbered from 44200
44186	090	N	Nov04		Laparoscopic Jejunostomy		Renumb			9.77	9.77			Yes	Renumbered from 44201
44187	090	N	Nov04	19	Laparoscopic Stoma	U1	Feb05	19	SAGES, ASCoRS	15.93	15.93			Yes	
44188	090	N	Nov04	19	Laparoscopic Stoma	U2	Feb05	19	SAGES, ASCoRS	18.00	17.61			Yes	
44200	090	D	Nov04		Laparoscopic Enterolysis		Deleted							Yes	
44201	090	D	Nov04		Laparoscopic Jejunostomy		Deleted							Yes	
44213	ZZZ	N	Nov04	18	Laparoscopic Splenic Flexure	T1	Feb05	18	SAGES, ASCoRS	3.50	3.50			Yes	

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44227	090	N	Nov04	18	Laparoscopic Enterostomy Closure	S1	Feb05	17	SAGES, ASCoRS	26.50	26.50			Yes	
44239	YYY	D	Nov04	23	Unlisted Laparoscopic Procedure		Deleted							Yes	
44310	090	R	Nov04	19	Laparoscopic Stoma		Feb05	19	SAGES, ASCoRS	15.93	15.93	Yes	Yes		
44320	090	R	Nov04	19	Laparoscopic Stoma		Feb05	19	SAGES, ASCoRS	17.61	17.61	Yes	Yes		
44620	090	R	Nov04	18	Laparoscopic Enterostomy Closure		Feb05	17	SAGES, ASCoRS	12.18	12.18	Yes	Yes		
44625	090	R	Nov04	18	Laparoscopic Enterostomy Closure		Feb05	17	SAGES, ASCoRS	15.03	15.03	Yes	Yes		
44626	090	R	Nov04	18	Laparoscopic Enterostomy Closure		Feb05	17	SAGES, ASCoRS	25.32	25.32	Yes	Yes		
45110	090	R	Nov04	20	Laparoscopic Proctectomy		Feb05	20	ASCoRS, SAGES	27.96	27.96	Yes	Yes		
45119	090	R	Nov04	20	Laparoscopic Proctectomy		Feb05	20	ASCoRS, SAGES	30.79	30.79	Yes	Yes		
45395	090	N	Nov04	20	Laparoscopic Proctectomy	V1	Feb05	20	ASCoRS, SAGES	30.50	30.50			Yes	
45397	090	N	Nov04	20	Laparoscopic Proctectomy	V2	Feb05	20	ASCoRS, SAGES	34.00	34.00			Yes	
45400	090	N	Nov04	21	Laparoscopic Proctopexy	W1	Feb05	21	ASCoRS, SAGES	18.06	18.06			Yes	

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45402	090	N	Nov04	21	Laparoscopic Proctopexy	W2	Feb05	21	ASCoRS, SAGES	25.27	25.04			Yes	
45499	YYY	N	Nov04	23	Unlisted Laparoscopic Procedure				Renumb					Yes	Carrier Priced - Renumbered from 44239
45540	090	R	Nov04	21	Laparoscopic Proctopexy		Feb05	21	ASCoRS, SAGES	16.25	16.25	Yes	Yes		
45550	090	R	Nov04	21	Laparoscopic Proctopexy		Feb05	21	ASCoRS, SAGES	22.97	22.97	Yes	Yes		
45990	000	N	Feb05	36	Diagnostic Rectal Exam Under Anesthesia	LL1	Apr05	18	ASGS, ASCoRS	1.80	1.80			Yes	
46505	010	N	Nov04	25	Anal Sphincter Chemodenervation	X1	Feb05	23	ASCoRS	3.50	2.86			Yes	
46710	090	N	Nov04	26	Ileoanal Pouch Fistula Repair	Y1	Feb05	22	ASCoRS	18.00	16.00			Yes	
46712	090	N	Nov04	26	Ileoanal Pouch Fistula Repair	Y2	Feb05	22	ASCoRS	34.00	34.00			Yes	
50250	090	N	Feb05	38	Open Cryoablation of Renal Tumor	MM1	Apr05	19	AUA	19.97	19.97			Yes	
50382	000	N	Feb05	39	Ureteral Stent Exchange/Remove	NN1	Apr05	20	SIR, ACR	6.74	5.50			Yes	
50384	000	N	Feb05	39	Ureteral Stent Exchange/Remove	NN2	Apr05	20	SIR, ACR	5.30	5.00			Yes	
50387	000	N	Feb05	39	Ureteral Stent Exchange/Remove	NN3	Apr05	20	SIR, ACR	2.63	2.00			Yes	
50389	000	N	Feb05	39	Ureteral Stent Exchange/Remove	NN4	Apr05	20	SIR, ACR	1.10	1.10			Yes	

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50592	010	N	Nov04	D	Percutaneous Radiofrequency Ablation of Renal Tumors	OO1	Apr05	21	SIR, ACR	8.11	6.75			Yes	
50668	010	R	Feb05	39	Ureteral Stent Exchange/Remove		Apr05	20	SIR, ACR	1.17	1.17	Yes	Yes		
51999	YYY	N	Nov04	29	Unlisted Bladder Laproscopy		Carrier Pr							Yes	Carrier Priced
52647	090	R	Nov04	30	Laser Prostate Vaporization		Editorial			10.34	10.34	Yes	Yes		
52648	090	R	Nov04	30	Laser Prostate Vaporization		Editorial			11.19	11.19	Yes	Yes		
57295	090	N	Feb05	22	Revision-Removal of Vaginal Graft	PP1	Apr05	22	ACOG	7.45	7.45			Yes	
57421	000	R	Feb05	42	Endometrial Sampling		Apr05	23		2.20	2.20	Yes	Yes		
58100	000	R	Feb05	42	Endometrial Sampling		Apr05	23		1.53	1.53	Yes	Yes		
58110	ZZZ	N	Feb05	42	Endometrial Sampling	QQ1	Apr05	23	ACOG	0.77	0.77			Yes	
61630	090	N	Feb05	44	Intracranial Angioplasty and Stenting	RR1	Apr05	24	SIR, ACR, AANS/C NS, ASNR	21.50	21.08			Yes	
61635	090	N	Feb05	44	Intracranial Angioplasty and Stenting	RR2	Apr05	24	SIR, ACR, AANS/C NS, ASNR	23.50	23.08			Yes	

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61640	090	N	Feb05	44	Intracranial Angioplasty and Stenting	RR3	Apr05	24	SIR, ACR, AANS/C NS, ASNR	12.71	12.32			Yes	
61641	ZZZ	N	Feb05	44	Intracranial Angioplasty and Stenting	RR4	Apr05	24	SIR, ACR, AANS/C NS, ASNR	5.00	4.33			Yes	
61642	ZZZ	N	Feb05	44	Intracranial Angioplasty and Stenting	RR5	Apr05	24	SIR, ACR, AANS/C NS, ASNR	9.03	8.66			Yes	
64613	010	R	Feb05	92	Needle EMG with Chemodenervation	XX4	Apr05	31	AAN, AANEM, AAPMR, AAO-HNS	1.96	1.96	Yes	Yes		
64614	010	R	Feb05	92	Needle EMG with Chemodenervation	XX5	Apr05	31	AAN, AANEM, AAPMR	2.20	2.20	Yes	Yes		
64650	000	N	Nov04	31	Hyperhidrosis Chemodenervation	Z1	Apr05	25	AAN, AAD	0.70	0.70			Yes	
64653	000	N	Nov04	31	Hyperhidrosis Chemodenervation	Z4	Apr05	25	AAN, AAD	0.88	0.88			Yes	

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67901	090	R	Nov04	31	Blepharoptosis Repair, Harvest of Fascia	AA1	Apr05	26	AAO	7.39	7.39		Yes	
67902	090	R	Nov04	31	Blepharoptosis Repair, Harvest of Fascia	AA2	Apr05	26	AAO	9.35	9.35		Yes	
69410	000	D	Aug04	20	Middle Ear Baffle Technique		Deleted						Yes	
75900	XXX	R	Feb05	07	Mechanical Thrombectomy		Apr05	15	SVS, SIR, ACR	0.49	0.49	Yes	Yes	
75956	XXX	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II8	Apr05	14	SVS, SIR, ACR	7.00	7.00		Yes	
75957	XXX	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II9	Apr05	14	SVS, SIR, ACR	6.00	6.00		Yes	
75958	XXX	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II10	Apr05	14	SVS, SIR, ACR	4.00	4.00		Yes	
75959	XXX	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II11	Apr05	14	SVS, SIR, ACR	3.50	3.50		Yes	
76012	XXX	R	Feb05	110	Vertebral Augmentation - Kyphoplasty		Apr05	09	NASS, AAPM, AANS/C, NS, SIR, ACR, ASA, ASNR, AAOS	1.31	1.31	Yes	Yes	

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76013	XXX	R	Feb05	110	Vertebral Augmentation - Kyphoplasty		Apr05	09	NASS, AAPM, AANS/CNS, SIR, ACR, ASA, ASNR, AAOS	1.38	1.38	Yes	Yes	Yes	
76375	XXX	D	Feb05	48	3D Image Rendering		Apr05	27						Yes	
76376	XXX	N	Feb05	48	3D Image Rendering	SS1	Apr05	27	ACR	0.20	0.20			Yes	
76377	XXX	N	Feb05	48	3D Image Rendering	SS2	Apr05	27	ACR	0.79	0.79			Yes	
77412	XXX	R	Nov04	A4	Neutron Therapy		Feb05	26		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
77413	XXX	R	Nov04	A4	Neutron Therapy		Feb05	26		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
77414	XXX	R	Nov04	A4	Neutron Therapy		Feb05	26		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
77416	XXX	R	Nov04	A4	Neutron Therapy		Feb05	26		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
77421	XXX	N	Feb05	30	Stereoscopic X-Ray Guidance	TT2	Apr05	28	ASTRO, ACR	0.39	0.39			Yes	
77422	XXX	N	Nov04	A4	Neutron Therapy	BB1	Feb05	26	ASTRO	0.00	0.00			Yes	PE Inputs Only
77423	XXX	N	Nov04	A4	Neutron Therapy	BB2	Feb05	26	ASTRO	0.00	0.00			Yes	PE Inputs Only
78160	XXX	D	Feb05	51	Radioactive Iron-Fibrinogen Studies		Deleted							Yes	
78162	XXX	D	Feb05	51	Radioactive Iron-Fibrinogen Studies		Deleted							Yes	

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78170	XXX	D	Feb05	51	Radioactive Iron-Fibrinogen Studies		Deleted					Yes	
78172	XXX	D	Feb05	51	Radioactive Iron-Fibrinogen Studies		Deleted					Yes	
78455	XXX	D	Feb05	51	Radioactive Iron-Fibrinogen Studies		Deleted					Yes	
80195	XXX	N	Feb05	55	Sirolimus Therapeutic Drug Assay		CLFS					No	
82270	XXX	N	Nov04	A6	Fecal Occult Blood Testing		CLFS					No	
82271	XXX	N	Nov04	A6	Fecal Occult Blood Testing		CLFS					No	
83036	XXX	R	Feb05	09	Glycosylated Hemoglobin Test		CLFS					No	
83037	XXX	R	Feb05	09	Glycosylated Hemoglobin Test		CLFS					No	
83630	XXX	R	Feb05	09	Quantitative Lactoferrin		CLFS					No	
83631	XXX	N	Feb05	09	Quantitative Lactoferrin		CLFS					No	
83695	XXX	N	Feb05	61	Lipoprotein(a) Quantitative Direct Measurement		CLFS					No	
83700	XXX	N	Feb05	62	Lipoprotein Procedures		CLFS					No	Renumbered from 83715
83701	XXX	N	Feb05	62	Lipoprotein Procedures		CLFS					No	Renumbered from 83716
83704	XXX	N	Feb05	62	Lipoprotein Procedures		CLFS					No	
83715	XXX	D	Feb05	62	Lipoprotein Procedures		Deleted					No	
83716	XXX	D	Feb05	62	Lipoprotein Procedures		Deleted					No	
83890	XXX	R	Feb05	11	Molecular Diagnostic Testing Component Procedures		CLFS					No	

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83898	XXX	R	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83900	XXX	N	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83901	XXX	R	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83907	XXX	N	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83908	XXX	N	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83909	XXX	N	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83914	XXX	N	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
84238	XXX	R	Feb05	65	Acetylcholine Receptor Antibody		CLFS						No	
86064	XXX	D	Feb05	F	Quantitative Flow Codes for T Cells		Deleted						No	
86200	XXX	N	May04	19	ELISA Detections - Cyclic Citrullinated Peptide		CLFS						No	
86355	XXX	N	Feb05	F	Quantitative Flow Codes for T Cells		CLFS						No	
86357	XXX	N	Feb05	F	Quantitative Flow Codes for T Cells		CLFS						No	
86367	XXX	N	Feb05	F	Quantitative Flow Codes for T Cells		CLFS						No	
86379	XXX	D	Feb05	F	Quantitative Flow Codes for T Cells		Deleted						No	
86480	XXX	N	Feb05	111	Tuberculin Invitro Testing		CLFS						No	

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86585	XXX	D	Nov04	A9	TB Tine Test			CLFS					No	
86587	XXX	D	Feb05	F	Quantitative Flow Codes for T Cells			Deleted					No	
86923	XXX	N	Feb05	71	Electronic Crossmatch			CLFS					No	
86960	XXX	N	Feb05	68	Platelet Volume Reduction			CLFS					No	
87209	XXX	N	Feb05	76	Trichrome Stain			CLFS					No	
87900	XXX	N	Feb05	98	Infectious Agent Genotype Analysis Nucleic Acid HIV-1			CLFS					No	
87904	XXX	R	Nov04	A9	Nucleic Acid Infections Agent Phenotype-Drug Resistance Analysis			CLFS					No	
88175	XXX	R	Nov04	A13	Limited Cytopathology Re-Screening			CLFS					No	
88333	XXX	N	Feb05	75	Intraoperative Consult and Touch Prep	UU1	Apr05	29	CAP	1.20	1.20		Yes	
88334	XXX	N	Feb05	75	Intraoperative Consult and Touch Prep	UU2	Apr05	29	CAP	0.80	0.80		Yes	
88384	XXX	N	Feb05	11	Multiple Molecular Marker Array-Based Evaluation	VV1	Apr05	30	CAP				Yes	Carrier Priced
88385	XXX	N	Feb05	11	Multiple Molecular Marker Array-Based Evaluation	VV2	Apr05	30	CAP	1.50	1.50		Yes	
88386	XXX	N	Feb05	11	Multiple Molecular Marker Array-Based Evaluation	VV3	Apr05	30	CAP	1.88	1.88		Yes	
89049	XXX	N	Nov04	A15	Caffeine Halothane Contracture Test	C1	Feb05	27	ASA	1.40	1.40		Yes	
90649	XXX	N	Feb05	78-9	Human Papilloma Virus			Vaccine					No	
90680	XXX	R	Nov04	A16	Rotavirus Vaccine			Vaccine					No	

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
90713	XXX	R	Nov04	A18	Intramuscular Polio Vaccine Injection							No	
90714	XXX	N	Nov04	B9	Thimerosal Reduced Diphtheria Vaccine							No	
90715	XXX	R	Nov04	A17	Tetanus Diphtheria Toxoid & Acellular Pertussis Vaccine Booster							No	
90736	XXX	N	Feb05	78-9	Zoster Vaccine							No	
90760	XXX	N	Aug04	07	Drug Administration - Hydration	H1	Oct04	12	ACRh, ADSA, ASH, ASCO, AGA	0.17	0.17	Yes	
90761	ZZZ	N	Aug04	07	Drug Administration - Hydration	H2	Oct04	12	ACRh, ADSA, ASH, ASCO, AGA	0.13	0.09	Yes	
90765	XXX	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Infusions	H3	Oct04	12	IDSA, ASH, ASCO	0.24	0.21	Yes	
90766	ZZZ	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Infusions	H5	Oct04	12	IDSA, ASH, ASCO	0.21	0.18	Yes	
90767	ZZZ	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Infusions	H4	Oct04	12	IDSA, ASH, ASCO	0.21	0.19	Yes	

CPT Code	Global Coding Period	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
90768	ZZZ	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Infusions	H6	Oct04	12	IDSA, ASH, ASCO	0.17	0.17		Yes	
90772	XXX	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	H7	Oct04	12	ACRrh, ASH, ASCO, ACG	0.17	0.17		Yes	
90773	XXX	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	H8	Oct04	12	ACRrh, ASH, ASCO, ACG				Yes	No RUC Recommendation
90774	XXX	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	H9	Oct04	12	ACRrh, ASH, ASCO, ACG	0.20	0.17		Yes	
90775	ZZZ	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	H10	Oct04	12	ACRrh, ASH, ASCO, ACG	0.16	0.10		Yes	
90779	YYY	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections		Oct04	12					Yes	Carrier Priced
90780	XXX	D	Aug04	07	Drug Administration - Hydration		Oct04	12	ACRrh, ADSA, ASH, ASCO, AGA				Yes	

CPT Code	Global Coding Period	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
90781	ZZZ	D	Aug04	07	Drug Administration - Hydration	Oct04	12	ACR <sub>h</sub> , ADSA, ASH, ASCO, AGA					Yes	
90782	XXX	D	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	Oct04	12						Yes	
90783	XXX	D	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	Oct04	12						Yes	
90784	XXX	D	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	Oct04	12						Yes	
90788	XXX	D	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	Oct04	12						Yes	
90799	YYY	D	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	Oct04	12						Yes	
90870	000	R	Feb05	81	Electroconvulsive Therapy	Editorial			1.88	<b>1.88</b>	Yes		Yes	
90871	000	D	Feb05	81	Electroconvulsive Therapy	Deleted							Yes	
90939	XXX	D	Feb05	83	Hemodialysis Access Flow Study	Deleted							Yes	
90940	XXX	R	Feb05	83	Hemodialysis Access Flow Study	Editorial			0.00	<b>0.00</b>	Yes		Yes	
91022	000	N	Aug04	08	Antroduodenal Manometry	11	Feb05	28	ASGE, AGA, ACG	1.50	<b>1.44</b>		Yes	
92330	XXX	D	Nov04	A20	Ocular Prosthetics	Deleted							Yes	

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
92335	XXX	D	Nov04	A20	Ocular Prosthetics		Deleted							Yes	
92390	XXX	D	Aug04	24	Supply of Ophthalmological Materials		Deleted							Yes	
92391	XXX	D	Aug04	24	Supply of Ophthalmological Materials		Deleted							Yes	
92392	XXX	D	Aug04	24	Supply of Ophthalmological Materials		Deleted							Yes	
92393	XXX	D	Aug04	24	Supply of Ophthalmological Materials		Deleted							Yes	
92395	XXX	D	Aug04	24	Supply of Ophthalmological Materials		Deleted							Yes	
92396	XXX	D	Aug04	24	Supply of Ophthalmological Materials		Deleted							Yes	
92520	XXX	R	May04	07	Laryngeal Function Studies	B1	Feb05	10	ASHA, AAO-HNS	0.75	0.75			Yes	
92568	XXX	R	Feb05	84	Acoustic Reflex Threshold		Editorial			0.00	0.00	Yes	Yes	Yes	PE Inputs Only
92569	XXX	R	Feb05	84	Acoustic Reflex Threshold		Editorial			0.00	0.00	Yes	Yes	Yes	PE Inputs Only
95250	XXX	R	Aug04	26	Continuous Glucose Monitoring		Feb05	29		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
95251	XXX	N	Aug04	26	Continuous Glucose Monitoring	J1	Feb05	29	AACE	0.85	0.85			Yes	
95858	XXX	D	Nov04	A22	Tensilon Test		Deletion							Yes	
95865	XXX	N	Feb05	91	Complex EMG	YY4	Apr05	A	AAN, AANEM, AAPMR, AAO-HNS	1.57	1.57			Yes	

CPT Code	Global Coding Period	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
95866	XXX	N	Feb05	91	Complex EMG	YY5	Apr05	A	AAN, AANEM, AAPMR	1.25	1.25		Yes	
95867	XXX	R	Feb05	91	Complex EMG	YY1	Apr05	A	AAN, AANEM, AAPMR	0.79	0.79	Yes	Yes	
95868	XXX	R	Feb05	91	Complex EMG	YY2	Apr05	A	AAN, AANEM, AAPMR	1.18	1.18	Yes	Yes	
95870	XXX	R	Feb05	91	Complex EMG	YY3	Apr05	A	AAN, AANEM, AAPMR	0.37	0.37	Yes	Yes	
95873	ZZZ	N	Feb05	92	Needle EMG with Chemodenervation	XX1	Apr05	31	AAN, AANEM, AAPMR	0.96	0.56		Yes	
95874	ZZZ	N	Feb05	92	Needle EMG with Chemodenervation	XX2	Apr05	31	AAN, AANEM, AAPMR	0.96	0.56		Yes	
96400	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12					Yes	
96401	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H11	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG	0.21	0.21		Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
96402	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H12	Oct04	12	ACR <sub>h</sub> , AUA, ASH, ASCO, AGA, ACG	0.19	0.19		Yes	
96405	000	R	Aug04	07	Drug Administration - Chemotherapy		Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	0.52	0.52	Yes	Yes	
96406	000	R	Aug04	07	Drug Administration - Chemotherapy		Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	0.80	0.80	Yes	Yes	
96408	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12					Yes	
96409	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H13	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	0.27	0.24		Yes	
96410	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12					Yes	
96411	ZZZ	N	Aug04	07	Drug Administration - Chemotherapy	H14	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	0.23	0.20		Yes	

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
96412	ZZZ	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12						Yes	
96413	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H15	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG	0.31	0.28			Yes	
96414	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12						Yes	
96415	ZZZ	N	Aug04	07	Drug Administration - Chemotherapy	H16	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG	0.22	0.19			Yes	
96416	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H17	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG	0.24	0.21			Yes	
96417	ZZZ	N	Aug04	07	Drug Administration - Chemotherpay	H18	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG	0.24	0.21			Yes	
96420	XXX	R	Aug04	07	Drug Administration - Chemotherapy	H19	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG					Yes	No RUC Recommendation

CPT Code	Global Coding Period	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
96422	XXX	R	Aug04	07	Drug Administration - Chemotherapy	H20	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG				Yes	No RUC Recommendation
96423	ZZZ	R	Aug04	07	Drug Administration - Chemotherapy	H21	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG				Yes	No RUC Recommendation
96425	XXX	R	Aug04	07	Drug Administration - Chemotherapy	H22	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG				Yes	No RUC Recommendation
96450	000	R	Aug04	07	Drug Administration - Chemotherapy	H23	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	1.53	1.53		Yes	
96520	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12					Yes	
96521	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H24	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	0.24	0.21		Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
96522	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H26	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA	0.24	0.21			Yes	
96523	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H25	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA	0.04	0.04			Yes	
96530	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12						Yes	
96542	XXX	R	Aug04	07	Drug Administration - Chemotherapy	H27	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA	0.75	0.75			Yes	
96545	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12						Yes	
97020	XXX	D	Nov04	A26	Physical Therapy Modality - Microwave		Deleted							Yes	
97024	XXX	R	Nov04	A26	Physical Therapy Modality - Microwave		Editorial			0.06	0.06	Yes	Yes	Yes	
97504	XXX	D	Feb05	95	Orthotic and Prosthetic Management		Deleted							Yes	
97542	XXX	R	Nov04	A27	Wheelchair Management		Editorial			0.45	0.45	Yes	Yes	Yes	
97703	XXX	D	Feb05	95	Orthotic and Prosthetic Management		Deleted							Yes	
97760	XXX	N	Feb05	95	Orthotic and Prosthetic Management		Renumb			0.45	0.45			Yes	Renumbered from 97504
97761	XXX	N	Feb05	95	Orthotic and Prosthetic Management		Renumb			0.45	0.45			Yes	Renumbered from 97520

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
97762	XXX	N	Feb05	95	Orthotic and Prosthetic Management						0.25	0.25		Yes	Renumbered from 97703
97810	XXX	R	Aug04	M	Acupuncture						0.00	0.00	Yes	Yes	
97811	ZZZ	R	Aug04	M	Acupuncture						0.00	0.00	Yes	Yes	
97813	XXX	R	Aug04	M	Acupuncture						0.00	0.00	Yes	Yes	
97814	ZZZ	R	Aug04	M	Acupuncture						0.00	0.00	Yes	Yes	
98960	XXX	N	Aug04	09	Education and Training for Patient Self Management	K1	Feb05	30	AACE, ADiA		0.00	0.00		Yes	PE Inputs Only
98961	XXX	N	Feb05	1	Education and Training for Patient Self Management	K2	Apr05	B	AACE, ADiA		0.00	0.00		Yes	PE Inputs Only
98962	XXX	N	Feb05	1	Education and Training for Patient Self Management	K3	Apr05	B	AACE, ADiA		0.00	0.00		Yes	PE Inputs Only
99050	XXX	R	Feb04	14	Special Services, Procedures and Reports									No	
99051	XXX	N	Feb04	14	Special Services, Procedures and Reports									No	
99052	XXX	D	Feb05	14	Special Services, Procedures and Reports									No	
99053	XXX	N	Feb05	14	Special Services, Procedures and Reports									No	
99054	XXX	D	Feb05	14	Special Services, Procedures and Reports									No	
99056	XXX	R	Feb05	14	Special Services, Procedures and Reports									No	
99058	XXX	R	Feb05	14	Special Services, Procedures and Reports									No	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
99060	XXX	N	Feb05	14	Special Services, Procedures and Reports								No	
99141	XXX	D	Feb05	15	Moderate (Conscious) Sedation		Apr05	C					Yes	
99142	XXX	D	Feb05	15	Moderate (Conscious) Sedation		Apr05	C					Yes	
99143	XXX	N	Feb05	15	Moderate (Conscious) Sedation	FFF1	Apr05	C	AAOMS, ACEP, AAP, NASS	0.85	0.70		Yes	
99144	XXX	N	Feb05	15	Moderate (Conscious) Sedation	FFF2	Apr05	C	AAOMS, ACEP, AAP, NASS	0.80	0.66		Yes	
99145	ZZZ	N	Feb05	15	Moderate (Conscious) Sedation	FFF3	Apr05	C	AAOMS, ACEP, AAP, NASS	0.27	0.23		Yes	
99148	XXX	N	Feb05	15	Moderate (Conscious) Sedation	FFF4	Apr05	C	AAOMS, ACEP, AAP, NASS	1.84	1.75		Yes	
99149	XXX	N	Feb05	15	Moderate (Conscious) Sedation	FFF5	Apr05	C	AAOMS, ACEP, AAP, NASS	1.73	1.64		Yes	
99150	ZZZ	N	Feb05	15	Moderate (Conscious) Sedation	FFF6	Apr05	C	AAOMS, ACEP, AAP, NASS	0.47	0.47		Yes	

CPT Code	Global Coding Period	Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
99261	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99262	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99263	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99271	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99272	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99273	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99274	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99275	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99298	XXX	R	Feb05	18	Continuing Neonatal Intensive Care Services		Apr05	D		2.75	2.75	Yes	Yes		
99299	XXX	R	Feb05	18	Continuing Neonatal Intensive Care Services		Apr05	D		2.50	2.50	Yes	Yes		
99300	XXX	N	Feb05	18	Continuing Neonatal Intensive Care Services	AAA1	Apr05	D	AAP	2.40	2.40		Yes		
99301	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	
99302	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	

CPT Code	Global	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
99303	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	
99304	XXX	N	Feb05	19	Nursing Facility Services	BBB1	Apr05	E	AMDA, AAFP	1.20	1.20			Yes	
99305	XXX	N	Feb05	19	Nursing Facility Services	BBB2	Apr05	E	AMDA, AAFP	1.61	1.61			Yes	
99306	XXX	N	Feb05	19	Nursing Facility Services	BBB3	Apr05	E	AMDA, AAFP	2.01	2.01			Yes	
99307	XXX	N	Feb05	19	Nursing Facility Services	BBB4	Apr05	E	AMDA, AAFP	0.60	0.60			Yes	
99308	XXX	N	Feb05	19	Nursing Facility Services	BBB5	Apr05	E	AMDA, AAFP	1.00	1.00			Yes	
99309	XXX	N	Feb05	19	Nursing Facility Services	BBB6	Apr05	E	AMDA, AAFP	1.42	1.42			Yes	
99310	XXX	N	Feb05	19	Nursing Facility Services	BBB7	Apr05	E	AMDA, AAFP	1.77	1.77			Yes	
99311	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	
99312	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	
99313	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	
99318	XXX	N	Feb05	19	Nursing Facility Services	BBB8	Apr05	E	AMDA, AAFP	1.20	1.20			Yes	
99321	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	E						Yes	
99322	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	E						Yes	
99323	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	E						Yes	

CPT Code	Global Coding Period	Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
99324	XXX	N	Feb05	20	Domiciliary Care Services	CCC1	Apr05	F	APMA, AGS	1.01	1.01			Yes	
99325	XXX	N	Feb05	20	Domiciliary Care Services	CCC2	Apr05	F	APMA, AGS	1.52	1.52			Yes	
99326	XXX	N	Feb05	20	Domiciliary Care Services	CCC3	Apr05	F	AGS	2.27	2.27			Yes	
99327	XXX	N	Feb05	20	Domiciliary Care Services	CCC4	Apr05	F	AGS	3.03	3.03			Yes	
99328	XXX	N	Feb05	20	Domiciliary Care Services	CCC5	Apr05	F	AGS	3.78	3.78			Yes	
99331	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	F						Yes	
99332	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	F						Yes	
99333	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	F						Yes	
99334	XXX	N	Feb05	20	Domiciliary Care Services	CCC6	Apr05	F	AGS	0.76	0.76			Yes	
99335	XXX	N	Feb05	20	Domiciliary Care Services	CCC7	Apr05	F	AGS	1.26	1.26			Yes	
99336	XXX	N	Feb05	20	Domiciliary Care Services	CCC8	Apr05	F	AGS	2.02	2.02			Yes	
99337	XXX	N	Feb05	20	Domiciliary Care Services	CCC9	Apr05	F	AGS	3.03	3.03			Yes	
99339	XXX	N	Feb05	22	Care Plan Oversight	DDD1	Apr05	G	AAP, AGS	1.25	1.25			Yes	
99340	XXX	N	Feb05	22	Care Plan Oversight	DDD2	Apr05	G	AAP, AGS	1.80	1.80			Yes	

## Specialty and Acronym

<u>Society</u>	<u>Acronym</u>
AMA CPT Editorial Panel	AMA/CPT
AMA Staff	AMA
AMA Staff	AMA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology	AAD
American Academy of Facial Plastic and Reconstructive Surgery	AAFPRS
American Academy of Family Physicians	AAFP
American Academy of Hospice and Palliative Medicine	AAHPM
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
American Academy of Pediatrics	AAP
American Academy of Pharmaceutical Physicians	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 Neuromuscular and Electrodiagnostic Medicine	AANEM
American Association of Plastic Surgeons	AAPS
American Burn Association	ABA
American Chiropractic Association	ACA

**Society**

**Acronym**

American Clinical Neurophysiology Society	ACNS
American College of Cardiology	ACC
American College of Chest Physicians	ACCP
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 <sub>h</sub>
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

**Society****Acronym**

American Psychological Association	APA
American Roentgen Ray Society	ARRS
American Society for Dermatologic Surgery	ASDS
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society for Therapeutic Radiology and Oncology	ASTRO
American Society of Abdominal Surgeons	ASAS
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Cataract and Refractive Surgery	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 Neuroimaging	ASN
American Society of Neuroradiology	ASNR
American Society of Neuroradiology	ASNR
American Society of Ophthalmic Plastic and Reconstructive Surgery	ASOPRS
American Society of Plastic Surgeons	ASPS
American Society of Transplant Surgeons	ASTS
American Speech, Language, and Hearing Association	ASHA
American Thoracic Society	ATS
American Urological Association	AUA
Association Military Surgeons of the U.S.	AMSUS
Centers for Medicare and Medicaid Services	CMS
CMD	CMD
College of American Pathologists	CAP



**Society****Acronym**

Former RUC Members	AGS
Former RUC Members	AMA
Former RUC Members	AOA
Former RUC Members	APSA
Former RUC Members	ASA
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
Infectious Diseases Society of America	IDSA
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**

Society of Interventional Radiology  
Society of Nuclear Medicine  
Society of Thoracic Surgeons  
The American Society for Aesthetic Plastic Surgery  
The Association of University Radiologists  
The Endocrine Society  
The Triological Society

**Acronym**

SIR  
SNM  
STS  
ASAPS  
AUR  
TES  
TTS



# AMERICAN SOCIETY *for* SURGERY OF THE HAND

## Council

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Terry R. Light, MD  
Loyola University Medical Center  
Department of Orthopaedics  
2160 South First Avenue  
Maywood, IL 60153

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May 3, 2005

Carolyn Mullen, Deputy Director  
Centers for Medicare and Medicaid Services  
Division of Practitioner Services  
C4-03-06  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Dear Carolyn,

It was suggested by the AMA RUC PLI workgroup that the ASSH provide data supporting the recommendations outlined in its letter of March 14, 2005. To that end we have surveyed our members. To date we have received approximately 448 responses. I have included the results of that survey with this letter. The perception that the majority of hand surgeons are orthopaedically trained and carry orthopaedic professional liability insurance is supported by the data gleaned from our survey. This survey was sent to the members of the ASSH. The composition of the ASSH is as follows:

<b>TOTAL</b>	<b>1780</b>
<b>ORTHO</b>	<b>1382</b>
<b>PLASTIC</b>	<b>304</b>
<b>GENERAL</b>	<b>63</b>
<b>UNSPECIFIED</b>	<b>31</b>

### Survey results:

What PERCENTAGE OF YOUR PRACTICE is dedicated to hand surgery?	Response Total	%
0-25%	11	2.46%
26-50%	28	6.25%
51-75%	80	17.86%
76-100%	329	73.44%
<b>Total Respondents</b>	<b>448</b>	

Continued

What is your PRIMARY SPECIALTY?	Response Total	%
Orthopaedic	377	84.15%
Plastic	57	12.72%
General	14	3.13%
<b>Total Respondents</b>	<b>448</b>	

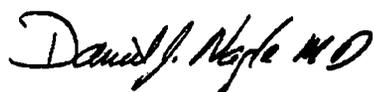
What is your professional liability insurance SPECIALTY DESIGNATION?	Response Total	%
Orthopaedic	251	56.79%
Plastic	46	10.41%
General	3	0.68%
Hand	142	32.13%
<b>Total Respondents</b>	<b>442</b>	

What is your MEDICARE DESIGNATION?	Response Total	%
Orthopaedic	249	56.59%
Plastic	40	9.09%
General	1	0.23%
Hand	150	34.09%
<b>Total Respondents</b>	<b>440</b>	

The ASSH believes this data supports our recommendation and we hope that CMS will assign a PLI risk factor that more accurately reflects the PLI experience of ASSH members.

Thank you very much for considering this request.

Sincerely yours,



Daniel J. Nagle MD  
ASSH Advisor to the AMA RUC  
Chair of the American Society for Surgery of the Hand CPT/RUC Committee

Enclosure

C: Sherry Smith, (AMA RUC)  
Gregory Przybylski, (Chair) of the PLI workgroup



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March 14, 2005

William Rich, MD, Chair  
AMA/Specialty Society RVS Update Committee  
American Medical Association  
515 North State Street  
Chicago, IL 60610

Dear Dr. Rich:

The American Society for Surgery of the Hand (ASSH) has reviewed the list of low Medicare utilization codes prepared by the AMA RUC staff with respect to dominant specialty designation for PLI. Attached are our comments about specialty designation for hand and upper extremity codes.

Additionally, in reviewing this list and the 2004 PLI Risk Factor summary table, we note that hand surgery risk factors are incorrect relative to other specialties. A majority of Hand Surgeons are trained and board certified in orthopaedics. Additionally, many hand surgeons are trained in microsurgery and are responsible for a majority of replantations performed in the US. However, the risk factors shown for hand surgery (4.71) are significantly lower than orthopaedics (non-spine) (4.71 vs 8.06), vascular surgery (6.85), and even plastic surgery (6.92). We understand that the PLI Workgroup and the RUC discussed crosswalking issues and incorrect PLI risk factor assignment at your last meeting, however, we did take note of this significant discrepancy in data and relativity. If the RUC agrees with this logic, we would ask the RUC to include a request to CMS to change the risk factor for hand surgery, crosswalking to orthopaedics, when it submits correspondence to CMS regarding the low utilization codes.

Thank you for considering our comments and recommendations.

Sincerely yours,

*Dan Nagle, MD/100*

Daniel J Nagle MD  
Chair ASSH CPT/RUC Committee  
ASSH AMA RUC Advisor

C: Terry Light, MD, ASSH President  
Mark Anderson, CAE  
Dan Sung, AAOS  
Bernie Pfeiffer  
ASSH CPT/RUC Committee

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
0008T	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with suturing of the esophagogastric junction	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10	
0010T	Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response	11	INTERNAL MEDICINE	PATHOLOGY	22	*
0017T	Destruction of macular drusen, photocoagulation	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
0023T	Infectious agent drug susceptibility phenotype prediction using genotypic comparison to known genotypic/phenotypic database, HIV 1	69	INDEPENDENT LABORATORY	PATHOLOGY	22	*
0024T	Non-surgical septal reduction therapy (eg, alcohol ablation), for hypertrophic obstructive cardiomyopathy, with coronary arteriograms, with or without temporary pacemaker	06	CARDIOLOGY	CARDIOLOGY	06	
0027T	Endoscopic lysis of epidural adhesions with direct visualization using mechanical means (eg, spinal endoscopic catheter system) or solution injection (eg, normal saline) including radiologic localization and epidurography	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05	
0028T	Dual energy x-ray absorptiometry (DEXA) body composition study, one or more sites	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
0031T	Speculoscopy,	16	OB-GYN	OB-GYN	16	
0033T	Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection, involving coverage of left subclavian artery origin, initial endoprosthesis	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
0034T	Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection, not involving coverage of left subclavian artery origin, initial endoprosthesis	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
0035T	Placement of proximal or distal extension prosthesis for endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection, initial extension	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
0036T	Placement of proximal or distal extension prosthesis for endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection; each additional extension (List separately in addition to code for primary procedure)	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
0038T	Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection involving coverage of left subclavian artery origin, initial endoprosthesis, radiological supervision and interpretation	94	INTERVENTIONAL RADIOLOGY	VASCULAR SURGERY	77	*
0039T	Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection not involving coverage of left subclavian artery origin, initial endoprosthesis, radiological supervision and interpretation	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
0040T	Placement of proximal or distal extension prosthesis for endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection, each extension, radiological supervision and interpretation	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
0042T	Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
0044T	Whole body integumentary photography, at request of a physician, for monitoring of high-risk patients; with dysplastic nevus syndrome or familial melanoma	19	ORAL SURGERY	DERMATOLOGY	07	*
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm (List separately in addition to code for primary procedure)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	07	DERMATOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
11951	Subcutaneous injection of filling material (eg, collagen), 1 1 to 5.0 cc	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
11952	Subcutaneous injection of filling material (eg, collagen), 5 1 to 10.0 cc	34	UROLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	91	SURGICAL ONCOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
11975	Insertion, implantable contraceptive capsules			OB-GYN	16	
11976	Removal, implantable contraceptive capsules	16	OB-GYN	OB-GYN	16	
11977	Removal with reinsertion, implantable contraceptive capsules			OB-GYN	16	
12017	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	93	
12018	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30 0 cm	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	93	
12047	Layer closure of wounds of neck, hands, feet and/or external genitalia; over 30.0 cm	02	GENERAL SURGERY	GENERAL SURGERY	02	
12056	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
12057	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
15775	Punch graft for hair transplant, 1 to 15 punch grafts			PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15776	Punch graft for hair transplant; more than 15 punch grafts			PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	07	DERMATOLOGY	DERMATOLOGY	07	
15782	Dermabrasion; regional, other than face	07	DERMATOLOGY	DERMATOLOGY	07	
15783	Dermabrasion; superficial, any site, (eg, tattoo removal)	07	DERMATOLOGY	DERMATOLOGY	07	
15792	Chemical peel, nonfacial; epidermal	07	DERMATOLOGY	DERMATOLOGY	07	
15793	Chemical peel, nonfacial; dermal	07	DERMATOLOGY	DERMATOLOGY	07	
15810	Salabrasion; 20 sq cm or less	16	OB-GYN	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
15811	Salabrasion; over 20 sq cm	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15819	Cervicoplasty	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
15824	Rhytidectomy; forehead	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15825	Rhytidectomy, neck with platysmal tightening (platysmal flap, P-flap)			PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15826	Rhytidectomy, glabellar frown lines			PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15828	Rhytidectomy, cheek, chin, and neck	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15832	Excision, excessive skin and subcutaneous tissue (including lipectomy), thigh	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
15833	Excision, excessive skin and subcutaneous tissue (including lipectomy), leg	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15834	Excision, excessive skin and subcutaneous tissue (including lipectomy), hip	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15835	Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15836	Excision, excessive skin and subcutaneous tissue (including lipectomy); arm	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15837	Excision, excessive skin and subcutaneous tissue (including lipectomy); forearm or hand	20	ORTHOPEDIC SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
15838	Excision, excessive skin and subcutaneous tissue (including lipectomy), submental fat pad	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
15841	Graft for facial nerve paralysis, free muscle graft (including obtaining graft)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15842	Graft for facial nerve paralysis, free muscle flap by microsurgical technique	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15876	Suction assisted lipectomy; head and neck	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15877	Suction assisted lipectomy, trunk	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15878	Suction assisted lipectomy; upper extremity	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15879	Suction assisted lipectomy; lower extremity	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15922	Excision, coccygeal pressure ulcer, with coccygectomy, with flap closure	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
15953	Excision, trochantenc pressure ulcer, with skin flap closure; with ostectomy	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
17380	Electrolysis epilation, each 1/2 hour	18	OPHTHALMOLOGY	DERMATOLOGY	07	*
19220	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)	02	GENERAL SURGERY	GENERAL SURGERY	02	
19272	Excision of chest wall tumor involving nbs, with plastic reconstruction; with mediastinal lymphadenectomy	33	THORACIC SURGERY	THORACIC SURGERY	33	
19324	Mammoplasty, augmentation; without prosthetic implant	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
19355	Correction of inverted nipples	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
19396	Preparation of moulage for custom breast implant	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
20101	Exploration of penetrating wound (separate procedure), chest	02	GENERAL SURGERY	GENERAL SURGERY	02	
20150	Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
20662	Application of halo, including removal; pelvic	34	UROLOGY	ORTHOPEDIC SURGERY	20	*
20663	Application of halo, including removal, femoral	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
20664	Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta), requiring general anesthesia	14	NEUROSURGERY	NEUROSURGERY	14	
20802	Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20	*
20805	Replantation, forearm (includes radius and ulna to radial carpal joint), complete amputation	08	FAMILY PRACTICE	ORTHOPEDIC SURGERY	20	*
20808	Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
20816	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
20822	Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
20824	Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
20827	Replantation, thumb (includes distal tip to MP joint), complete amputation	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
20838	Replantation, foot, complete amputation	25	PHYSICAL MEDICINE AND REHABILITATION	ORTHOPEDIC SURGERY	20	*
20910	Cartilage graft; costochondral	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
20936	Autograft for spine surgery only (includes harvesting the graft), local (eg, ribs, spinous process, or lamina fragments) obtained from same incision	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
20956	Bone graft with microvascular anastomosis; iliac crest	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
20957	Bone graft with microvascular anastomosis; metatarsal	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
20962	Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
20972	Free osteocutaneous flap with microvascular anastomosis; metatarsal	48	PODIATRY	ORTHOPEDIC SURGERY	20	*
20973	Free osteocutaneous flap with microvascular anastomosis; great toe with web space	48	PODIATRY	ORTHOPEDIC SURGERY	20	*
21010	Arthrotomy, temporomandibular joint	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
21047	Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21049	Excision of benign tumor or cyst of maxilla; requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21050	Condylectomy, temporomandibular joint (separate procedure)	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
21070	Coronoidectomy (separate procedure)	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
21077	Impression and custom preparation; orbital prosthesis	19	ORAL SURGERY	ORAL SURGERY	19	
21082	Impression and custom preparation, palatal augmentation prosthesis	19	ORAL SURGERY	ORAL SURGERY	19	
21083	Impression and custom preparation, palatal lift prosthesis	19	ORAL SURGERY	ORAL SURGERY	19	
21084	Impression and custom preparation; speech aid prosthesis	19	ORAL SURGERY	ORAL SURGERY	19	
21086	Impression and custom preparation, auricular prosthesis	19	ORAL SURGERY	ORAL SURGERY	19	
21088	Impression and custom preparation; facial prosthesis	19	ORAL SURGERY	ORAL SURGERY	19	
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	19	ORAL SURGERY	ORAL SURGERY	19	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21121	Genioplasty; sliding osteotomy, single piece	19	ORAL SURGERY	ORAL SURGERY	19	
21122	Genioplasty; sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)			PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21125	Augmentation, mandibular body or angle; prosthetic material	19	ORAL SURGERY	ORAL SURGERY	19	
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	19	ORAL SURGERY	ORAL SURGERY	19	
21137	Reduction forehead; contouring only	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21138	Reduction forehead, contouring and application of prosthetic material or bone graft (includes obtaining autograft)	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21139	Reduction forehead, contouring and setback of anterior frontal sinus wall	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21141	Reconstruction midface, LeFort I, single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
21142	Reconstruction midface, LeFort I, two pieces, segment movement in any direction, without bone graft	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
21143	Reconstruction midface, LeFort I, three or more pieces, segment movement in any direction, without bone graft	04	OTOLARYNGOLOGY	MAXILLOFACIAL SURGERY	85	*
21145	Reconstruction midface, LeFort I, single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
21146	Reconstruction midface, LeFort I, two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	19	ORAL SURGERY	MAXILLOFACIAL SURGERY	85	*
21147	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)			MAXILLOFACIAL SURGERY	85	
21150	Reconstruction midface, LeFort II, anterior intrusion (eg, Treacher-Collins Syndrome)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21151	Reconstruction midface, LeFort II, any direction, requiring bone grafts (includes obtaining autografts)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I			OTOLARYNGOLOGY	04	
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I			OTOLARYNGOLOGY	04	
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I			OTOLARYNGOLOGY	04	
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	14	NEUROSURGERY	NEUROSURGERY	14	
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims, with grafts (allograft or prosthetic material)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims, with autograft (includes obtaining grafts)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts), total area of bone grafting less than 40 sq cm	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts), total area of bone grafting greater than 40 sq cm but less than 80 sq cm	18	OPHTHALMOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts), total area of bone grafting greater than 80 sq cm	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	19	ORAL SURGERY	ORAL SURGERY	19	
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy, with bone graft (includes obtaining graft)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	19	ORAL SURGERY	OTOLARYNGOLOGY	04	*
21209	Osteoplasty, facial bones, reduction	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
21230	Graft; nb cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21242	Arthroplasty, temporomandibular joint, with allograft	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	19	ORAL SURGERY	ORAL SURGERY	19	
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	19	ORAL SURGERY	ORAL SURGERY	19	
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	18	OPHTHALMOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21260	Periorbital osteotomies for orbital hypertelonsm, with bone grafts; extracranial approach	30	DIAGNOSTIC RADIOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21261	Periorbital osteotomies for orbital hypertelonsm, with bone grafts; combined intra- and extracranial approach	20	ORTHOPEDIC SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
21263	Penorbital osteotomies for orbital hypertelonsm, with bone grafts; with forehead advancement			OPHTHALMOLOGY	18	
21267	Orbital repositioning, penorbital osteotomies, unilateral, with bone grafts, extracranial approach	18	OPHTHALMOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21268	Orbital repositioning, penorbital osteotomies, unilateral, with bone grafts, combined intra- and extracranial approach	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21270	Malar augmentation, prosthetic material	18	OPHTHALMOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21275	Secondary revision of orbitocraniofacial reconstruction	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy), extraoral approach			OTOLARYNGOLOGY	04	
21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21300	Closed treatment of skull fracture without operation	14	NEUROSURGERY	NEUROSURGERY	14	
21338	Open treatment of nasoethmoid fracture, without external fixation	24	PLASTIC AND RECONSTRUCTIVE SURGERY	OTOLARYNGOLOGY	04	*
21339	Open treatment of nasoethmoid fracture; with external fixation	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21343	Open treatment of depressed frontal sinus fracture	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21344	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21347	Open treatment of nasomaxillary complex fracture (LeFort II type), requiring multiple open approaches	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21348	Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)	85	MAXILLOFACIAL SURGERY	OTOLARYNGOLOGY	04	*
21355	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21366	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21386	Open treatment of orbital floor blowout fracture; penorbital approach	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21387	Open treatment of orbital floor blowout fracture; combined approach	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21395	Open treatment of orbital floor blowout fracture, penorbital approach with bone graft (includes obtaining graft)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21400	Closed treatment of fracture of orbit, except blowout, without manipulation	93	EMERGENCY MEDICINE	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21401	Closed treatment of fracture of orbit, except blowout; with manipulation	02	GENERAL SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21406	Open treatment of fracture of orbit, except blowout; without implant	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
21408	Open treatment of fracture of orbit, except blowout, with bone grafting (includes obtaining graft)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	19	ORAL SURGERY	ORAL SURGERY	19	
21423	Open treatment of palatal or maxillary fracture (LeFort I type), complicated (comminuted or involving cranial nerve foramina), multiple approaches	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint	19	ORAL SURGERY	ORAL SURGERY	19	
21432	Open treatment of craniofacial separation (LeFort III type), with wiring and/or internal fixation	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21433	Open treatment of craniofacial separation (LeFort III type), complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21435	Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21436	Open treatment of craniofacial separation (LeFort III type), complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
21445	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	19	ORAL SURGERY	ORAL SURGERY	19	
21451	Closed treatment of mandibular fracture, with manipulation	19	ORAL SURGERY	ORAL SURGERY	19	
21452	Percutaneous treatment of mandibular fracture, with external fixation	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
21454	Open treatment of mandibular fracture with external fixation	19	ORAL SURGERY	ORAL SURGERY	19	
21465	Open treatment of mandibular condylar fracture	19	ORAL SURGERY	ORAL SURGERY	19	
21490	Open treatment of temporomandibular dislocation	19	ORAL SURGERY	ORAL SURGERY	19	
21493	Closed treatment of hyoid fracture; without manipulation			OTOLARYNGOLOGY	04	
21494	Closed treatment of hyoid fracture; with manipulation	01	GENERAL PRACTICE	OTOLARYNGOLOGY	04	*
21495	Open treatment of hyoid fracture	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
21497	Interdental wiring, for condition other than fracture	19	ORAL SURGERY	ORAL SURGERY	19	
21502	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax, with partial rib osteotomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
21510	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax	33	THORACIC SURGERY	THORACIC SURGERY	33	
21610	Costotransversectomy (separate procedure)	14	NEUROSURGERY	NEUROSURGERY	14	
21615	Excision first and/or cervical nb;	77	VASCULAR SURGERY	THORACIC SURGERY	33	*
21616	Excision first and/or cervical nb; with sympathectomy	33	THORACIC SURGERY	THORACIC SURGERY	33	
21632	Radical resection of sternum; with mediastinal lymphadenectomy	33	THORACIC SURGERY	THORACIC SURGERY	33	
21700	Division of scalenus anticus, without resection of cervical nb	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
21705	Division of scalenus anticus; with resection of cervical rib	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
21720	Division of sternocleidomastoid for torticollis, open operation; without cast application	14	NEUROSURGERY	NEUROSURGERY	14	
21725	Division of sternocleidomastoid for torticollis, open operation, with cast application	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
21740	Reconstructive repair of pectus excavatum or carinatum; open	78	CARDIAC SURGERY	THORACIC SURGERY	33	*
21805	Open treatment of rib fracture without fixation, each	33	THORACIC SURGERY	THORACIC SURGERY	33	
21810	Treatment of nb fracture requiring external fixation (flail chest)	33	THORACIC SURGERY	THORACIC SURGERY	33	
21825	Open treatment of sternum fracture with or without skeletal fixation	24	PLASTIC AND RECONSTRUCTIVE SURGERY	THORACIC SURGERY	33	*

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
22100	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment, cervical	14	NEUROSURGERY	NEUROSURGERY	14	
22101	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; thoracic	14	NEUROSURGERY	NEUROSURGERY	14	
22110	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment, cervical	14	NEUROSURGERY	NEUROSURGERY	14	
22112	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; thoracic	20	ORTHOPEDIC SURGERY	NEUROSURGERY	14	*
22220	Osteotomy of spine, including diskectomy, anterior approach, single vertebral segment; cervical	14	NEUROSURGERY	NEUROSURGERY	14	
22222	Osteotomy of spine, including diskectomy, anterior approach, single vertebral segment, thoracic	20	ORTHOPEDIC SURGERY	NEUROSURGERY	14	*
22319	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoidum), anterior approach, including placement of internal fixation; with grafting	14	NEUROSURGERY	NEUROSURGERY	14	
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process	14	NEUROSURGERY	NEUROSURGERY	14	
22812	Arthrodesis, anterior, for spinal deformity, with or without cast, 8 or more vertebral segments	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements), single or 2 segments	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
22819	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements), 3 or more segments	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
22847	Anterior instrumentation, 8 or more vertebral segments	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23000	Removal of subdeltoid calcareous deposits, open	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23100	Arthrotomy, glenohumeral joint, including biopsy	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23106	Arthrotomy; sternoclavicular joint, with synovectomy, with or without biopsy	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23125	Claviculectomy; total	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23145	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23146	Excision or curettage of bone cyst or benign tumor of clavicle or scapula, with allograft	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23155	Excision or curettage of bone cyst or benign tumor of proximal humerus; with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23156	Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23172	Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23182	Partial excision (cratization, saucenization, or diaphysectomy) bone (eg, osteomyelitis), scapula	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23190	Osteotomy of scapula, partial (eg, superior medial angle)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23195	Resection, humeral head	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23200	Radical resection for tumor; clavicle	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23210	Radical resection for tumor; scapula	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23220	Radical resection of bone tumor, proximal humerus,	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23221	Radical resection of bone tumor, proximal humerus, with autograft (includes obtaining graft)			ORTHOPEDIC SURGERY	20	
23222	Radical resection of bone tumor, proximal humerus; with prosthetic replacement	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23397	Muscle transfer, any type, shoulder or upper arm; multiple	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23400	Scapulopexy (eg, Sprengels deformity or for paralysis)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23406	Tenotomy, shoulder area; multiple tendons through same incision	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	

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23460	Capsulorrhaphy, anterior, any type, with bone block	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23462	Capsulorrhaphy, anterior, any type, with coracoid process transfer	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23480	Osteotomy, clavicle, with or without internal fixation,	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, clavicle	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23491	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, proximal humerus	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23520	Closed treatment of sternoclavicular dislocation, without manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23525	Closed treatment of sternoclavicular dislocation, with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23530	Open treatment of sternoclavicular dislocation, acute or chronic,	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23532	Open treatment of sternoclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23545	Closed treatment of acromioclavicular dislocation; with manipulation	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	93	
23552	Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23575	Closed treatment of scapular fracture; with manipulation, with or without skeletal traction (with or without shoulder joint involvement)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23800	Arthrodesis, glenohumeral joint,	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23802	Arthrodesis, glenohumeral joint; with autogenous graft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23900	Interthoracoscapular amputation (forequarter)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23920	Disarticulation of shoulder;	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
23921	Disarticulation of shoulder; secondary closure or scar revision	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24100	Arthrotomy, elbow; with synovial biopsy only	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24110	Excision or curettage of bone cyst or benign tumor, humerus;	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24115	Excision or curettage of bone cyst or benign tumor, humerus; with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24116	Excision or curettage of bone cyst or benign tumor, humerus; with allograft	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24125	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24126	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process, with allograft	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24136	Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24138	Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24145	Partial excision (cratization, saucenization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24150	Radical resection for tumor, shaft or distal humerus;	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24151	Radical resection for tumor, shaft or distal humerus, with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24152	Radical resection for tumor, radial head or neck;	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24153	Radical resection for tumor, radial head or neck; with autograft (includes obtaining graft)	34	UROLOGY	ORTHOPEDIC SURGERY	20	*
24155	Resection of elbow joint (arthrectomy)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24164	Implant removal, radial head	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24301	Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24320	Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24330	Flexor-plasty, elbow (eg, Steindler type advancement);	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
24331	Flexor-plasty, elbow (eg, Steindler type advancement), with extensor advancement	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24332	Tenolysis, triceps	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24340	Tenodesis of biceps tendon at elbow (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24344	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24345	Repair medial collateral ligament, elbow, with local tissue	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24346	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24352	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with annular ligament resection	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24354	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with stripping	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24360	Arthroplasty, elbow; with membrane (eg, fascial)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24361	Arthroplasty, elbow, with distal humeral prosthetic replacement	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24362	Arthroplasty, elbow, with implant and fascia lata ligament reconstruction	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24365	Arthroplasty, radial head;	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24420	Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24470	Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)			ORTHOPEDIC SURGERY	20	
24565	Closed treatment of humeral epicondylar fracture, medial or lateral; with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24566	Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24577	Closed treatment of humeral condylar fracture, medial or lateral; with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24582	Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24587	Open treatment of penarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius); with implant arthroplasty	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24640	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	93	
24800	Arthrodesis, elbow joint; local	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24802	Arthrodesis, elbow joint, with autogenous graft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24920	Amputation, arm through humerus; open, circular (guillotine)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24925	Amputation, arm through humerus; secondary closure or scar revision	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24930	Amputation, arm through humerus, re-amputation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
24931	Amputation, arm through humerus; with implant			ORTHOPEDIC SURGERY	20	
24935	Stump elongation, upper extremity	02	GENERAL SURGERY	GENERAL SURGERY	02	
25025	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25031	Incision and drainage, forearm and/or wrist; bursa	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25085	Capsulotomy, wrist (eg, contracture)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25100	Arthrotomy, wrist joint; with biopsy	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25107	Arthrotomy, distal radioulnar joint including repair of triangular cartilage, complex	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25119	Synovectomy, extensor tendon sheath, wrist, single compartment; with resection of distal ulna	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25125	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25126	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with allograft	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
25135	Excision or curettage of bone cyst or benign tumor of carpal bones, with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25136	Excision or curettage of bone cyst or benign tumor of carpal bones; with allograft	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25145	Sequestrectomy (eg, for osteomyelitis or bone abscess), forearm and/or wrist	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25151	Partial excision (cratization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis), radius	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25170	Radical resection for tumor, radius or ulna	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25250	Removal of wrist prosthesis; (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25251	Removal of wrist prosthesis; complicated, including total wrist	40	HAND SURGERY	ORTHOPEDIC SURGERY	20	*
25263	Repair, tendon or muscle, flexor, forearm and/or wrist, secondary, single, each tendon or muscle	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25265	Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25275	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25300	Tenodesis at wrist; flexors of fingers	40	HAND SURGERY	ORTHOPEDIC SURGERY	20	*
25315	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist,	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
25316	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist, with tendon(s) transfer	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25335	Centralization of wrist on ulna (eg, radial club hand)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
25355	Osteotomy, radius, middle or proximal third	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25365	Osteotomy; radius AND ulna	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna			ORTHOPEDIC SURGERY	20	
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure), radius AND ulna	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25391	Osteoplasty, radius OR ulna; lengthening with autograft	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25392	Osteoplasty, radius AND ulna, shortening (excluding 64876)			ORTHOPEDIC SURGERY	20	
25393	Osteoplasty, radius AND ulna; lengthening with autograft	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25394	Osteoplasty, carpal bone, shortening	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25415	Repair of nonunion or malunion, radius AND ulna, without graft (eg, compression technique)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25420	Repair of nonunion or malunion, radius AND ulna; with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25425	Repair of defect with autograft, radius OR ulna	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25426	Repair of defect with autograft, radius AND ulna	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25430	Insertion of vascular pedicle into carpal bone (eg, Hon procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25431	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25441	Arthroplasty with prosthetic replacement; distal radius	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25442	Arthroplasty with prosthetic replacement; distal ulna	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25443	Arthroplasty with prosthetic replacement; scaphoid carpal (navicular)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25444	Arthroplasty with prosthetic replacement; lunate	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25449	Revision of arthroplasty, including removal of implant, wrist joint	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25450	Epiphyseal arrest by epiphysodesis or stapling; distal radius OR ulna	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25455	Epiphyseal arrest by epiphysodesis or stapling; distal radius AND ulna	40	HAND SURGERY	ORTHOPEDIC SURGERY	20	*
25490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, radius	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
25491	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, ulna	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25492	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, radius AND ulna	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25520	Closed treatment of radial shaft fracture and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25526	Open treatment of radial shaft fracture, with internal and/or external fixation and open treatment, with or without internal or external fixation of distal radioulnar joint (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25635	Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)), with manipulation, each bone	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25645	Open treatment of carpal bone fracture (other than carpal scaphoid (navicular)), each bone	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25651	Percutaneous skeletal fixation of ulnar styloid fracture	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25671	Percutaneous skeletal fixation of distal radioulnar dislocation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25676	Open treatment of distal radioulnar dislocation, acute or chronic	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25685	Open treatment of trans-scaphopenlunar type of fracture dislocation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25690	Closed treatment of lunate dislocation, with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25695	Open treatment of lunate dislocation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25805	Arthrodesis, wrst, with sliding graft	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25830	Arthrodesis, distal radioulnar joint with segmental resection of ulna, with or without bone graft (eg, Sauve-Kapandji procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25905	Amputation, forearm, through radius and ulna, open, circular (guillotine)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25907	Amputation, forearm, through radius and ulna, secondary closure or scar revision	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25909	Amputation, forearm, through radius and ulna, re-amputation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25915	Krukenberg procedure			ORTHOPEDIC SURGERY	20	
25920	Disarticulation through wrst;	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25922	Disarticulation through wrst; secondary closure or scar revision			ORTHOPEDIC SURGERY	20	
25924	Disarticulation through wrst; re-amputation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25927	Transmetacarpal amputation;	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20	*
25929	Transmetacarpal amputation, secondary closure or scar revision	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
25931	Transmetacarpal amputation, re-amputation	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20	*
26035	Decompression fingers and/or hand, injection injury (eg, grease gun)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26100	Arthrotomy with biopsy; carpometacarpal joint, each	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26105	Arthrotomy with biopsy; metacarpophalangeal joint, each	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26185	Sesamoidectomy, thumb or finger (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26205	Excision or curettage of bone cyst or benign tumor of metacarpal, with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26215	Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger; with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26250	Radical resection, metacarpal (eg, tumor),	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26255	Radical resection, metacarpal (eg, tumor), with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26260	Radical resection, proximal or middle phalanx of finger (eg, tumor),	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26261	Radical resection, proximal or middle phalanx of finger (eg, tumor); with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26262	Radical resection, distal phalanx of finger (eg, tumor)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
26352	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land), secondary with free graft (includes obtaining graft), each tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26357	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land), secondary, without free graft, each tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26358	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land), secondary, with free graft (includes obtaining graft), each tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26372	Repair or advancement of profundus tendon, with intact superficialis tendon, secondary with free graft (includes obtaining graft), each tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26373	Repair or advancement of profundus tendon, with intact superficialis tendon, secondary without free graft, each tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26390	Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26392	Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26415	Excision of extensor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26416	Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
26420	Repair, extensor tendon, finger, primary or secondary, with free graft (includes obtaining graft) each tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26428	Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); with free graft (includes obtaining graft), each finger	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26434	Repair of extensor tendon, distal insertion, primary or secondary; with free graft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26474	Tenodesis; of distal joint, each joint	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26476	Lengthening of tendon, extensor, hand or finger, each tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26479	Shortening of tendon, flexor, hand or finger, each tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26489	Transfer or transplant of tendon, palmar; with free tendon graft (includes obtaining graft), each tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26492	Opponensplasty, tendon transfer with graft (includes obtaining graft), each tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26494	Opponensplasty; hypothenar muscle transfer	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26497	Transfer of tendon to restore intrinsic function, ring and small finger	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26498	Transfer of tendon to restore intrinsic function, all four fingers	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26499	Correction claw finger, other methods	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26502	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26504	Reconstruction of tendon pulley, each tendon; with tendon prosthesis (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26517	Capsulodesis, metacarpophalangeal joint, two digits	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26518	Capsulodesis, metacarpophalangeal joint, three or four digits	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26546	Repair non-union, metacarpal or phalanx, (includes obtaining bone graft with or without external or internal fixation)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26550	Policization of a digit	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26551	Transfer, toe-to-hand with microvascular anastomosis, great toe wrap-around with bone graft			ORTHOPEDIC SURGERY	20	
26553	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, single			ORTHOPEDIC SURGERY	20	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
26554	Transfer, toe-to-hand with microvascular anastomosis, other than great toe, double			ORTHOPEDIC SURGERY	20	
26555	Transfer, finger to another position without microvascular anastomosis	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26556	Transfer, free toe joint, with microvascular anastomosis			ORTHOPEDIC SURGERY	24	
26560	Repair of syndactyly (web finger) each web space, with skin flaps	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
26561	Repair of syndactyly (web finger) each web space; with skin flaps and grafts	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
26562	Repair of syndactyly (web finger) each web space, complex (eg, involving bone, nails)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
26565	Osteotomy, metacarpal, each	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26568	Osteoplasty, lengthening, metacarpal or phalanx	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26580	Repair cleft hand	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26587	Reconstruction of polydactylous digit, soft tissue and bone	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20	*
26590	Repair macrodactylia, each digit	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26596	Excision of constricting ring of finger, with multiple Z-plasties	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26665	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26675	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; requiring anesthesia	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26685	Open treatment of carpometacarpal dislocation, other than thumb; with or without internal or external fixation, each joint	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26686	Open treatment of carpometacarpal dislocation, other than thumb; complex, multiple or delayed reduction	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26706	Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26820	Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26843	Arthrodesis, carpometacarpal joint, digit, other than thumb, each;	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26844	Arthrodesis, carpometacarpal joint, digit, other than thumb, each, with autograft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
26863	Arthrodesis, interphalangeal joint, with or without internal fixation, with autograft (includes obtaining graft), each additional joint (List separately in addition to code for primary procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27003	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27005	Tenotomy, hip flexor(s), open (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27035	Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral, or obturator nerves	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
27050	Arthrotomy, with biopsy, sacroiliac joint	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27060	Excision; ischial bursa	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
27067	Excision of bone cyst or benign tumor; with autograft requiring separate incision	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27075	Radical resection of tumor or infection, wing of ilium, one pubic or ischial ramus or symphysis pubis	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27077	Radical resection of tumor or infection; innominate bone, total	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27078	Radical resection of tumor or infection; ischial tuberosity and greater trochanter of femur	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27079	Radical resection of tumor or infection; ischial tuberosity and greater trochanter of femur, with skin flaps	02	GENERAL SURGERY	GENERAL SURGERY	02	
27097	Release or recession, hamstring, proximal	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27098	Transfer, adductor to ischium	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
27100	Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27105	Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27110	Transfer iliopectus; to greater trochanter of femur	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27111	Transfer iliopectus; to femoral neck	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27120	Acetabuloplasty, (eg, Whitman, Colonna, Haygroves, or cup type)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27146	Osteotomy, iliac, acetabular or innominate bone,	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27147	Osteotomy, iliac, acetabular or innominate bone, with open reduction of hip	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27151	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27156	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27158	Osteotomy, pelvis, bilateral (eg, congenital malformation)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27161	Osteotomy, femoral neck (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27175	Treatment of slipped femoral epiphysis; by traction, without reduction	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27176	Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27177	Open treatment of slipped femoral epiphysis, single or multiple pinning or bone graft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27178	Open treatment of slipped femoral epiphysis, closed manipulation with single or multiple pinning	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27179	Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27181	Open treatment of slipped femoral epiphysis, osteotomy and internal fixation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27185	Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27202	Open treatment of coccygeal fracture	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27215	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s) (eg, pelvic fracture(s) which do not disrupt the pelvic ring), with internal fixation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27258	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27259	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27280	Arthrodesis, sacroiliac joint (including obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27282	Arthrodesis, symphysis pubis (including obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27284	Arthrodesis, hip joint (including obtaining graft);	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27286	Arthrodesis, hip joint (including obtaining graft); with subtrochanteric osteotomy	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27290	Interpelvial abdominal amputation (hindquarter amputation)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27306	Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27307	Tenotomy, percutaneous, adductor or hamstring, multiple tendons	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27315	Neurectomy, hamstring muscle	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27320	Neurectomy, popliteal (gastrocnemius)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27330	Arthrotomy, knee; with synovial biopsy only	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee, medial AND lateral	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27358	Excision or curettage of bone cyst or benign tumor of femur; with internal fixation (List in addition to code for primary procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27390	Tenotomy, open, hamstring, knee to hip; single tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
27391	Tenotomy, open, hamstring, knee to hip, multiple tendons, one leg	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27392	Tenotomy, open, hamstring, knee to hip, multiple tendons, bilateral	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27393	Lengthening of hamstring tendon; single tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27395	Lengthening of hamstring tendon, multiple tendons, bilateral	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27396	Transplant, hamstring tendon to patella, single tendon	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27397	Transplant, hamstring tendon to patella, multiple tendons	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27400	Transfer, tendon or muscle, hamstrings to femur (eg, Egger's type procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27407	Repair, primary, torn ligament and/or capsule, knee; cruciate	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27409	Repair, primary, torn ligament and/or capsule, knee, collateral and cruciate ligaments	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27424	Reconstruction of dislocating patella; with patellectomy	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27428	Ligamentous reconstruction (augmentation), knee, intra-articular (open)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27429	Ligamentous reconstruction (augmentation), knee, intra-articular (open) and extra-articular	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27440	Arthroplasty, knee, tibial plateau,	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee, with debridement and partial synovectomy	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27454	Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, Sofield type procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27455	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)), before epiphyseal closure	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27465	Osteoplasty, femur; shortening (excluding 64876)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27466	Osteoplasty, femur; lengthening	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27468	Osteoplasty, femur; combined, lengthening and shortening with femoral segment transfer	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27475	Arrest, epiphyseal, any method (eg, epiphysiodesis); distal femur			ORTHOPEDIC SURGERY	20	
27477	Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27479	Arrest, epiphyseal, any method (eg, epiphysiodesis); combined distal femur, proximal tibia and fibula	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27485	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27496	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27497	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor); with debridement of nonviable muscle and/or nerve	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27498	Decompression fasciotomy, thigh and/or knee, multiple compartments;	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27499	Decompression fasciotomy, thigh and/or knee, multiple compartments; with debridement of nonviable muscle and/or nerve	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27516	Closed treatment of distal femoral epiphyseal separation; without manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27517	Closed treatment of distal femoral epiphyseal separation; with manipulation, with or without skin or skeletal traction	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27519	Open treatment of distal femoral epiphyseal separation, with or without internal or external fixation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
27556	Open treatment of knee dislocation, with or without internal or external fixation, without primary ligamentous repair or augmentation/reconstruction	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
27557	Open treatment of knee dislocation, with or without internal or external fixation, with primary ligamentous repair	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27558	Open treatment of knee dislocation, with or without internal or external fixation, with primary ligamentous repair, with augmentation/reconstruction	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27562	Closed treatment of patellar dislocation; requiring anesthesia	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27566	Open treatment of patellar dislocation, with or without partial or total patellectomy	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27637	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with autograft (includes obtaining graft)	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27638	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograft	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27645	Radical resection of tumor, bone, tibia	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27646	Radical resection of tumor, bone, fibula	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27656	Repair, fascial defect of leg	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27665	Repair, extensor tendon, leg, secondary, with or without graft, each tendon	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27676	Repair, dislocating peroneal tendons, with fibular osteotomy	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision(s))	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27696	Repair, primary, disrupted ligament, ankle, both collateral ligaments	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27700	Arthroplasty, ankle;	48	PODIATRY	ORTHOPEdic SURGERY	20	*
27703	Arthroplasty, ankle; revision, total ankle	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27712	Osteotomy, multiple, with realignment on intramedullary rod (eg, Sofield type procedure)	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27715	Osteoplasty, tibia and fibula, lengthening or shortening	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27722	Repair of nonunion or malunion, tibia, with sliding graft	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27725	Repair of nonunion or malunion, tibia, by synostosis, with fibula, any method	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27727	Repair of congenital pseudarthrosis, tibia	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27730	Arrest, epiphyseal (epiphysiodesis), open, distal tibia	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27732	Arrest, epiphyseal (epiphysiodesis), open; distal fibula	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27734	Arrest, epiphyseal (epiphysiodesis), open, distal tibia and fibula	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27740	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula;	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27742	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula; and distal femur	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27830	Closed treatment of proximal tibiofibular joint dislocation; without anesthesia	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27831	Closed treatment of proximal tibiofibular joint dislocation; requiring anesthesia	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27832	Open treatment of proximal tibiofibular joint dislocation, with or without internal or external fixation, or with excision of proximal fibula	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
27893	Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
28050	Arthrotomy with biopsy; intertarsal or tarsometatarsal joint	48	PODIATRY	PODIATRY	48	
28054	Arthrotomy with biopsy; interphalangeal joint	48	PODIATRY	PODIATRY	48	
28102	Excision or curettage of bone cyst or benign tumor, talus or calcaneus, with iliac or other autograft (includes obtaining graft)	20	ORTHOPEdic SURGERY	ORTHOPEdic SURGERY	20	
28103	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft	48	PODIATRY	PODIATRY	48	
28106	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus, with iliac or other autograft (includes obtaining graft)	48	PODIATRY	PODIATRY	48	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
28107	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus, with allograft	48	PODIATRY	PODIATRY	48	
28130	Talectomy (astragalectomy)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28171	Radical resection of tumor, bone, tarsal (except talus or calcaneus)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28202	Repair, tendon, flexor, foot, secondary with free graft, each tendon (includes obtaining graft)	48	PODIATRY	PODIATRY	48	
28210	Repair, tendon, extensor, foot, secondary with free graft, each tendon (includes obtaining graft)	48	PODIATRY	PODIATRY	48	
28262	Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28264	Capsulotomy, midtarsal (eg, Heyman type procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28302	Osteotomy, talus	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28305	Osteotomy, tarsal bones, other than calcaneus or talus, with autograft (includes obtaining graft) (eg, Fowler type)	48	PODIATRY	PODIATRY	48	
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28340	Reconstruction, toe, macrodactyly, soft tissue resection	48	PODIATRY	PODIATRY	48	
28341	Reconstruction, toe, macrodactyly; requiring bone resection	48	PODIATRY	PODIATRY	48	
28344	Reconstruction, toe(s); polydactyly	48	PODIATRY	PODIATRY	48	
28345	Reconstruction, toe(s), syndactyly, with or without skin graft(s), each web	48	PODIATRY	PODIATRY	48	
28360	Reconstruction, cleft foot			ORTHOPEDIC SURGERY	20	
28420	Open treatment of calcaneal fracture, with or without internal or external fixation; with primary iliac or other autogenous bone graft (includes obtaining graft)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28435	Closed treatment of talus fracture; with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28436	Percutaneous skeletal fixation of talus fracture, with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28456	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28531	Open treatment of sesamoid fracture, with or without internal fixation	48	PODIATRY	PODIATRY	48	
28545	Closed treatment of tarsal bone dislocation, other than talotarsal; requiring anesthesia	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28546	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28570	Closed treatment of talotarsal joint dislocation; without anesthesia	48	PODIATRY	PODIATRY	48	
28575	Closed treatment of talotarsal joint dislocation, requiring anesthesia	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28576	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28605	Closed treatment of tarsometatarsal joint dislocation, requiring anesthesia	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28636	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
28666	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29000	Application of halo type body cast (see 20661-20663 for insertion)	14	NEUROSURGERY	NEUROSURGERY	14	
29010	Application of Risser jacket, localizer, body, only	14	NEUROSURGERY	ORTHOPEDIC SURGERY	20	*
29015	Application of Risser jacket, localizer, body; including head	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29020	Application of tumbuckle jacket, body; only	26	PSYCHIATRY	ORTHOPEDIC SURGERY	20	*
29025	Application of tumbuckle jacket, body, including head	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29035	Application of body cast, shoulder to hips;	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29040	Application of body cast, shoulder to hips; including head, Minerva type	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
29044	Application of body cast, shoulder to hips, including one thigh	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29046	Application of body cast, shoulder to hips; including both thighs	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29049	Application, cast; figure-of-eight	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29055	Application, cast, shoulder spica	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29305	Application of hip spica cast; one leg	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29325	Application of hip spica cast; one and one-half spica or both legs	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29710	Removal or bivalving, shoulder or hip spica, Minerva, or Risser jacket, etc	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29715	Removal or bivalving, tumbuckle jacket	08	FAMILY PRACTICE	ORTHOPEDIC SURGERY	20	*
29750	Wedging of clubfoot cast	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29834	Arthroscopy, elbow, surgical; with removal of loose body or foreign body	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29835	Arthroscopy, elbow, surgical; synovectomy, partial	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29836	Arthroscopy, elbow, surgical; synovectomy, complete	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29837	Arthroscopy, elbow, surgical; debndement, limited	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29843	Arthroscopy, wrist, surgical; for infection, lavage and drainage	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29844	Arthroscopy, wrist, surgical; synovectomy, partial	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29847	Arthroscopy, wrist, surgical; internal fixation for fracture or instability	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29850	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation, without internal or external fixation (includes arthroscopy)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29851	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation, with internal or external fixation (includes arthroscopy)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29856	Arthroscopically aided treatment of tibial fracture, proximal (plateau), bicondylar, with or without internal or external fixation (includes arthroscopy)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29860	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29861	Arthroscopy, hip, surgical, with removal of loose body or foreign body	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29863	Arthroscopy, hip, surgical; with synovectomy	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29885	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debndement of base of lesion)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29900	Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29901	Arthroscopy, metacarpophalangeal joint, surgical, with debndement	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
29902	Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (eg, Stenar lesion)			ORTHOPEDIC SURGERY	20	
30125	Excision dermoid cyst, nose, complex, under bone or cartilage	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
30160	Rhinectomy; total	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
30320	Removal foreign body, intranasal; by lateral rhinotomy	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
30430	Rhinoplasty, secondary, minor revision (small amount of nasal tip work)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
30435	Rhinoplasty, secondary, intermediate revision (bony work with osteotomies)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening, tip, septum, osteotomies	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
30540	Repair choanal atresia; intranasal	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
30545	Repair choanal atresia; transpalatine	24	PLASTIC AND RECONSTRUCTIVE SURGERY	OTOLARYNGOLOGY	04	*
30600	Repair fistula, oronasal	19	ORAL SURGERY	ORAL SURGERY	19	
31002	Lavage by cannulation; sphenoid sinus	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31040	Pterygomaxillary fossa surgery, any approach	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31080	Sinusotomy frontal; oblitative without osteoplastic flap, brow incision (includes ablation)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31081	Sinusotomy frontal, oblitative, without osteoplastic flap, coronal incision (includes ablation)	14	NEUROSURGERY	OTOLARYNGOLOGY	04	*
31084	Sinusotomy frontal, oblitative, with osteoplastic flap, brow incision	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31086	Sinusotomy frontal, nonoblitative, with osteoplastic flap, brow incision	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31087	Sinusotomy frontal; nonoblitative, with osteoplastic flap, coronal incision	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31230	Maxillectomy; with orbital exenteration (en bloc)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31291	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak, sphenoid region	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31293	Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31294	Nasal/sinus endoscopy, surgical; with optic nerve decompression	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31320	Laryngotomy (thyrotomy, laryngofissure), diagnostic	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31367	Laryngectomy; subtotal supraglottic, without radical neck dissection	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31368	Laryngectomy, subtotal supraglottic, with radical neck dissection	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31370	Partial laryngectomy (hemilaryngectomy), horizontal	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31375	Partial laryngectomy (hemilaryngectomy); lateroververtical	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31380	Partial laryngectomy (hemilaryngectomy); anterovertical	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31382	Partial laryngectomy (hemilaryngectomy), antero-latero-vertical	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31395	Pharyngolaryngectomy, with radical neck dissection; with reconstruction	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31420	Epiglottidectomy	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31512	Laryngoscopy, indirect, with removal of lesion	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31520	Laryngoscopy direct, with or without tracheoscopy; diagnostic, newborn	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31527	Laryngoscopy direct, with or without tracheoscopy, with insertion of obturator	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31529	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31560	Laryngoscopy, direct, operative, with arytenoidectomy;	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31578	Laryngoscopy, flexible fiberoptic; with removal of lesion	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31580	Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31584	Laryngoplasty, with open reduction of fracture	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31585	Treatment of closed laryngeal fracture; without manipulation	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31586	Treatment of closed laryngeal fracture; with closed manipulative reduction	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31587	Laryngoplasty, cricoid split	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31590	Laryngeal reinnervation by neuromuscular pedicle	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
31595	Section recurrent laryngeal nerve, therapeutic (separate procedure), unilateral	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31601	Tracheostomy, planned (separate procedure); under two years	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31656	Bronchoscopy, (rigid or flexible); with injection of contrast material for segmental bronchography (fiberscope only)	29	PULMONARY DISEASE	PULMONARY DISEASE	29	
31700	Catheterization, transglottic (separate procedure)	29	PULMONARY DISEASE	PULMONARY DISEASE	29	
31708	Instillation of contrast material for laryngography or bronchography, without catheterization	29	PULMONARY DISEASE	PULMONARY DISEASE	29	
31710	Catheterization for bronchography, with or without instillation of contrast material	48	PODIATRY	PULMONARY DISEASE	29	*
31715	Transtacheal injection for bronchography	29	PULMONARY DISEASE	PULMONARY DISEASE	29	
31717	Catheterization with bronchial brush biopsy	29	PULMONARY DISEASE	PULMONARY DISEASE	29	
31755	Tracheoplasty; tracheopharyngeal fistulization, each stage	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31760	Tracheoplasty, intrathoracic	33	THORACIC SURGERY	THORACIC SURGERY	33	
31766	Cannal reconstruction	33	THORACIC SURGERY	THORACIC SURGERY	33	
31770	Bronchoplasty; graft repair	33	THORACIC SURGERY	THORACIC SURGERY	33	
31775	Bronchoplasty; excision stenosis and anastomosis	33	THORACIC SURGERY	THORACIC SURGERY	33	
31780	Excision tracheal stenosis and anastomosis; cervical	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31781	Excision tracheal stenosis and anastomosis; cervicothoracic	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31785	Excision of tracheal tumor or carcinoma, cervical	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31786	Excision of tracheal tumor or carcinoma, thoracic	33	THORACIC SURGERY	THORACIC SURGERY	33	
31800	Suture of tracheal wound or injury, cervical	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
31805	Suture of tracheal wound or injury; intrathoracic	33	THORACIC SURGERY	THORACIC SURGERY	33	
32151	Thoracotomy, major; with removal of intrapulmonary foreign body	33	THORACIC SURGERY	THORACIC SURGERY	33	
32200	Pneumonostomy; with open drainage of abscess or cyst	33	THORACIC SURGERY	THORACIC SURGERY	33	
32442	Removal of lung, total pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)	33	THORACIC SURGERY	THORACIC SURGERY	33	
32491	Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure	33	THORACIC SURGERY	THORACIC SURGERY	33	
32522	Resection of lung; with reconstruction of chest wall, without prosthesis	33	THORACIC SURGERY	THORACIC SURGERY	33	
32603	Thoracoscopy, diagnostic (separate procedure); pericardial sac, without biopsy	33	THORACIC SURGERY	THORACIC SURGERY	33	
32604	Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biopsy	33	THORACIC SURGERY	THORACIC SURGERY	33	
32605	Thoracoscopy, diagnostic (separate procedure); mediastinal space, without biopsy	33	THORACIC SURGERY	THORACIC SURGERY	33	
32654	Thoracoscopy, surgical; with control of traumatic hemorrhage	33	THORACIC SURGERY	THORACIC SURGERY	33	
32658	Thoracoscopy, surgical, with removal of clot or foreign body from pericardial sac	33	THORACIC SURGERY	THORACIC SURGERY	33	
32660	Thoracoscopy, surgical, with total pericardiectomy	33	THORACIC SURGERY	THORACIC SURGERY	33	
32661	Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass	33	THORACIC SURGERY	THORACIC SURGERY	33	
32665	Thoracoscopy, surgical; with esophagomyotomy (Heller type)	33	THORACIC SURGERY	THORACIC SURGERY	33	
32800	Repair lung hernia through chest wall	33	THORACIC SURGERY	THORACIC SURGERY	33	
32810	Closure of chest wall following open flap drainage for empyema (Clagett type procedure)	33	THORACIC SURGERY	THORACIC SURGERY	33	
32820	Major reconstruction, chest wall (posttraumatic)	33	THORACIC SURGERY	THORACIC SURGERY	33	
32852	Lung transplant, single; with cardiopulmonary bypass	33	THORACIC SURGERY	THORACIC SURGERY	33	
32853	Lung transplant, double (bilateral sequential or en bloc), without cardiopulmonary bypass	33	THORACIC SURGERY	THORACIC SURGERY	33	
32854	Lung transplant, double (bilateral sequential or en bloc), with cardiopulmonary bypass	33	THORACIC SURGERY	THORACIC SURGERY	33	
32905	Thoracoplasty, Schede type or extrapleural (all stages),	33	THORACIC SURGERY	THORACIC SURGERY	33	
32906	Thoracoplasty, Schede type or extrapleural (all stages), with closure of bronchopleural fistula	33	THORACIC SURGERY	THORACIC SURGERY	33	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
32940	Pneumonolysis, extraperitoneal, including filling or packing procedures	33	THORACIC SURGERY	THORACIC SURGERY	33	
32960	Pneumothorax, therapeutic, intrapleural injection of air	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
32997	Total lung lavage (unilateral)	29	PULMONARY DISEASE	PULMONARY DISEASE	29	
33050	Excision of pericardial cyst or tumor	33	THORACIC SURGERY	THORACIC SURGERY	33	
33130	Resection of external cardiac tumor	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33236	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33237	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; dual lead system	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33238	Removal of permanent transvenous electrode(s) by thoracotomy	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33250	Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci), without cardiopulmonary bypass	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33261	Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33310	Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33321	Suture repair of aorta or great vessels; with shunt bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33330	Insertion of graft, aorta or great vessels; without shunt, or cardiopulmonary bypass	02	GENERAL SURGERY	THORACIC SURGERY	33	*
33332	Insertion of graft, aorta or great vessels; with shunt bypass	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33401	Valvuloplasty, aortic valve, open, with inflow occlusion	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33403	Valvuloplasty, aortic valve, using transventricular dilation, with cardiopulmonary bypass	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33404	Construction of apical-aortic conduit	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33412	Replacement, aortic valve, with transventricular aortic annulus enlargement (Konno procedure)	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33414	Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract	33	CARDIAC SURGERY	CARDIAC SURGERY	33	
33415	Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33420	Valvotomy, mitral valve; closed heart	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33422	Valvotomy, mitral valve; open heart, with cardiopulmonary bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33460	Valvectomy, tricuspid valve, with cardiopulmonary bypass	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33468	Tricuspid valve repositioning and plication for Ebstein anomaly	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33470	Valvotomy, pulmonary valve, closed heart; transventricular	06	CARDIOLOGY	CARDIAC SURGERY	78	*
33471	Valvotomy, pulmonary valve, closed heart; via pulmonary artery	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33472	Valvotomy, pulmonary valve, open heart; with inflow occlusion			CARDIAC SURGERY	78	
33474	Valvotomy, pulmonary valve, open heart; with cardiopulmonary bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33475	Replacement, pulmonary valve	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33476	Right ventricular resection for infundibular stenosis, with or without commissurotomy	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33478	Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33496	Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33500	Repair of coronary arteriovenous or arteriocardiac chamber fistula; with cardiopulmonary bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33501	Repair of coronary arteriovenous or arteriocardiac chamber fistula; without cardiopulmonary bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33502	Repair of anomalous coronary artery; by ligation	78	CARDIAC SURGERY	CARDIAC SURGERY	78	

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33503	Repair of anomalous coronary artery; by graft, without cardiopulmonary bypass	06	CARDIOLOGY	CARDIAC SURGERY	78	*
33504	Repair of anomalous coronary artery, by graft, with cardiopulmonary bypass	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33505	Repair of anomalous coronary artery; with construction of intrapulmonary artery tunnel (Takeuchi procedure)	97	PHYSICIANS ASSISTANT	CARDIAC SURGERY	78	*
33506	Repair of anomalous coronary artery, by translocation from pulmonary artery to aorta	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33600	Closure of atrioventricular valve (mitral or tricuspid) by suture or patch	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33602	Closure of semilunar valve (aortic or pulmonary) by suture or patch	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33606	Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33608	Repair of complex cardiac anomaly other than pulmonary atresia with ventricular septal defect by construction or replacement of conduit from right or left ventricle to pulmonary artery	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33610	Repair of complex cardiac anomalies (eg, single ventricle with subaortic obstruction) by surgical enlargement of ventricular septal defect	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33611	Repair of double outlet right ventricle with intraventricular tunnel repair;	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33612	Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33615	Repair of complex cardiac anomalies (eg, tricuspid atresia) by closure of atrial septal defect and anastomosis of atria or vena cava to pulmonary artery (simple Fontan procedure)	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33617	Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33619	Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33645	Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33647	Repair of atrial septal defect and ventricular septal defect, with direct or patch closure	06	CARDIOLOGY	CARDIAC SURGERY	78	*
33660	Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33665	Repair of intermediate or transitional atrioventricular canal, with or without atrioventricular valve repair	02	GENERAL SURGERY	CARDIAC SURGERY	78	*
33670	Repair of complete atrioventricular canal, with or without prosthetic valve			CARDIAC SURGERY	78	
33684	Closure of ventricular septal defect, with or without patch; with pulmonary valvotomy or infundibular resection (acyanotic)	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33688	Closure of ventricular septal defect, with or without patch; with removal of pulmonary artery band, with or without gusset			CARDIAC SURGERY	78	
33690	Banding of pulmonary artery	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33692	Complete repair tetralogy of Fallot without pulmonary atresia,			CARDIAC SURGERY	78	
33694	Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33697	Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33702	Repair sinus of Valsalva fistula, with cardiopulmonary bypass;	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33710	Repair sinus of Valsalva fistula, with cardiopulmonary bypass; with repair of ventricular septal defect	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33720	Repair sinus of Valsalva aneurysm, with cardiopulmonary bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33722	Closure of aortico-left ventricular tunnel			CARDIAC SURGERY	78	*
33730	Complete repair of anomalous venous return (supracardiac, intracardiac, or infracardiac types)	33	THORACIC SURGERY	CARDIAC SURGERY	78	*

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33732	Repair of cor trnatatum or supraavalvular mitral rring by resection of left atrnal membrane	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33735	Atrnal septectomy or septostomy; closed heart (Blalock-Hanlon type operation)	11	INTERNAL MEDICINE	CARDIAC SURGERY	78	*
33736	Atrnal septectomy or septostomy; open heart with cardiopulmonary bypass	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33737	Atrnal septectomy or septostomy, open heart, with inflow occlusion	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33750	Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)			CARDIAC SURGERY	78	*
33755	Shunt; ascending aorta to pulmonary artery (Waterston type operation)	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33762	Shunt; descending aorta to pulmonary artery (Potts-Smith type operation)	77	VASCULAR SURGERY	CARDIAC SURGERY	78	*
33764	Shunt; central, with prosthetic graft	02	GENERAL SURGERY	CARDIAC SURGERY	78	*
33766	Shunt; supenor vena cava to pulmonary artery for flow to one lung (classical Glenn procedure)			CARDIAC SURGERY	78	*
33767	Shunt; supenor vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure)			CARDIAC SURGERY	78	
33770	Repair of transposition of the great artenes with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33771	Repair of transposition of the great artenes with ventricular septal defect and subpulmonary stenosis; with surgical enlargement of ventricular septal defect			CARDIAC SURGERY	78	
33774	Repair of transposition of the great artenes, atrnal baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass;	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33775	Repair of transposition of the great artenes, atrnal baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with removal of pulmonary band	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33776	Repair of transposition of the great artenes, atrnal baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass, with closure of ventricular septal defect	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33777	Repair of transposition of the great artenes, atrnal baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with repair of subpulmonic obstruction			CARDIAC SURGERY	33	
33778	Repair of transposition of the great artenes, aortic pulmonary artery reconstruction (eg, Jatene type);	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33779	Repair of transposition of the great artenes, aortic pulmonary artery reconstruction (eg, Jatene type); with removal of pulmonary band			CARDIAC SURGERY	78	
33780	Repair of transposition of the great artenes, aortic pulmonary artery reconstruction (eg, Jatene type), with closure of ventricular septal defect	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33781	Repair of transposition of the great artenes, aortic pulmonary artery reconstruction (eg, Jatene type); with repair of subpulmonic obstruction			CARDIAC SURGERY	78	
33786	Total repair, truncus artenosus (Rastelli type operation)			CARDIAC SURGERY	78	
33788	Reimplantation of an anomalous pulmonary artery			CARDIAC SURGERY	78	
33800	Aortic suspension (aortopexy) for tracheal decompression (eg, for tracheomalacia) (separate procedure)	33	THORACIC SURGERY	THORACIC SURGERY	33	
33802	Division of aberrant vessel (vascular rring);	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33803	Division of aberrant vessel (vascular rring); with reanastomosis			CARDIAC SURGERY	78	
33813	Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33814	Obliteration of aortopulmonary septal defect, with cardiopulmonary bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33820	Repair of patent ductus artenosus; by ligation	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33822	Repair of patent ductus artenosus, by division, under 18 years	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33824	Repair of patent ductus artenosus, by division, 18 years and older	77	VASCULAR SURGERY	CARDIAC SURGERY	78	*

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
33840	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis	06	CARDIOLOGY	CARDIAC SURGERY	78	*
33845	Excision of coarctation of aorta, with or without associated patent ductus arteriosus, with graft	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33851	Excision of coarctation of aorta, with or without associated patent ductus arteriosus, repair using either left subclavian artery or prosthetic material as gusset for enlargement	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33852	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass	06	CARDIOLOGY	CARDIAC SURGERY	78	*
33853	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material, with cardiopulmonary bypass	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33910	Pulmonary artery embolectomy; with cardiopulmonary bypass	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33915	Pulmonary artery embolectomy; without cardiopulmonary bypass	30	DIAGNOSTIC RADIOLOGY	CARDIAC SURGERY	78	*
33916	Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33917	Repair of pulmonary artery stenosis by reconstruction with patch or graft	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33918	Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries, without cardiopulmonary bypass			CARDIAC SURGERY	78	
33919	Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries, with cardiopulmonary bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33920	Repair of pulmonary atresia with ventricular septal defect, by construction or replacement of conduit from right or left ventricle to pulmonary artery			CARDIAC SURGERY	78	*
33922	Transection of pulmonary artery with cardiopulmonary bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33924	Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
33960	Prolonged extracorporeal circulation for cardiopulmonary insufficiency, initial 24 hours	78	CARDIAC SURGERY	THORACIC SURGERY	33	*
33961	Prolonged extracorporeal circulation for cardiopulmonary insufficiency, each additional 24 hours (List separately in addition to code for primary procedure)	11	INTERNAL MEDICINE	CARDIAC SURGERY	78	*
33976	Insertion of ventricular assist device; extracorporeal, biventricular	33	THORACIC SURGERY	THORACIC SURGERY	33	
33978	Removal of ventricular assist device; extracorporeal, biventricular	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
34051	Embolectomy or thrombectomy, with or without catheter; innominate, subclavian artery, by thoracic incision	02	GENERAL SURGERY	GENERAL SURGERY	02	
34451	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
34471	Thrombectomy, direct or with catheter; subclavian vein, by neck incision	02	GENERAL SURGERY	GENERAL SURGERY	02	
34501	Valvuloplasty, femoral vein	02	GENERAL SURGERY	GENERAL SURGERY	02	
34510	Venous valve transposition, any vein donor	02	GENERAL SURGERY	GENERAL SURGERY	02	
34530	Saphenopopliteal vein anastomosis	02	GENERAL SURGERY	GENERAL SURGERY	02	
34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
34832	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis	77	VASCULAR SURGERY	VASCULAR SURGERY	77	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
34834	Open brachial artery exposure to assist in the deployment of infrarenal aortic or iliac endovascular prosthesis by arm incision, unilateral	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35002	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, carotid, subclavian artery, by neck incision	02	GENERAL SURGERY	GENERAL SURGERY	02	
35005	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, vertebral artery	02	GENERAL SURGERY	GENERAL SURGERY	02	
35021	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, innominate, subclavian artery, by thoracic incision	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
35022	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for ruptured aneurysm, innominate, subclavian artery, by thoracic incision	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
35111	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, splenic artery	02	GENERAL SURGERY	GENERAL SURGERY	02	
35112	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, splenic artery	02	GENERAL SURGERY	GENERAL SURGERY	02	
35122	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, hepatic, celiac, renal, or mesentenc artery	02	GENERAL SURGERY	GENERAL SURGERY	02	
35152	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for ruptured aneurysm, popliteal artery	02	GENERAL SURGERY	GENERAL SURGERY	02	
35180	Repair, congenital artenovenous fistula; head and neck	30	DIAGNOSTIC RADIOLOGY	GENERAL SURGERY	02	*
35182	Repair, congenital artenovenous fistula, thorax and abdomen	02	GENERAL SURGERY	GENERAL SURGERY	02	
35188	Repair, acquired or traumatic artenovenous fistula; head and neck	02	GENERAL SURGERY	GENERAL SURGERY	02	
35189	Repair, acquired or traumatic artenovenous fistula; thorax and abdomen	02	GENERAL SURGERY	GENERAL SURGERY	02	
35246	Repair blood vessel with vein graft, intrathoracic, without bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
35271	Repair blood vessel with graft other than vein, intrathoracic, with bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
35276	Repair blood vessel with graft other than vein; intrathoracic, without bypass	33	THORACIC SURGERY	CARDIAC SURGERY	78	*
35311	Thromboendarterectomy, with or without patch graft, subclavian, innominate, by thoracic incision	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35363	Thromboendarterectomy, with or without patch graft, combined aortoiliofemoral	02	GENERAL SURGERY	VASCULAR SURGERY	77	*
35480	Transluminal peripheral atherectomy, open; renal or other visceral artery	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35481	Transluminal peripheral atherectomy, open; aortic	33	THORACIC SURGERY	THORACIC SURGERY	33	
35482	Transluminal peripheral atherectomy, open; iliac	02	GENERAL SURGERY	GENERAL SURGERY	02	
35484	Transluminal peripheral atherectomy, open; brachiocephalic trunk or branches, each vessel	02	GENERAL SURGERY	GENERAL SURGERY	02	
35485	Transluminal peripheral atherectomy, open, tibioperoneal trunk and branches	33	THORACIC SURGERY	THORACIC SURGERY	33	
35491	Transluminal peripheral atherectomy, percutaneous, aortic	06	CARDIOLOGY	CARDIOLOGY	06	
35494	Transluminal peripheral atherectomy, percutaneous, brachiocephalic trunk or branches, each vessel	30	DIAGNOSTIC RADIOLOGY	CARDIOLOGY	06	*
35507	Bypass graft, with vein, subclavian-carotid	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35508	Bypass graft, with vein, carotid-vertebral	33	THORACIC SURGERY	VASCULAR SURGERY	77	*
35511	Bypass graft, with vein, subclavian-subclavian	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35512	Bypass graft, with vein; subclavian-brachial			VASCULAR SURGERY	77	
35515	Bypass graft, with vein; subclavian-vertebral	77	VASCULAR SURGERY	VASCULAR SURGERY	77	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
35516	Bypass graft, with vein; subclavian-axillary	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35518	Bypass graft, with vein; axillary-axillary	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35521	Bypass graft, with vein; axillary-femoral	02	GENERAL SURGERY	VASCULAR SURGERY	77	*
35526	Bypass graft, with vein, aortosubclavian or carotid	33	THORACIC SURGERY	VASCULAR SURGERY	77	*
35533	Bypass graft, with vein; axillary-femoral-femoral	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35536	Bypass graft, with vein; splenorenal	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35541	Bypass graft, with vein, aortoiliac or bi-iliac	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35548	Bypass graft, with vein, aortoiliofemoral, unilateral	02	GENERAL SURGERY	VASCULAR SURGERY	77	*
35549	Bypass graft, with vein; aortoiliofemoral, bilateral	02	GENERAL SURGERY	VASCULAR SURGERY	77	*
35551	Bypass graft, with vein; aortofemoral-popliteal	02	GENERAL SURGERY	VASCULAR SURGERY	77	*
35563	Bypass graft, with vein; ilioiliac	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35612	Bypass graft, with other than vein; subclavian-subclavian	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35616	Bypass graft, with other than vein, subclavian-axillary	02	GENERAL SURGERY	VASCULAR SURGERY	77	*
35636	Bypass graft, with other than vein, splenorenal (splenic to renal arterial anastomosis)	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35642	Bypass graft, with other than vein, carotid-vertebral	02	GENERAL SURGERY	VASCULAR SURGERY	77	*
35645	Bypass graft, with other than vein; subclavian-vertebral	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35651	Bypass graft, with other than vein; aortofemoral-popliteal	02	GENERAL SURGERY	VASCULAR SURGERY	77	*
35691	Transposition and/or reimplantation, vertebral to carotid artery	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35693	Transposition and/or reimplantation, vertebral to subclavian artery	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35694	Transposition and/or reimplantation, subclavian to carotid artery	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35695	Transposition and/or reimplantation, carotid to subclavian artery	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
35905	Excision of infected graft, thorax	02	GENERAL SURGERY	GENERAL SURGERY	02	
36261	Revision of implanted intra-arterial infusion pump	02	GENERAL SURGERY	GENERAL SURGERY	02	
36400	Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine venipuncture, femoral or jugular vein	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	93	
36405	Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	93	
36420	Venipuncture, cutdown; under age 1 year	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	93	
36440	Push transfusion, blood, 2 years or under	02	GENERAL SURGERY	PEDIATRIC MEDICINE	37	*
36450	Exchange transfusion, blood, newborn	08	FAMILY PRACTICE	PEDIATRIC MEDICINE	37	*
36460	Transfusion, intravenous, fetal	02	GENERAL SURGERY	OB-GYN	16	*
36468	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia), limb or trunk	02	GENERAL SURGERY	GENERAL SURGERY	02	
36469	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face			PEDIATRIC MEDICINE	37	
36510	Catheterization of umbilical vein for diagnosis or therapy, newborn	83	HEMATOLOGY/ONCOLOGY	HEMATOLOGY/ONCOLOGY	83	
36660	Catheterization, umbilical artery, newborn, for diagnosis or therapy	93	EMERGENCY MEDICINE	PEDIATRIC MEDICINE	37	*
37145	Venous anastomosis, open; renoportal	02	GENERAL SURGERY	GENERAL SURGERY	02	
37160	Venous anastomosis, open; caval-mesenteric	02	GENERAL SURGERY	GENERAL SURGERY	02	
37180	Venous anastomosis, open; splenorenal, proximal	02	GENERAL SURGERY	GENERAL SURGERY	02	
37181	Venous anastomosis, open, splenorenal, distal (selective decompression of esophagogastric varices, any technique)	02	GENERAL SURGERY	GENERAL SURGERY	02	
37195	Thrombolysis, cerebral, by intravenous infusion	13	NEUROLOGY	NEUROLOGY	13	
37606	Ligation, internal or common carotid artery, with gradual occlusion, as with Selverstone or Crutchfield clamp	14	NEUROSURGERY	NEUROSURGERY	14	
37615	Ligation, major artery (eg, post-traumatic, rupture); neck	02	GENERAL SURGERY	GENERAL SURGERY	2	
37616	Ligation, major artery (eg, post-traumatic, rupture), chest	78	CARDIAC SURGERY	CARDIAC SURGERY	78	
37660	Ligation of common iliac vein	02	GENERAL SURGERY	GENERAL SURGERY	02	
37788	Penile revascularization, artery, with or without vein graft	34	UROLOGY	UROLOGY	34	
37790	Penile venous occlusive procedure	34	UROLOGY	UROLOGY	34	
38101	Splenectomy; partial (separate procedure)	02	GENERAL SURGERY	GENERAL SURGERY	02	
38200	Injection procedure for splenoportography	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
38242	Bone marrow or blood-derived peripheral stem cell transplantation, allogeneic donor lymphocyte infusions	83	HEMATOLOGY/ONCOLOGY	HEMATOLOGY/ONCOLOGY	83	
38380	Suture and/or ligation of thoracic duct, cervical approach	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
38381	Suture and/or ligation of thoracic duct, thoracic approach	33	THORACIC SURGERY	THORACIC SURGERY	33	
38382	Suture and/or ligation of thoracic duct, abdominal approach	02	GENERAL SURGERY	GENERAL SURGERY	02	
38550	Excision of cystic hygroma, axillary or cervical, without deep neurovascular dissection	02	GENERAL SURGERY	GENERAL SURGERY	02	
38555	Excision of cystic hygroma, axillary or cervical; with deep neurovascular dissection	02	GENERAL SURGERY	GENERAL SURGERY	02	
38794	Cannulation, thoracic duct	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
39503	Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia	02	GENERAL SURGERY	GENERAL SURGERY	02	
39530	Repair, diaphragmatic hernia (esophageal hiatal), combined, thoracoabdominal	02	GENERAL SURGERY	GENERAL SURGERY	02	
39531	Repair, diaphragmatic hernia (esophageal hiatal), combined, thoracoabdominal, with dilation of stricture (with or without gastroplasty)	02	GENERAL SURGERY	GENERAL SURGERY	02	
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute	02	GENERAL SURGERY	GENERAL SURGERY	02	
39545	Imbrication of diaphragm for eventration, transthoracic or transabdominal, paralytic or nonparalytic	33	THORACIC SURGERY	THORACIC SURGERY	33	
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure			PLASTIC AND RECONSTRUCTIVE SURGERY	24	
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, one of two stages			PLASTIC AND RECONSTRUCTIVE SURGERY	24	
40720	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
40761	Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
40805	Removal of embedded foreign body, vestibule of mouth, complicated	19	ORAL SURGERY	ORAL SURGERY	19	
40806	Incision of labial frenum (frenotomy)	19	ORAL SURGERY	ORAL SURGERY	19	
40840	Vestibuloplasty, anterior	19	ORAL SURGERY	ORAL SURGERY	19	
40842	Vestibuloplasty, posterior, unilateral	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
40843	Vestibuloplasty, posterior, bilateral	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
40844	Vestibuloplasty; entire arch	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
40845	Vestibuloplasty; complex (including ridge extension, muscle repositioning)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
41005	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial	19	ORAL SURGERY	ORAL SURGERY	19	
41006	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth, sublingual, deep, suprathyroid	19	ORAL SURGERY	ORAL SURGERY	19	
41007	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth, submental space	19	ORAL SURGERY	ORAL SURGERY	19	
41010	Incision of lingual frenum (frenotomy)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth, sublingual	19	ORAL SURGERY	ORAL SURGERY	19	
41018	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth, masticator space	19	ORAL SURGERY	ORAL SURGERY	19	
41115	Excision of lingual frenum (frenectomy)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
41140	Glossectomy, complete or total, with or without tracheostomy, without radical neck dissection	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
41145	Glossectomy, complete or total, with or without tracheostomy, with unilateral radical neck dissection	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
41251	Repair of laceration 2.5 cm or less, posterior one-third of tongue	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	93	
41500	Fixation of tongue, mechanical, other than suture (eg, K-wire)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
41510	Suture of tongue to lip for micrognathia (Douglas type procedure)	30	DIAGNOSTIC RADIOLOGY	OTOLARYNGOLOGY	04	*
41520	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
41820	Gingivectomy, excision gingiva, each quadrant	19	ORAL SURGERY	ORAL SURGERY	19	
41821	Operculectomy, excision pericoronal tissues			ORAL SURGERY	19	
41822	Excision of fibrous tuberosities, dentoalveolar structures	19	ORAL SURGERY	ORAL SURGERY	19	
41823	Excision of osseous tuberosities, dentoalveolar structures	19	ORAL SURGERY	ORAL SURGERY	19	
41850	Destruction of lesion (except excision), dentoalveolar structures	19	ORAL SURGERY	ORAL SURGERY	19	
41870	Penodontal mucosal grafting	19	ORAL SURGERY	ORAL SURGERY	19	
41872	Gingivoplasty, each quadrant (specify)	19	ORAL SURGERY	ORAL SURGERY	19	
42000	Drainage of abscess of palate, uvula	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42180	Repair, laceration of palate, up to 2 cm	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42182	Repair, laceration of palate, over 2 cm or complex	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42200	Palatoplasty for cleft palate, soft and/or hard palate only	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
42205	Palatoplasty for cleft palate, with closure of alveolar ridge, soft tissue only	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
42210	Palatoplasty for cleft palate, with closure of alveolar ridge, with bone graft to alveolar ridge (includes obtaining graft)	19	ORAL SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
42215	Palatoplasty for cleft palate; major revision	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
42220	Palatoplasty for cleft palate; secondary lengthening procedure	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
42225	Palatoplasty for cleft palate; attachment pharyngeal flap	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
42226	Lengthening of palate, and pharyngeal flap	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42227	Lengthening of palate, with island flap	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42235	Repair of anterior palate, including vomer flap	10	GASTROENTEROLOGY	OTOLARYNGOLOGY	04	*
42260	Repair of nasolabial fistula	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
42281	Insertion of pin-retained palatal prosthesis	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42320	Drainage of abscess; submaxillary, external	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42325	Fistulization of sublingual salivary cyst (ranula);	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42326	Fistulization of sublingual salivary cyst (ranula); with prosthesis	10	GASTROENTEROLOGY	OTOLARYNGOLOGY	04	*
42340	Sialolithotomy, parotid, extraoral or complicated intraoral	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42409	Marsupialization of sublingual salivary cyst (ranula)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42505	Plastic repair of salivary duct, sialodochoplasty; secondary or complicated	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42507	Parotid duct diversion, bilateral (Wilke type procedure),	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42508	Parotid duct diversion, bilateral (Wilke type procedure), with excision of one submandibular gland	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42509	Parotid duct diversion, bilateral (Wilke type procedure), with excision of both submandibular glands	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42510	Parotid duct diversion, bilateral (Wilke type procedure), with ligation of both submandibular (Wharton's) ducts	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42600	Closure salivary fistula	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42665	Ligation salivary duct, intraoral	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42725	Incision and drainage abscess, retropharyngeal or parapharyngeal, external approach	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42810	Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
42820	Tonsillectomy and adenoidectomy, under age 12	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42825	Tonsillectomy, primary or secondary; under age 12	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42830	Adenoidectomy, primary, under age 12	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42835	Adenoidectomy, secondary; under age 12			OTOLARYNGOLOGY	04	
42836	Adenoidectomy, secondary, age 12 or over	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42844	Radical resection of tonsil, tonsillar pillars, and/or retromolar triangle, closure with local flap (eg, tongue, buccal)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42845	Radical resection of tonsil, tonsillar pillars, and/or retromolar triangle, closure with other flap	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42860	Excision of tonsil tags	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42900	Suture pharynx for wound or injury	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42955	Pharyngostomy (fistulization of pharynx, external for feeding)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42961	Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy), complicated, requiring hospitalization	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42971	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); complicated, requiring hospitalization	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
42972	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy), with secondary surgical intervention	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
43020	Esophagotomy, cervical approach, with removal of foreign body	02	GENERAL SURGERY	GENERAL SURGERY	02	
43045	Esophagotomy, thoracic approach, with removal of foreign body	33	THORACIC SURGERY	THORACIC SURGERY	33	
43100	Excision of lesion, esophagus, with primary repair, cervical approach	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
43101	Excision of lesion, esophagus, with primary repair; thoracic or abdominal approach	02	GENERAL SURGERY	GENERAL SURGERY	02	
43108	Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)	02	GENERAL SURGERY	GENERAL SURGERY	02	
43113	Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	33	THORACIC SURGERY	THORACIC SURGERY	33	
43116	Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction	04	OTOLARYNGOLOGY	THORACIC SURGERY	33	*
43118	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy, with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	02	GENERAL SURGERY	GENERAL SURGERY	02	
43121	Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrotomy, with or without pyloroplasty	33	THORACIC SURGERY	THORACIC SURGERY	33	
43123	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy, with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	02	GENERAL SURGERY	THORACIC SURGERY	02	*
43124	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy	33	THORACIC SURGERY	THORACIC SURGERY	33	
43300	Esophagoplasty (plastic repair or reconstruction), cervical approach, without repair of tracheoesophageal fistula	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
43312	Esophagoplasty (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula	33	THORACIC SURGERY	THORACIC SURGERY	33	
43313	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach, without repair of congenital tracheoesophageal fistula	08	FAMILY PRACTICE	THORACIC SURGERY	33	*
43314	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula	02	GENERAL SURGERY	THORACIC SURGERY	33	*

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
43320	Esophagogastrotomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach	02	GENERAL SURGERY	GENERAL SURGERY	02	
43325	Esophagogastnc fundoplasty, with fundic patch (Thal-Nissen procedure)	02	GENERAL SURGERY	GENERAL SURGERY	02	
43331	Esophagomyotomy (Heller type), thoracic approach	33	THORACIC SURGERY	THORACIC SURGERY	33	
43340	Esophagojejunostomy (without total gastrectomy); abdominal approach	02	GENERAL SURGERY	GENERAL SURGERY	02	
43341	Esophagojejunostomy (without total gastrectomy); thoracic approach	02	GENERAL SURGERY	GENERAL SURGERY	02	
43350	Esophagostomy, fistulization of esophagus, external, abdominal approach	11	INTERNAL MEDICINE	GENERAL SURGERY	02	*
43351	Esophagostomy, fistulization of esophagus, external; thoracic approach	33	THORACIC SURGERY	THORACIC SURGERY	33	
43352	Esophagostomy, fistulization of esophagus, external; cervical approach	33	THORACIC SURGERY	THORACIC SURGERY	33	
43360	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty	02	GENERAL SURGERY	GENERAL SURGERY	02	
43361	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion, with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	02	GENERAL SURGERY	GENERAL SURGERY	02	
43400	Ligation, direct, esophageal vances	10	GASTROENTEROLOGY	GENERAL SURGERY	02	*
43401	Transection of esophagus with repair, for esophageal vances	02	GENERAL SURGERY	GENERAL SURGERY	02	
43405	Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation	02	GENERAL SURGERY	GENERAL SURGERY	02	
43410	Suture of esophageal wound or injury; cervical approach	33	THORACIC SURGERY	GENERAL SURGERY	02	*
43420	Closure of esophagostomy or fistula, cervical approach	04	OTOLARYNGOLOGY	GENERAL SURGERY	02	*
43425	Closure of esophagostomy or fistula, transthoracic or transabdominal approach	02	GENERAL SURGERY	GENERAL SURGERY	02	
43460	Esophagogastric tamponade, with balloon (Sengstaaken type)	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10	
43496	Free jejunum transfer with microvascular anastomosis	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
43502	Gastrotomy, with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)	02	GENERAL SURGERY	GENERAL SURGERY	02	
43510	Gastrotomy, with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)	02	GENERAL SURGERY	GENERAL SURGERY	02	
43634	Gastrectomy, partial, distal, with formation of intestinal pouch	02	GENERAL SURGERY	GENERAL SURGERY	02	
43641	Vagotomy including pyloroplasty, with or without gastrotomy, parietal cell (highly selective)	02	GENERAL SURGERY	GENERAL SURGERY	02	
43651	Laparoscopy, surgical; transection of vagus nerves, truncal	02	GENERAL SURGERY	GENERAL SURGERY	02	
43652	Laparoscopy, surgical; transection of vagus nerves, selective or highly selective	02	GENERAL SURGERY	GENERAL SURGERY	02	
43752	Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
43810	Gastroduodenostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
43831	Gastrostomy, open; neonatal, for feeding	02	GENERAL SURGERY	GENERAL SURGERY	02	
43850	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
43855	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy	02	GENERAL SURGERY	GENERAL SURGERY	02	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
44126	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine, without tapering	02	GENERAL SURGERY	GENERAL SURGERY	02	
44127	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering	02	GENERAL SURGERY	GENERAL SURGERY	02	
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)	02	GENERAL SURGERY	GENERAL SURGERY	02	
44151	Colectomy, total, abdominal, without proctectomy; with continent ileostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
44156	Colectomy, total, abdominal, with proctectomy; with continent ileostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
44203	Laparoscopy, surgical, each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)	02	GENERAL SURGERY	GENERAL SURGERY	02	
44211	Laparoscopy, surgical, colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
44212	Laparoscopy, surgical, colectomy, total, abdominal, with proctectomy, with ileostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
44239	Unlisted laparoscopy procedure, rectum	02	GENERAL SURGERY	GENERAL SURGERY	02	
44316	Continent ileostomy (Kock procedure) (separate procedure)	02	GENERAL SURGERY	GENERAL SURGERY	02	
44322	Colostomy or skin level cecostomy, with multiple biopsies (eg, for congenital megacolon) (separate procedure)	02	GENERAL SURGERY	GENERAL SURGERY	02	
44370	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10	
44379	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10	
44390	Colonoscopy through stoma, with removal of foreign body	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10	
44397	Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10	
44680	Intestinal plication (separate procedure)	02	GENERAL SURGERY	GENERAL SURGERY	02	
44850	Suture of mesentery (separate procedure)	02	GENERAL SURGERY	GENERAL SURGERY	02	
45108	Anorectal myomectomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
45113	Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
45114	Proctectomy, partial, with anastomosis; abdominal and transsacral approach	02	GENERAL SURGERY	GENERAL SURGERY	02	
45116	Proctectomy, partial, with anastomosis, transsacral approach only (Kraske type)	02	GENERAL SURGERY	GENERAL SURGERY	02	
45120	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation)	02	GENERAL SURGERY	GENERAL SURGERY	02	
45121	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies	02	GENERAL SURGERY	GENERAL SURGERY	02	
45126	Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof	02	GENERAL SURGERY	GENERAL SURGERY	02	
45135	Excision of rectal procidentia, with anastomosis; abdominal and perineal approach	02	GENERAL SURGERY	GENERAL SURGERY	02	
45136	Excision of ileoanal reservoir with ileostomy	28	COLORECTAL SURGERY	COLORECTAL SURGERY	28	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
45150	Division of structure of rectum	02	GENERAL SURGERY	GENERAL SURGERY	02	
45327	Proctosigmoidoscopy, rigid, with transendoscopic stent placement (includes predilation)	02	GENERAL SURGERY	GENERAL SURGERY	02	
45563	Exploration, repair, and presacral drainage for rectal injury; with colostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
45805	Closure of rectovesical fistula, with colostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
45820	Closure of rectourethral fistula,	34	UROLOGY	GENERAL SURGERY	02	*
45825	Closure of rectourethral fistula, with colostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
46070	Incision, anal septum (infant)	02	GENERAL SURGERY	GENERAL SURGERY	02	
46210	Cryptectomy; single	02	GENERAL SURGERY	GENERAL SURGERY	02	
46211	Cryptectomy; multiple (separate procedure)	02	GENERAL SURGERY	GENERAL SURGERY	02	
46612	Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	02	GENERAL SURGERY	GENERAL SURGERY	02	
46705	Anoplasty, plastic operation for stricture, infant	02	GENERAL SURGERY	GENERAL SURGERY	02	
46715	Repair of low imperforate anus, with anopenneal fistula (cut-back procedure)			GENERAL SURGERY	02	
46716	Repair of low imperforate anus, with transposition of anopenneal or anovestibular fistula			GENERAL SURGERY	02	
46730	Repair of high imperforate anus without fistula, penneal or sacropenneal approach			GENERAL SURGERY	02	
46735	Repair of high imperforate anus without fistula, combined transabdominal and sacropenneal approaches			GENERAL SURGERY	02	
46740	Repair of high imperforate anus with rectourethral or rectovaginal fistula; penneal or sacropenneal approach	02	GENERAL SURGERY	GENERAL SURGERY	02	
46742	Repair of high imperforate anus with rectourethral or rectovaginal fistula, combined transabdominal and sacropenneal approaches			GENERAL SURGERY	02	
46744	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacropenneal approach	16	OB-GYN	GENERAL SURGERY	02	*
46746	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacropenneal approach,	02	GENERAL SURGERY	GENERAL SURGERY	02	
46748	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacropenneal approach; with vaginal lengthening by intestinal graft or pedicle flaps			GENERAL SURGERY	02	
46751	Sphincteroplasty, anal, for incontinence or prolapse; child			GENERAL SURGERY	02	
46754	Removal of Thiersch wire or suture, anal canal	02	GENERAL SURGERY	GENERAL SURGERY	02	
46760	Sphincteroplasty, anal, for incontinence, adult, muscle transplant	28	COLORECTAL SURGERY	COLORECTAL SURGERY	28	
46762	Sphincteroplasty, anal, for incontinence, adult, implantation artificial sphincter	28	COLORECTAL SURGERY	COLORECTAL SURGERY	28	
46937	Cryosurgery of rectal tumor; benign	07	DERMATOLOGY	GENERAL SURGERY	02	*
46938	Cryosurgery of rectal tumor; malignant	02	GENERAL SURGERY	GENERAL SURGERY	02	
47015	Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es)	02	GENERAL SURGERY	GENERAL SURGERY	02	
47360	Management of liver hemorrhage; complex suture of liver wound or injury, with or without hepatic artery ligation	02	GENERAL SURGERY	GENERAL SURGERY	02	
47362	Management of liver hemorrhage; re-exploration of hepatic wound for removal of packing	02	GENERAL SURGERY	GENERAL SURGERY	02	
47371	Laparoscopy, surgical, ablation of one or more liver tumor(s); cryosurgical	02	GENERAL SURGERY	GENERAL SURGERY	02	
47381	Ablation, open, of one or more liver tumor(s); cryosurgical	02	GENERAL SURGERY	GENERAL SURGERY	02	
47400	Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus	02	GENERAL SURGERY	GENERAL SURGERY	02	
47425	Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; with transduodenal sphincterotomy or sphincteroplasty	02	GENERAL SURGERY	GENERAL SURGERY	02	
47561	Laparoscopy, surgical; with guided transhepatic cholangiography with biopsy	02	GENERAL SURGERY	GENERAL SURGERY	02	
47570	Laparoscopy, surgical, cholecystoenterostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
47700	Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or without cholangiography	02	GENERAL SURGERY	GENERAL SURGERY	02	
47701	Portoenterostomy (eg, Kasai procedure)	02	GENERAL SURGERY	GENERAL SURGERY	02	
47712	Excision of bile duct tumor, with or without primary repair of bile duct, intrahepatic	02	GENERAL SURGERY	GENERAL SURGERY	02	
47715	Excision of choledochal cyst	02	GENERAL SURGERY	GENERAL SURGERY	02	
47716	Anastomosis, choledochal cyst, without excision	02	GENERAL SURGERY	GENERAL SURGERY	02	
47740	Cholecystoenterostomy; Roux-en-Y	02	GENERAL SURGERY	GENERAL SURGERY	02	
47765	Anastomosis, of intrahepatic ducts and gastrointestinal tract	02	GENERAL SURGERY	GENERAL SURGERY	02	
47800	Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis	02	GENERAL SURGERY	GENERAL SURGERY	02	
47802	U-tube hepaticoenterostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
48001	Placement of drains, penpancreatic, for acute pancreatitis, with cholecystostomy, gastrostomy, and jejunostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
48020	Removal of pancreatic calculus	02	GENERAL SURGERY	GENERAL SURGERY	02	
48145	Pancreatectomy, distal subtotal, with or without splenectomy, with pancreaticojejunostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
48146	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)	02	GENERAL SURGERY	GENERAL SURGERY	02	
48148	Excision of ampulla of Vater	02	GENERAL SURGERY	GENERAL SURGERY	02	
48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreatojejunostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
48154	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); without pancreatojejunostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
48155	Pancreatectomy, total	02	GENERAL SURGERY	GENERAL SURGERY	02	
48400	Injection procedure for intraoperative pancreatography (List separately in addition to code for primary procedure)	30	DIAGNOSTIC RADIOLOGY	GENERAL SURGERY	02	*
48500	Marsupialization of pancreatic cyst	02	GENERAL SURGERY	GENERAL SURGERY	02	
48545	Pancreatorrhaphy for injury	02	GENERAL SURGERY	GENERAL SURGERY	02	
48547	Duodenal exclusion with gastrojejunostomy for pancreatic injury	02	GENERAL SURGERY	GENERAL SURGERY	02	
48550	Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation	02	GENERAL SURGERY	GENERAL SURGERY	02	
48556	Removal of transplanted pancreatic allograft	02	GENERAL SURGERY	GENERAL SURGERY	02	
49220	Staging laparotomy for Hodgkins disease or lymphoma (includes splenectomy, needle or open biopsies of both liver lobes, possibly also removal of abdominal nodes, abdominal node and/or bone marrow biopsies, ovarian repositioning)	02	GENERAL SURGERY	GENERAL SURGERY	02	
49428	Ligation of portoneal-venous shunt	02	GENERAL SURGERY	GENERAL SURGERY	02	
49491	Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; reducible	02	GENERAL SURGERY	GENERAL SURGERY	02	
49492	Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; incarcerated or strangulated	02	GENERAL SURGERY	GENERAL SURGERY	02	
49495	Repair, initial inguinal hernia, full term infant under age 6 months, or preterm infant over 50 weeks postconception age and under age 6 months at the time of surgery, with or without hydrocelectomy, reducible	02	GENERAL SURGERY	GENERAL SURGERY	02	
49496	Repair, initial inguinal hernia, full term infant under age 6 months, or preterm infant over 50 weeks postconception age and under age 6 months at the time of surgery, with or without hydrocelectomy, incarcerated or strangulated	02	GENERAL SURGERY	GENERAL SURGERY	02	
49500	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible	02	GENERAL SURGERY	GENERAL SURGERY	02	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
49501	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; incarcerated or strangulated	02	GENERAL SURGERY	GENERAL SURGERY	02	
49580	Repair umbilical hernia, under age 5 years; reducible	02	GENERAL SURGERY	GENERAL SURGERY	02	
49600	Repair of small omphalocele, with primary closure	02	GENERAL SURGERY	GENERAL SURGERY	02	
49605	Repair of large omphalocele or gastroschisis, with or without prosthesis	02	GENERAL SURGERY	GENERAL SURGERY	02	
49606	Repair of large omphalocele or gastroschisis, with removal of prosthesis, final reduction and closure, in operating room	02	GENERAL SURGERY	GENERAL SURGERY	02	
49610	Repair of omphalocele (Gross type operation), first stage	02	GENERAL SURGERY	GENERAL SURGERY	02	
49611	Repair of omphalocele (Gross type operation), second stage			GENERAL SURGERY	02	
49906	Free omental flap with microvascular anastomosis	02	GENERAL SURGERY	GENERAL SURGERY	02	
50045	Nephrotomy, with exploration	34	UROLOGY	UROLOGY	34	
50060	Nephrolithotomy; removal of calculus	34	UROLOGY	UROLOGY	34	
50065	Nephrolithotomy, secondary surgical operation for calculus	34	UROLOGY	UROLOGY	34	
50070	Nephrolithotomy; complicated by congenital kidney abnormality	34	UROLOGY	UROLOGY	34	
50075	Nephrolithotomy; removal of large staghorn calculus filling renal pelvis and calyces (including anastrophic pyelolithotomy)	34	UROLOGY	UROLOGY	34	
50100	Transection or repositioning of aberrant renal vessels (separate procedure)	02	GENERAL SURGERY	GENERAL SURGERY	02	
50120	Pyelotomy; with exploration	34	UROLOGY	UROLOGY	34	
50125	Pyelotomy; with drainage, pyelostomy	34	UROLOGY	UROLOGY	34	
50135	Pyelotomy; complicated (eg, secondary operation, congenital kidney abnormality)	34	UROLOGY	UROLOGY	34	
50290	Excision of pararenal cyst	34	UROLOGY	UROLOGY	34	
50380	Renal autotransplantation, reimplantation of kidney	02	GENERAL SURGERY	GENERAL SURGERY	02	
50500	Nephrorrhaphy, suture of kidney wound or injury	02	GENERAL SURGERY	GENERAL SURGERY	02	
50520	Closure of nephrocutaneous or pyelocutaneous fistula	34	UROLOGY	UROLOGY	34	
50525	Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; abdominal approach			UROLOGY	34	
50526	Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; thoracic approach			UROLOGY	34	
50540	Symphysiotomy for horseshoe kidney with or without pyeloplasty and/or other plastic procedure, unilateral or bilateral (one operation)	34	UROLOGY	UROLOGY	34	
50544	Laparoscopy, surgical; pyeloplasty	34	UROLOGY	UROLOGY	34	
50555	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with biopsy	34	UROLOGY	UROLOGY	34	
50557	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with fulguration and/or incision, with or without biopsy	34	UROLOGY	UROLOGY	34	
50562	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with resection of tumor	34	UROLOGY	UROLOGY	34	
50570	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	34	UROLOGY	UROLOGY	34	
50572	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with ureteral catheterization, with or without dilation of ureter	34	UROLOGY	UROLOGY	34	
50574	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with biopsy	34	UROLOGY	UROLOGY	34	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
50576	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with fulguration and/or incision, with or without biopsy	34	UROLOGY	UROLOGY	34	
50580	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with removal of foreign body or calculus	34	UROLOGY	UROLOGY	34	
50610	Ureterolithotomy; upper one-third of ureter	34	UROLOGY	UROLOGY	34	
50620	Ureterolithotomy; middle one-third of ureter	34	UROLOGY	UROLOGY	34	
50660	Ureterectomy, total, ectopic ureter, combination abdominal, vaginal and/or penneal approach	34	UROLOGY	UROLOGY	34	
50686	Manometric studies through ureterostomy or indwelling ureteral catheter	34	UROLOGY	UROLOGY	34	
50722	Ureterolysis for ovarian vein syndrome	16	OB-GYN	OB-GYN	16	
50725	Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava	34	UROLOGY	UROLOGY	34	
50728	Revision of urinary-cutaneous anastomosis (any type urostomy); with repair of fascial defect and hernia	34	UROLOGY	UROLOGY	34	
50740	Ureteropyelostomy, anastomosis of ureter and renal pelvis	02	GENERAL SURGERY	UROLOGY	34	*
50750	Ureterocalycostomy, anastomosis of ureter to renal calyx	34	UROLOGY	UROLOGY	34	
50770	Transureteroureterostomy, anastomosis of ureter to contralateral ureter	34	UROLOGY	UROLOGY	34	
50782	Ureteroneocystostomy, anastomosis of duplicated ureter to bladder	34	UROLOGY	UROLOGY	34	
50783	Ureteroneocystostomy, with extensive ureteral tailoring	34	UROLOGY	UROLOGY	34	
50810	Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or penneal colostomy, including intestine anastomosis	02	GENERAL SURGERY	GENERAL SURGERY	02	
50815	Ureterocolon conduit, including intestine anastomosis	34	UROLOGY	UROLOGY	34	
50830	Urinary diversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with ureteroureterostomy or ureteroneocystostomy)	34	UROLOGY	UROLOGY	34	
50840	Replacement of all or part of ureter by intestine segment, including intestine anastomosis	34	UROLOGY	UROLOGY	34	
50845	Cutaneous appendico-vesicostomy	34	UROLOGY	UROLOGY	34	
50860	Ureterostomy, transplantation of ureter to skin	34	UROLOGY	UROLOGY	34	
50920	Closure of ureterocutaneous fistula	34	UROLOGY	UROLOGY	34	
50930	Closure of ureterovisceral fistula (including visceral repair)	34	UROLOGY	UROLOGY	34	
50940	Ligation of ureter	34	UROLOGY	UROLOGY	34	
50945	Laparoscopy, surgical, ureterolithotomy	34	UROLOGY	UROLOGY	34	
50947	Laparoscopy, surgical, ureteroneocystostomy with cystoscopy and ureteral stent placement	34	UROLOGY	UROLOGY	34	
50948	Laparoscopy, surgical, ureteroneocystostomy without cystoscopy and ureteral stent placement	34	UROLOGY	UROLOGY	34	
50949	Unlisted laparoscopy procedure, ureter	34	UROLOGY	UROLOGY	34	
50955	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with biopsy	34	UROLOGY	UROLOGY	34	
50957	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with fulguration and/or incision, with or without biopsy	34	UROLOGY	UROLOGY	34	
50970	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service,	34	UROLOGY	UROLOGY	34	
50972	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	34	UROLOGY	UROLOGY	34	

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50974	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with biopsy	34	UROLOGY	UROLOGY	34	
50976	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	34	UROLOGY	UROLOGY	34	
50980	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with removal of foreign body or calculus	34	UROLOGY	UROLOGY	34	
51030	Cystotomy or cystostomy, with cryosurgical destruction of intravesical lesion	34	UROLOGY	UROLOGY	34	
51060	Transvesical ureterolithotomy	34	UROLOGY	UROLOGY	34	
51080	Drainage of perivesical or prevesical space abscess	34	UROLOGY	UROLOGY	34	
51500	Excision of urachal cyst or sinus, with or without umbilical hernia repair	34	UROLOGY	UROLOGY	34	
51520	Cystotomy, for simple excision of vesical neck (separate procedure)	34	UROLOGY	UROLOGY	34	
51535	Cystotomy for excision, incision, or repair of ureterocele	34	UROLOGY	UROLOGY	34	
51580	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations;	34	UROLOGY	UROLOGY	34	
51585	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	34	UROLOGY	UROLOGY	34	
51820	Cystourethroplasty with unilateral or bilateral ureteroneocystostomy	16	OB-GYN	UROLOGY	34	*
51900	Closure of vesicovaginal fistula, abdominal approach	34	UROLOGY	UROLOGY	34	
51920	Closure of vesicouterine fistula;	02	GENERAL SURGERY	UROLOGY	34	*
51925	Closure of vesicouterine fistula; with hysterectomy	16	OB-GYN	OB-GYN	16	
51940	Closure, extrophy of bladder	34	UROLOGY	UROLOGY	34	
51980	Cutaneous vesicostomy	34	UROLOGY	UROLOGY	34	
52301	Cystourethroscopy, with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral	34	UROLOGY	UROLOGY	34	
52343	Cystourethroscopy, with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	34	UROLOGY	UROLOGY	34	
52346	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	34	UROLOGY	UROLOGY	34	
52402	Cystourethroscopy with transurethral resection or incision of ejaculatory ducts			UROLOGY	34	
52510	Transurethral balloon dilation of the prostatic urethra	34	UROLOGY	UROLOGY	34	
52700	Transurethral drainage of prostatic abscess	34	UROLOGY	UROLOGY	34	
53025	Meatotomy, cutting of meatus (separate procedure), infant	34	UROLOGY	UROLOGY	34	
53040	Drainage of deep penurethral abscess	34	UROLOGY	UROLOGY	34	
53060	Drainage of Skene's gland abscess or cyst	16	OB-GYN	OB-GYN	16	
53080	Drainage of penneal urinary extravasation, uncomplicated (separate procedure)	34	UROLOGY	UROLOGY	34	
53210	Urethrectomy, total, including cystostomy; female	34	UROLOGY	UROLOGY	34	
53235	Excision of urethral diverticulum (separate procedure), male	34	UROLOGY	UROLOGY	34	
53240	Marsupialization of urethral diverticulum, male or female	34	UROLOGY	UROLOGY	34	
53250	Excision of bulbourethral gland (Cowper's gland)	34	UROLOGY	UROLOGY	34	
53270	Excision or fulguration; Skene's glands	34	UROLOGY	UROLOGY	34	
53405	Urethroplasty; second stage (formation of urethra), including urinary diversion	34	UROLOGY	UROLOGY	34	
53420	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage	34	UROLOGY	UROLOGY	34	
53425	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; second stage	34	UROLOGY	UROLOGY	34	
53431	Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure)	34	UROLOGY	UROLOGY	34	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
53442	Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)	34	UROLOGY	UROLOGY	34	
53448	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue	34	UROLOGY	UROLOGY	34	
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)	34	UROLOGY	UROLOGY	34	
53502	Urethrorrhaphy, suture of urethral wound or injury, female	34	UROLOGY	UROLOGY	34	
53505	Urethrorrhaphy, suture of urethral wound or injury; penile	34	UROLOGY	UROLOGY	34	
53510	Urethrorrhaphy, suture of urethral wound or injury; perineal	34	UROLOGY	UROLOGY	34	
53515	Urethrorrhaphy, suture of urethral wound or injury, prostaticmembranous	34	UROLOGY	UROLOGY	34	
53520	Closure of urethroostomy or urethrocutaneous fistula, male (separate procedure)	34	UROLOGY	UROLOGY	34	
54000	Slitting of prepuce, dorsal or lateral (separate procedure); newborn	34	UROLOGY	UROLOGY	34	
54110	Excision of penile plaque (Peyronie disease);	34	UROLOGY	UROLOGY	34	
54111	Excision of penile plaque (Peyronie disease); with graft to 5 cm in length	34	UROLOGY	UROLOGY	34	
54112	Excision of penile plaque (Peyronie disease); with graft greater than 5 cm in length	34	UROLOGY	UROLOGY	34	
54115	Removal foreign body from deep penile tissue (eg, plastic implant)	34	UROLOGY	UROLOGY	34	
54130	Amputation of penis, radical; with bilateral inguino-femoral lymphadenectomy	34	UROLOGY	UROLOGY	34	
54135	Amputation of penis, radical; in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	34	UROLOGY	UROLOGY	34	
54150	Circumcision, using clamp or other device, newborn	34	UROLOGY	UROLOGY	34	
54160	Circumcision, surgical excision other than clamp, device or dorsal slit; newborn	34	UROLOGY	UROLOGY	34	
54164	Frenulotomy of penis	34	UROLOGY	UROLOGY	34	
54205	Injection procedure for Peyronie disease; with surgical exposure of plaque	34	UROLOGY	UROLOGY	34	
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra	34	UROLOGY	UROLOGY	34	
54304	Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps	34	UROLOGY	UROLOGY	34	
54308	Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm			UROLOGY	34	
54312	Urethroplasty for second stage hypospadias repair (including urinary diversion); greater than 3 cm	34	UROLOGY	UROLOGY	34	
54316	Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia			UROLOGY	34	
54318	Urethroplasty for third stage hypospadias repair to release penis from scrotum (eg, third stage Cecil repair)			UROLOGY	34	
54322	One stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap)	34	UROLOGY	UROLOGY	34	
54324	One stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps (eg, flip-flap, prepuce flap)	34	UROLOGY	UROLOGY	34	
54326	One stage distal hypospadias repair (with or without chordee or circumcision), with urethroplasty by local skin flaps and mobilization of urethra	34	UROLOGY	UROLOGY	34	
54328	One stage distal hypospadias repair (with or without chordee or circumcision); with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap	34	UROLOGY	UROLOGY	34	
54332	One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	34	UROLOGY	UROLOGY	34	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
54336	One stage penneal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	34	UROLOGY	UROLOGY	34	
54340	Repair of hypospadias complications (ie, fistula, stricture, diverticula), by closure, incision, or excision, simple	34	UROLOGY	UROLOGY	34	
54344	Repair of hypospadias complications (ie, fistula, stricture, diverticula), requiring mobilization of skin flaps and urethroplasty with flap or patch graft	34	UROLOGY	UROLOGY	34	
54348	Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)			UROLOGY	34	
54352	Repair of hypospadias crnpple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts	34	UROLOGY	UROLOGY	34	
54380	Plastic operation on penis for epispadias distal to external sphincter;	34	UROLOGY	UROLOGY	34	
54385	Plastic operation on penis for epispadias distal to external sphincter, with incontinence			UROLOGY	34	
54390	Plastic operation on penis for epispadias distal to external sphincter, with exstrophy of bladder			UROLOGY	34	
54417	Removal and replacement of non-inflatable (semi-ngid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irngation and debndement of infected tissue	34	UROLOGY	UROLOGY	34	
54420	Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral	34	UROLOGY	UROLOGY	34	
54430	Corpora cavernosa-corporis spongiosum shunt (priapism operation), unilateral or bilateral	34	UROLOGY	UROLOGY	34	
54435	Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism	34	UROLOGY	UROLOGY	34	
54440	Plastic operation of penis for injury	34	UROLOGY	UROLOGY	34	
54500	Biopsy of testis, needle (separate procedure)	34	UROLOGY	UROLOGY	34	
54535	Orchiectomy, radical, for tumor; with abdominal exploration	34	UROLOGY	UROLOGY	34	
54550	Exploration for undescended testis (inguinal or scrotal area)	34	UROLOGY	UROLOGY	34	
54560	Exploration for undescended testis with abdominal exploration	34	UROLOGY	UROLOGY	34	
54600	Reduction of torsion of testis, surgical, with or without fixation of contralateral testis	34	UROLOGY	UROLOGY	34	
54620	Fixation of contralateral testis (separate procedure)	34	UROLOGY	UROLOGY	34	
54650	Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)	34	UROLOGY	UROLOGY	34	
54660	Insertion of testicular prosthesis (separate procedure)	34	UROLOGY	UROLOGY	34	
54670	Suture or repair of testicular injury	34	UROLOGY	UROLOGY	34	
54680	Transplantation of testis(es) to thigh (because of scrotal destruction)	34	UROLOGY	UROLOGY	34	
54690	Laparoscopy, surgical, orchiectomy	34	UROLOGY	UROLOGY	34	
54692	Laparoscopy, surgical; orchiopexy for intra-abdominal testis	34	UROLOGY	UROLOGY	34	
54699	Unlisted laparoscopy procedure, testis	34	UROLOGY	UROLOGY	34	
54800	Biopsy of epididymis, needle	34	UROLOGY	UROLOGY	34	
54820	Exploration of epididymis, with or without biopsy	34	UROLOGY	UROLOGY	34	
54861	Epididymectomy; bilateral	34	UROLOGY	UROLOGY	34	
54900	Epididymovasostomy, anastomosis of epididymis to vas deferens, unilateral	34	UROLOGY	UROLOGY	34	
54901	Epididymovasostomy, anastomosis of epididymis to vas deferens, bilateral	34	UROLOGY	UROLOGY	34	
55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)	34	UROLOGY	UROLOGY	34	
55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral	34	UROLOGY	UROLOGY	34	
55400	Vasovasostomy, vasovasorrhaphy	34	UROLOGY	UROLOGY	34	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)	34	UROLOGY	UROLOGY	34	
55535	Excision of varicocele or ligation of spermatic veins for varicocele, abdominal approach	34	UROLOGY	UROLOGY	34	
55550	Laparoscopy, surgical, with ligation of spermatic veins for varicocele	34	UROLOGY	UROLOGY	34	
55605	Vesiculotomy; complicated	34	UROLOGY	UROLOGY	34	
55650	Vesiculectomy, any approach	34	UROLOGY	UROLOGY	34	
55680	Excision of Mullenan duct cyst	34	UROLOGY	UROLOGY	34	
55725	Prostatotomy, external drainage of prostatic abscess, any approach, complicated	34	UROLOGY	UROLOGY	34	
55801	Prostatectomy, penneal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	34	UROLOGY	UROLOGY	34	
55812	Prostatectomy, penneal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	34	UROLOGY	UROLOGY	34	
55862	Exposure of prostate, any approach, for insertion of radioactive substance; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	08	FAMILY PRACTICE	UROLOGY	34	*
55865	Exposure of prostate, any approach, for insertion of radioactive substance; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	34	UROLOGY	UROLOGY	34	
55870	Electroejaculation	34	UROLOGY	UROLOGY	34	
56634	Vulvectomy, radical, complete, with unilateral inguinofemoral lymphadenectomy	98	GYNECOLOGY/ONCOLOGY	GYNECOLOGY/ONCOLOGY	98	
56640	Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy	98	GYNECOLOGY/ONCOLOGY	GYNECOLOGY/ONCOLOGY	98	
56700	Partial hymenectomy or revision of hymenal ring	16	OB-GYN	OB-GYN	16	
56720	Hymenotomy, simple incision	16	OB-GYN	OB-GYN	16	
56805	Clitoroplasty for intersex state	16	OB-GYN	OB-GYN	16	
57000	Colpotomy, with exploration	16	OB-GYN	OB-GYN	16	
57010	Colpotomy; with drainage of pelvic abscess	16	OB-GYN	OB-GYN	16	
57022	Incision and drainage of vaginal hematoma, obstetrical/postpartum	16	OB-GYN	OB-GYN	16	
57023	Incision and drainage of vaginal hematoma; non-obstetrical (eg, post-trauma, spontaneous bleeding)	16	OB-GYN	OB-GYN	16	
57109	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)	16	OB-GYN	GYNECOLOGY/ONCOLOGY	16	*
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)	16	OB-GYN	GYNECOLOGY/ONCOLOGY	16	*
57112	Vaginectomy, complete removal of vaginal wall, with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)	98	GYNECOLOGY/ONCOLOGY	GYNECOLOGY/ONCOLOGY	98	
57130	Excision of vaginal septum	16	OB-GYN	OB-GYN	16	
57230	Plastic repair of urethrocele	16	OB-GYN	OB-GYN	16	
57291	Construction of artificial vagina; without graft	16	OB-GYN	OB-GYN	16	
57292	Construction of artificial vagina; with graft	16	OB-GYN	OB-GYN	16	
57307	Closure of rectovaginal fistula; abdominal approach, with concomitant colostomy	02	GENERAL SURGERY	GENERAL SURGERY	02	
57308	Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction, with or without levator plication	16	OB-GYN	OB-GYN	16	
57310	Closure of urethrovaginal fistula;	34	UROLOGY	UROLOGY	34	
57311	Closure of urethrovaginal fistula; with bulbocavernosus transplant	34	UROLOGY	UROLOGY	34	
57330	Closure of vesicovaginal fistula; transvesical and vaginal approach	34	UROLOGY	UROLOGY	34	
57335	Vaginoplasty for intersex state	16	OB-GYN	OB-GYN	16	
57531	Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling biopsy, with or without removal of tube(s), with or without removal of ovary(s)	16	OB-GYN	OB-GYN	16	
57540	Excision of cervical stump, abdominal approach,	16	OB-GYN	OB-GYN	16	

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57545	Excision of cervical stump, abdominal approach, with pelvic floor repair	16	OB-GYN	OB-GYN	16	
57550	Excision of cervical stump, vaginal approach,	16	OB-GYN	OB-GYN	16	
57555	Excision of cervical stump, vaginal approach, with anterior and/or posterior repair	16	OB-GYN	OB-GYN	16	
57700	Cerclage of uterine cervix, nonobstetrical	16	OB-GYN	OB-GYN	16	
57720	Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach	16	OB-GYN	OB-GYN	16	
58146	Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach	16	OB-GYN	OB-GYN	16	
58285	Vaginal hysterectomy, radical (Schauta type operation)	98	GYNECOLOGY/ONCOLOGY	GYNECOLOGY/ONCOLOGY	98	
58291	Vaginal hysterectomy, for uterus greater than 250 grams, with removal of tube(s) and/or ovary(s)	16	OB-GYN	OB-GYN	16	
58292	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s), with repair of enterocele	16	OB-GYN	OB-GYN	16	
58293	Vaginal hysterectomy, for uterus greater than 250 grams, with colpo-urethrocytopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	16	OB-GYN	OB-GYN	16	
58294	Vaginal hysterectomy, for uterus greater than 250 grams, with repair of enterocele	16	OB-GYN	OB-GYN	16	
58300	Insertion of intrauterine device (IUD)			OB-GYN	16	
58321	Artificial insemination, intra-cervical	16	OB-GYN	OB-GYN	16	
58322	Artificial insemination; intra-uterine	16	OB-GYN	OB-GYN	16	
58323	Sperm washing for artificial insemination	16	OB-GYN	OB-GYN	16	
58345	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography	16	OB-GYN	OB-GYN	16	
58346	Insertion of Heyman capsules for clinical brachytherapy	92	RADIATION ONCOLOGY	GYNECOLOGY/ONCOLOGY	98	*
58350	Chromotubation of oviduct, including materials	16	OB-GYN	OB-GYN	16	
58410	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrotuberous ligaments; with presacral sympathectomy	16	OB-GYN	OB-GYN	16	
58520	Hysterorrhaphy, repair of ruptured uterus (nonobstetrical)	16	OB-GYN	OB-GYN	16	
58540	Hysteroplasty, repair of uterine anomaly (Strassman type)	16	OB-GYN	OB-GYN	16	
58545	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas	16	OB-GYN	OB-GYN	16	
58546	Laparoscopy, surgical, myomectomy, excision, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams	16	OB-GYN	OB-GYN	16	
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;	16	OB-GYN	OB-GYN	16	
58560	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)	16	OB-GYN	OB-GYN	16	
58562	Hysteroscopy, surgical, with removal of impacted foreign body	16	OB-GYN	OB-GYN	16	
58579	Unlisted hysteroscopy procedure, uterus	16	OB-GYN	OB-GYN	16	
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	16	OB-GYN	OB-GYN	16	
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)	16	OB-GYN	OB-GYN	16	
58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	16	OB-GYN	OB-GYN	16	
58672	Laparoscopy, surgical, with fimbrioplasty	16	OB-GYN	OB-GYN	16	
58673	Laparoscopy, surgical, with salpingostomy (salpingoneostomy)	16	OB-GYN	OB-GYN	16	
58679	Unlisted laparoscopy procedure, oviduct, ovary	16	OB-GYN	OB-GYN	16	
58750	Tubotubal anastomosis	16	OB-GYN	OB-GYN	16	
58752	Tubouterine implantation	16	OB-GYN	OB-GYN	16	
58760	Fimbrioplasty	16	OB-GYN	OB-GYN	16	

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58770	Salpingostomy (salpingoneostomy)	16	OB-GYN	OB-GYN	16	
58800	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure), vaginal approach	16	OB-GYN	OB-GYN	16	
58820	Drainage of ovarian abscess, vaginal approach, open	16	OB-GYN	OB-GYN	16	
58822	Drainage of ovarian abscess, abdominal approach	02	GENERAL SURGERY	OB-GYN	16	*
58825	Transposition, ovary(s)	16	OB-GYN	OB-GYN	16	
58900	Biopsy of ovary, unilateral or bilateral (separate procedure)	02	GENERAL SURGERY	OB-GYN	16	*
58920	Wedge resection or bisection of ovary, unilateral or bilateral	02	GENERAL SURGERY	OB-GYN	16	*
58970	Follicle puncture for oocyte retrieval, any method	16	OB-GYN	OB-GYN	16	
58974	Embryo transfer, intrauterine	16	OB-GYN	OB-GYN	16	
58976	Gamete, zygote, or embryo intrafallopian transfer, any method			OB-GYN	16	
59001	Amniocentesis, therapeutic amniotic fluid reduction (includes ultrasound guidance)	16	OB-GYN	OB-GYN	16	
59012	Cordocentesis (intrauterine), any method	16	OB-GYN	OB-GYN	16	
59015	Chorionic villus sampling, any method	16	OB-GYN	OB-GYN	16	
59020	Fetal contraction stress test	16	OB-GYN	OB-GYN	16	
59030	Fetal scalp blood sampling	16	OB-GYN	OB-GYN	16	
59050	Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report, supervision and interpretation	16	OB-GYN	OB-GYN	16	
59070	Transabdominal amniocentesis, including ultrasound guidance			OB-GYN	16	
59072	Fetal umbilical cord occlusion, including ultrasound guidance			OB-GYN	16	
59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance			OB-GYN	16	
59076	Fetal shunt placement, including ultrasound guidance			OB-GYN	16	
59100	Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)	16	OB-GYN	OB-GYN	16	
59120	Surgical treatment of ectopic pregnancy, tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	16	OB-GYN	OB-GYN	16	
59121	Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy	16	OB-GYN	OB-GYN	16	
59130	Surgical treatment of ectopic pregnancy, abdominal pregnancy	16	OB-GYN	OB-GYN	16	
59135	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy	16	OB-GYN	OB-GYN	16	
59136	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy with partial resection of uterus	16	OB-GYN	OB-GYN	16	
59140	Surgical treatment of ectopic pregnancy; cervical, with evacuation	16	OB-GYN	OB-GYN	16	
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	16	OB-GYN	OB-GYN	16	
59151	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy	16	OB-GYN	OB-GYN	16	
59160	Curettage, postpartum	16	OB-GYN	OB-GYN	16	
59300	Episiotomy or vaginal repair, by other than attending physician	16	OB-GYN	OB-GYN	16	
59320	Cerclage of cervix, during pregnancy, vaginal	16	OB-GYN	OB-GYN	16	
59325	Cerclage of cervix, during pregnancy; abdominal			OB-GYN	16	
59350	Hysterorrhaphy of ruptured uterus	16	OB-GYN	OB-GYN	16	
59412	External cephalic version, with or without tocolysis	16	OB-GYN	OB-GYN	16	
59414	Delivery of placenta (separate procedure)	16	OB-GYN	OB-GYN	16	
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)	16	OB-GYN	OB-GYN	16	
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	16	OB-GYN	OB-GYN	16	
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	16	OB-GYN	OB-GYN	16	

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59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	16	OB-GYN	OB-GYN	16	
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	16	OB-GYN	OB-GYN	16	
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery,	16	OB-GYN	OB-GYN	16	
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care	16	OB-GYN	OB-GYN	16	
59821	Treatment of missed abortion, completed surgically; second trimester	16	OB-GYN	OB-GYN	16	
59830	Treatment of septic abortion, completed surgically	16	OB-GYN	OB-GYN	16	
59840	Induced abortion, by dilation and curettage	16	OB-GYN	OB-GYN	16	
59841	Induced abortion, by dilation and evacuation	16	OB-GYN	OB-GYN	16	
59850	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines,			OB-GYN	16	
59851	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines, with dilation and curettage and/or evacuation	16	OB-GYN	OB-GYN	16	
59852	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines, with hysterotomy (failed intra-amniotic injection)			OB-GYN	16	
59855	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines,	16	OB-GYN	OB-GYN	16	
59856	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	16	OB-GYN	OB-GYN	16	
59857	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed medical evacuation)			OB-GYN	16	
59866	Multifetal pregnancy reduction(s) (MPR)			OB-GYN	16	
59870	Uterine evacuation and curettage for hydatidiform mole	16	OB-GYN	OB-GYN	16	
59871	Removal of cerclage suture under anesthesia (other than local)	16	OB-GYN	OB-GYN	16	
60000	Incision and drainage of thyroglossal duct cyst, infected	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
60281	Excision of thyroglossal duct cyst or sinus; recurrent	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
60605	Excision of carotid body tumor; with excision of carotid artery	77	VASCULAR SURGERY	VASCULAR SURGERY	77	
61000	Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial	34	UROLOGY	NEUROSURGERY	14	*
61001	Subdural tap through fontanelle, or suture, infant, unilateral or bilateral, subsequent taps	14	NEUROSURGERY	NEUROSURGERY	14	
61120	Burr hole(s) for ventricular puncture (including injection of gas, contrast media, dye, or radioactive material)	14	NEUROSURGERY	NEUROSURGERY	14	
61150	Burr hole(s) or trephine, with drainage of brain abscess or cyst	14	NEUROSURGERY	NEUROSURGERY	14	
61151	Burr hole(s) or trephine; with subsequent tapping (aspiration) of intracranial abscess or cyst	14	NEUROSURGERY	NEUROSURGERY	14	
61250	Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery	14	NEUROSURGERY	NEUROSURGERY	14	

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61253	Burr hole(s) or trephine, infratentorial, unilateral or bilateral	14	NEUROSURGERY	NEUROSURGERY	14	
61305	Craniectomy or craniotomy, exploratory, infratentorial (posterior fossa)	14	NEUROSURGERY	NEUROSURGERY	14	
61316	Incision and subcutaneous placement of cranial bone graft (List separately in addition to code for primary procedure)	14	NEUROSURGERY	NEUROSURGERY	14	
61321	Craniectomy or craniotomy, drainage of intracranial abscess; infratentorial	14	NEUROSURGERY	NEUROSURGERY	14	
61322	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma, without lobectomy	14	NEUROSURGERY	NEUROSURGERY	14	
61323	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; with lobectomy	14	NEUROSURGERY	NEUROSURGERY	14	
61330	Decompression of orbit only, transcranial approach	18	OPHTHALMOLOGY	NEUROSURGERY	14	*
61332	Exploration of orbit (transcranial approach), with biopsy	14	NEUROSURGERY	NEUROSURGERY	14	
61333	Exploration of orbit (transcranial approach), with removal of lesion	14	NEUROSURGERY	NEUROSURGERY	14	
61334	Exploration of orbit (transcranial approach), with removal of foreign body	04	OTOLARYNGOLOGY	NEUROSURGERY	14	*
61340	Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome)	14	NEUROSURGERY	NEUROSURGERY	14	
61345	Other cranial decompression, posterior fossa	14	NEUROSURGERY	NEUROSURGERY	14	
61440	Craniotomy for section of tentorium cerebelli (separate procedure)	14	NEUROSURGERY	NEUROSURGERY	14	
61450	Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion	14	NEUROSURGERY	NEUROSURGERY	14	
61460	Craniectomy, suboccipital, for section of one or more cranial nerves	14	NEUROSURGERY	NEUROSURGERY	14	
61470	Craniectomy, suboccipital, for medullary tractotomy	14	NEUROSURGERY	NEUROSURGERY	14	
61480	Craniectomy, suboccipital; for mesencephalic tractotomy or pedunculotomy			NEUROSURGERY	14	
61490	Craniotomy for lobotomy, including cingulotomy	14	NEUROSURGERY	NEUROSURGERY	14	
61521	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; midline tumor at base of skull	14	NEUROSURGERY	NEUROSURGERY	14	
61522	Craniectomy, infratentorial or posterior fossa; for excision of brain abscess	14	NEUROSURGERY	NEUROSURGERY	14	
61524	Craniectomy, infratentorial or posterior fossa; for excision or fenestration of cyst	14	NEUROSURGERY	NEUROSURGERY	14	
61526	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;	04	OTOLARYNGOLOGY	NEUROSURGERY	14	*
61530	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa craniotomy/craniectomy	14	NEUROSURGERY	NEUROSURGERY	14	
61531	Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring	14	NEUROSURGERY	NEUROSURGERY	14	
61534	Craniotomy with elevation of bone flap; for excision of epileptogenic focus without electrocorticography during surgery	14	NEUROSURGERY	NEUROSURGERY	14	
61535	Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)	14	NEUROSURGERY	NEUROSURGERY	14	
61536	Craniotomy with elevation of bone flap, for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)	14	NEUROSURGERY	NEUROSURGERY	14	
61539	Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, with electrocorticography during surgery	14	NEUROSURGERY	NEUROSURGERY	14	
61541	Craniotomy with elevation of bone flap; for transection of corpus callosum	14	NEUROSURGERY	NEUROSURGERY	14	
61542	Craniotomy with elevation of bone flap; for total hemispherectomy	14	NEUROSURGERY	NEUROSURGERY	14	

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61543	Craniotomy with elevation of bone flap; for partial or subtotal (functional) hemispherectomy	14	NEUROSURGERY	NEUROSURGERY	14	
61544	Craniotomy with elevation of bone flap, for excision or coagulation of choroid plexus			NEUROSURGERY	14	
61545	Craniotomy with elevation of bone flap; for excision of craniopharyngioma	14	NEUROSURGERY	NEUROSURGERY	14	
61546	Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach	14	NEUROSURGERY	NEUROSURGERY	14	
61550	Craniectiony for craniostynostosis; single cranial suture	04	OTOLARYNGOLOGY	NEUROSURGERY	14	*
61552	Craniectiony for craniostynostosis; multiple cranial sutures			NEUROSURGERY	14	
61556	Craniotomy for craniostynostosis; frontal or panetal bone flap	14	NEUROSURGERY	NEUROSURGERY	14	
61557	Craniotomy for craniostynostosis; bfrontal bone flap	14	NEUROSURGERY	NEUROSURGERY	14	
61558	Extensive craniectiony for multiple cranial suture craniostynostosis (eg, cloverleaf skull), not requirng bone grafts			NEUROSURGERY	14	
61559	Extensive craniectiony for multiple cranial suture craniostynostosis (eg, cloverleaf skull), recontourng with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts)	14	NEUROSURGERY	NEUROSURGERY	14	
61563	Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia), without optic nerve decompression	14	NEUROSURGERY	NEUROSURGERY	14	
61564	Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); with optic nerve decompression	14	NEUROSURGERY	NEUROSURGERY	14	
61570	Craniectiony or craniotomy, with excision of foreign body from brain	14	NEUROSURGERY	NEUROSURGERY	14	
61571	Craniectiony or craniotomy, with treatment of penetrating wound of brain	14	NEUROSURGERY	NEUROSURGERY	14	
61575	Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion;	14	NEUROSURGERY	NEUROSURGERY	14	
61576	Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion; requirng splitting of tongue and/or mandible (including tracheostomy)	04	OTOLARYNGOLOGY	NEUROSURGERY	14	*
61581	Craniofacial approach to anterior cranial fossa, extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
61582	Craniofacial approach to anterior cranial fossa; extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa	14	NEUROSURGERY	NEUROSURGERY	14	
61585	Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s), with orbital exenteration	14	NEUROSURGERY	NEUROSURGERY	14	
61586	Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft	14	NEUROSURGERY	NEUROSURGERY	14	
61591	Infratemporal post-auncular approach to middle cranial fossa (internal auditory meatus, petrous apex, tentonum, cavernous sinus, parasellar area, infratemporal fossa) including mastoidectomy, resection of sigmoid sinus, with or without decompression and/or mobilization of contents of auditory canal or petrous carotid artery	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
61596	Transcochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve and/or petrous carotid artery	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
61598	Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus	14	NEUROSURGERY	NEUROSURGERY	14	

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61606	Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; intradural, including dural repair, with or without graft	14	NEUROSURGERY	NEUROSURGERY	14	
61607	Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base, extradural	14	NEUROSURGERY	NEUROSURGERY	14	
61609	Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure)	14	NEUROSURGERY	NEUROSURGERY	14	
61610	Transection or ligation, carotid artery in cavernous sinus; with repair by anastomosis or graft (List separately in addition to code for primary procedure)	14	NEUROSURGERY	NEUROSURGERY	14	
61611	Transection or ligation, carotid artery in petrous canal, without repair (List separately in addition to code for primary procedure)			NEUROSURGERY	14	
61612	Transection or ligation, carotid artery in petrous canal, with repair by anastomosis or graft (List separately in addition to code for primary procedure)			NEUROSURGERY	14	
61613	Obliteration of carotid aneurysm, arterovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus	14	NEUROSURGERY	NEUROSURGERY	14	
61615	Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 vertebral bodies; extradural	04	OTOLARYNGOLOGY	NEUROSURGERY	14	*
61619	Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by local or regionalized vascularized pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle)	14	NEUROSURGERY	NEUROSURGERY	14	
61680	Surgery of intracranial arterovenous malformation; supratentorial, simple	14	NEUROSURGERY	NEUROSURGERY	14	
61684	Surgery of intracranial arterovenous malformation, infratentorial, simple	14	NEUROSURGERY	NEUROSURGERY	14	
61686	Surgery of intracranial arterovenous malformation; infratentorial, complex	14	NEUROSURGERY	NEUROSURGERY	14	
61690	Surgery of intracranial arterovenous malformation; dural, simple	14	NEUROSURGERY	NEUROSURGERY	14	
61692	Surgery of intracranial arterovenous malformation; dural, complex	14	NEUROSURGERY	NEUROSURGERY	14	
61698	Surgery of complex intracranial aneurysm, intracranial approach, vertebrobasilar circulation	14	NEUROSURGERY	NEUROSURGERY	14	
61702	Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation	14	NEUROSURGERY	NEUROSURGERY	14	
61703	Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)	14	NEUROSURGERY	NEUROSURGERY	14	
61705	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery	14	NEUROSURGERY	NEUROSURGERY	14	
61708	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial electrothrombosis	30	DIAGNOSTIC RADIOLOGY	NEUROSURGERY	14	*
61711	Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries	14	NEUROSURGERY	NEUROSURGERY	14	
61735	Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages, subcortical structure(s) other than globus pallidus or thalamus	13	NEUROLOGY	NEUROSURGERY	13	*
61760	Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring	14	NEUROSURGERY	NEUROSURGERY	14	
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	14	NEUROSURGERY	NEUROSURGERY	14	
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical	14	NEUROSURGERY	NEUROSURGERY	14	
61870	Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical	14	NEUROSURGERY	NEUROSURGERY	14	

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61875	Craniectomy for implantation of neurostimulator electrodes, cerebellar, subcortical			NEUROSURGERY	14	
62000	Elevation of depressed skull fracture; simple, extradural	34	UROLOGY	NEUROSURGERY	14	*
62005	Elevation of depressed skull fracture; compound or comminuted, extradural	14	NEUROSURGERY	NEUROSURGERY	14	
62010	Elevation of depressed skull fracture, with repair of dura and/or debndement of brain	14	NEUROSURGERY	NEUROSURGERY	14	
62115	Reduction of craniomegalic skull (eg, treated hydrocephalus); not requiring bone grafts or cranioplasty			NEUROSURGERY	14	
62116	Reduction of craniomegalic skull (eg, treated hydrocephalus), with simple cranioplasty	14	NEUROSURGERY	NEUROSURGERY	14	
62117	Reduction of craniomegalic skull (eg, treated hydrocephalus), requiring craniotomy and reconstruction with or without bone graft (includes obtaining grafts)	14	NEUROSURGERY	NEUROSURGERY	04	
62120	Repair of encephalocele, skull vault, including cranioplasty	04	OTOLARYNGOLOGY	NEUROSURGERY	14	*
62121	Craniotomy for repair of encephalocele, skull base	14	NEUROSURGERY	NEUROSURGERY	14	
62146	Cranioplasty with autograft (includes obtaining bone grafts), up to 5 cm diameter	14	NEUROSURGERY	NEUROSURGERY	14	
62147	Cranioplasty with autograft (includes obtaining bone grafts), larger than 5 cm diameter	14	NEUROSURGERY	NEUROSURGERY	14	
62148	Incision and retrieval of subcutaneous cranial bone graft for cranioplasty (List separately in addition to code for primary procedure)	14	NEUROSURGERY	NEUROSURGERY	14	
62161	Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)	14	NEUROSURGERY	NEUROSURGERY	14	
62162	Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage	14	NEUROSURGERY	NEUROSURGERY	14	
62163	Neuroendoscopy, intracranial; with retrieval of foreign body	14	NEUROSURGERY	NEUROSURGERY	14	
62164	Neuroendoscopy, intracranial; with excision of brain tumor, including placement of external ventricular catheter for drainage	14	NEUROSURGERY	NEUROSURGERY	14	
62165	Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach	14	NEUROSURGERY	NEUROSURGERY	14	
62180	Ventriculocisternostomy (Torkildsen type operation)	14	NEUROSURGERY	NEUROSURGERY	14	
62190	Creation of shunt, subarachnoid/subdural-atral, -jugular, -auricular	14	NEUROSURGERY	NEUROSURGERY	14	
62194	Replacement or imigation, subarachnoid/subdural catheter	14	NEUROSURGERY	NEUROSURGERY	14	
62200	Ventriculocisternostomy, third ventricle;	14	NEUROSURGERY	NEUROSURGERY	14	
62201	Ventriculocisternostomy, third ventricle; stereotactic, neuroendoscopic method	14	NEUROSURGERY	NEUROSURGERY	14	
62292	Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05	
62294	Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal	30	DIAGNOSTIC RADIOLOGY	NEUROSURGERY	14	*
63066	Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic, each additional segment (List separately in addition to code for primary procedure)	14	NEUROSURGERY	NEUROSURGERY	14	
63170	Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic, or thoracolumbar	14	NEUROSURGERY	NEUROSURGERY	14	
63173	Laminectomy with drainage of intramedullary cyst/syrinx; to peritoneal or pleural space	14	NEUROSURGERY	NEUROSURGERY	14	
63180	Laminectomy and section of dentate ligaments, with or without dural graft, cervical; one or two segments	14	NEUROSURGERY	NEUROSURGERY	14	
63182	Laminectomy and section of dentate ligaments, with or without dural graft, cervical, more than two segments	14	NEUROSURGERY	NEUROSURGERY	14	
63185	Laminectomy with rhizotomy; one or two segments	14	NEUROSURGERY	NEUROSURGERY	14	

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63190	Laminectomy with rhizotomy; more than two segments	14	NEUROSURGERY	NEUROSURGERY	14	
63191	Laminectomy with section of spinal accessory nerve	14	NEUROSURGERY	NEUROSURGERY	14	
63194	Laminectomy with cordotomy, with section of one spinothalamic tract, one stage, cervical	14	NEUROSURGERY	NEUROSURGERY	14	
63195	Laminectomy with cordotomy, with section of one spinothalamic tract, one stage, thoracic	14	NEUROSURGERY	NEUROSURGERY	14	
63196	Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage, cervical	14	NEUROSURGERY	NEUROSURGERY	14	
63197	Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage; thoracic			NEUROSURGERY	14	
63198	Laminectomy with cordotomy with section of both spinothalamic tracts, two stages within 14 days, cervical			NEUROSURGERY	14	
63199	Laminectomy with cordotomy with section of both spinothalamic tracts, two stages within 14 days; thoracic			NEUROSURGERY	14	
63200	Laminectomy, with release of tethered spinal cord, lumbar	14	NEUROSURGERY	NEUROSURGERY	14	
63250	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord, cervical	14	NEUROSURGERY	NEUROSURGERY	14	
63251	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracic	14	NEUROSURGERY	NEUROSURGERY	14	
63252	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar	14	NEUROSURGERY	NEUROSURGERY	14	
63268	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral	14	NEUROSURGERY	NEUROSURGERY	14	
63270	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural, cervical	14	NEUROSURGERY	NEUROSURGERY	14	
63273	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural, sacral	14	NEUROSURGERY	NEUROSURGERY	14	
63278	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral	14	NEUROSURGERY	NEUROSURGERY	14	
63283	Laminectomy for biopsy/excision of intraspinal neoplasm, intradural, sacral	14	NEUROSURGERY	NEUROSURGERY	14	
63285	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical	14	NEUROSURGERY	NEUROSURGERY	14	
63286	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic	14	NEUROSURGERY	NEUROSURGERY	14	
63287	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar	14	NEUROSURGERY	NEUROSURGERY	14	
63290	Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level	14	NEUROSURGERY	NEUROSURGERY	14	
63300	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical	14	NEUROSURGERY	NEUROSURGERY	14	
63301	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach	14	NEUROSURGERY	NEUROSURGERY	14	
63302	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by thoracolumbar approach	14	NEUROSURGERY	NEUROSURGERY	14	
63303	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal approach	14	NEUROSURGERY	NEUROSURGERY	14	
63304	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical	14	NEUROSURGERY	NEUROSURGERY	14	
63305	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by transthoracic approach	14	NEUROSURGERY	NEUROSURGERY	14	

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63306	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment, intradural, thoracic by thoracolumbar approach	14	NEUROSURGERY	NEUROSURGERY	14	
63307	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment, intradural, lumbar or sacral by transperitoneal or retroperitoneal approach	20	ORTHOPEDIC SURGERY	NEUROSURGERY	14	*
63308	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment, each additional segment (List separately in addition to codes for single segment)	14	NEUROSURGERY	NEUROSURGERY	14	
63610	Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery	09	INTERVENTIONAL PAIN MANAGEMENT	NEUROSURGERY	14	*
63615	Stereotactic biopsy, aspiration, or excision of lesion, spinal cord	14	NEUROSURGERY	NEUROSURGERY	14	
63700	Repair of meningocele; less than 5 cm diameter	20	ORTHOPEDIC SURGERY	NEUROSURGERY	14	*
63702	Repair of meningocele; larger than 5 cm diameter	14	NEUROSURGERY	NEUROSURGERY	14	
63704	Repair of myelomeningocele; less than 5 cm diameter	20	ORTHOPEDIC SURGERY	NEUROSURGERY	14	*
63706	Repair of myelomeningocele, larger than 5 cm diameter	14	NEUROSURGERY	NEUROSURGERY	14	
63746	Removal of entire lumbosubarachnoid shunt system without replacement	14	NEUROSURGERY	NEUROSURGERY	14	
64410	Injection, anesthetic agent, phrenic nerve	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05	
64508	Injection, anesthetic agent; carotid sinus (separate procedure)	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05	
64553	Percutaneous implantation of neurostimulator electrodes, cranial nerve	04	OTOLARYNGOLOGY	NEUROSURGERY	14	*
64560	Percutaneous implantation of neurostimulator electrodes; autonomic nerve	08	FAMILY PRACTICE	NEUROSURGERY	14	*
64577	Incision for implantation of neurostimulator electrodes; autonomic nerve	14	NEUROSURGERY	NEUROSURGERY	14	
64580	Incision for implantation of neurostimulator electrodes; neuromuscular	34	UROLOGY	NEUROSURGERY	14	*
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale	14	NEUROSURGERY	NEUROSURGERY	14	
64732	Transection or avulsion of; supraorbital nerve	14	NEUROSURGERY	NEUROSURGERY	14	
64734	Transection or avulsion of; infraorbital nerve	14	NEUROSURGERY	NEUROSURGERY	14	
64736	Transection or avulsion of; mental nerve	19	ORAL SURGERY	ORAL SURGERY	19	
64738	Transection or avulsion of; inferior alveolar nerve by osteotomy	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
64740	Transection or avulsion of, lingual nerve	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85	
64742	Transection or avulsion of, facial nerve, differential or complete	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
64746	Transection or avulsion of, phrenic nerve	33	THORACIC SURGERY	THORACIC SURGERY	33	
64752	Transection or avulsion of; vagus nerve (vagusotomy), transthoracic	02	GENERAL SURGERY	GENERAL SURGERY	02	
64755	Transection or avulsion of; vagus nerves limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)	02	GENERAL SURGERY	GENERAL SURGERY	02	
64760	Transection or avulsion of; vagus nerve (vagusotomy), abdominal	02	GENERAL SURGERY	GENERAL SURGERY	02	
64761	Transection or avulsion of; pudendal nerve	16	OB-GYN	OB-GYN	16	
64763	Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
64766	Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy	16	OB-GYN	OB-GYN	16	
64771	Transection or avulsion of other cranial nerve, extradural	14	NEUROSURGERY	NEUROSURGERY	14	
64778	Excision of neuroma; digital nerve, each additional digit (List separately in addition to code for primary procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
64783	Excision of neuroma; hand or foot, each additional nerve, except same digit (List separately in addition to code for primary procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	

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64786	Excision of neuroma, sciatic nerve	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
64802	Sympathectomy, cervical	72	DIAGNOSTIC LABORATORY	NEUROSURGERY	14	*
64804	Sympathectomy, cervicothoracic	14	NEUROSURGERY	NEUROSURGERY	14	
64809	Sympathectomy, thoracolumbar	05	ANESTHESIOLOGY	NEUROSURGERY	14	*
64821	Sympathectomy; radial artery	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
64822	Sympathectomy, ulnar artery	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
64823	Sympathectomy; superficial palmar arch	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
64835	Suture of one nerve, hand or foot, median motor thenar	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
64836	Suture of one nerve, hand or foot, ulnar motor	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	24	*
64837	Suture of each additional nerve, hand or foot (List separately in addition to code for primary procedure)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	24	*
64840	Suture of posterior tibial nerve	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	24	*
64858	Suture of sciatic nerve	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
64859	Suture of each additional major peripheral nerve (List separately in addition to code for primary procedure)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
64861	Suture of, brachial plexus	14	NEUROSURGERY	NEUROSURGERY	14	
64862	Suture of, lumbar plexus	14	NEUROSURGERY	NEUROSURGERY	14	
64865	Suture of facial nerve; infratemporal, with or without grafting	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
64866	Anastomosis; facial-spinal accessory	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
64868	Anastomosis; facial-hypoglossal	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
64870	Anastomosis; facial-phrenic			OTOLARYNGOLOGY	04	
64872	Suture of nerve; requiring secondary or delayed suture (List separately in addition to code for primary neurotaphy)	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
64874	Suture of nerve; requiring extensive mobilization, or transposition of nerve (List separately in addition to code for nerve suture)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
64876	Suture of nerve; requiring shortening of bone of extremity (List separately in addition to code for nerve suture)			ORTHOPEDIC SURGERY	20	
64885	Nerve graft (includes obtaining graft), head or neck, up to 4 cm in length	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
64886	Nerve graft (includes obtaining graft), head or neck; more than 4 cm length	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
64890	Nerve graft (includes obtaining graft), single strand, hand or foot, up to 4 cm length	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
64891	Nerve graft (includes obtaining graft), single strand, hand or foot; more than 4 cm length	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20	*
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
64893	Nerve graft (includes obtaining graft), single strand, arm or leg; more than 4 cm length	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
64895	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
64897	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg, up to 4 cm length	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
64898	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; more than 4 cm length	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
64901	Nerve graft, each additional nerve, single strand (List separately in addition to code for primary procedure)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*

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64902	Nerve graft, each additional nerve, multiple strands (cable) (List separately in addition to code for primary procedure)	24	PLASTIC AND RECONSTRUCTIVE SURGERY	ORTHOPEDIC SURGERY	20	*
64905	Nerve pedicle transfer; first stage	18	OPHTHALMOLOGY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	*
64907	Nerve pedicle transfer; second stage	24	PLASTIC AND RECONSTRUCTIVE SURGERY	PLASTIC AND RECONSTRUCTIVE SURGERY	24	
65110	Exenteration of orbit (does not include skin graft), removal of orbital contents, only	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65112	Exenteration of orbit (does not include skin graft), removal of orbital contents, with therapeutic removal of bone	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65114	Exenteration of orbit (does not include skin graft), removal of orbital contents, with muscle or myocutaneous flap	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65125	Modification of ocular implant with placement or replacement of pegs (eg, drilling receptacle for prosthesis appendage) (separate procedure)	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65130	Insertion of ocular implant secondary; after evisceration, in scleral shell	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65135	Insertion of ocular implant secondary, after enucleation, muscles not attached to implant	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65140	Insertion of ocular implant secondary, after enucleation, muscles attached to implant	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65150	Reinsertion of ocular implant, with or without conjunctival graft	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65155	Reinsertion of ocular implant, with use of foreign material for reinforcement and/or attachment of muscles to implant	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65260	Removal of foreign body, intraocular; from posterior segment, magnetic extraction, anterior or posterior route	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65272	Repair of laceration, conjunctiva, by mobilization and rearrangement, without hospitalization	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65273	Repair of laceration; conjunctiva, by mobilization and rearrangement, with hospitalization	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65290	Repair of wound, extraocular muscle, tendon and/or Tenon's capsule	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65760	Keratomileusis			OPHTHALMOLOGY	18	
65765	Keratophakia			OPHTHALMOLOGY	18	
65767	Epikeratoplasty	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
65771	Radial keratotomy			OPHTHALMOLOGY	18	
65780	Ocular surface reconstruction, amniotic membrane transplantation			OPHTHALMOLOGY	18	
65781	Ocular surface reconstruction; limbal stem cell allograft (eg, cadaveric or living donor)			OPHTHALMOLOGY	18	
65782	Ocular surface reconstruction, limbal conjunctival autograft (includes obtaining graft)			OPHTHALMOLOGY	18	
65820	Goniotomy	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
66155	Fistulization of sclera for glaucoma; thermocauterization with indectomy	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
66165	Fistulization of sclera for glaucoma; indencleisis or indotasis	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
66220	Repair of scleral staphyloma; without graft	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
66505	Indotomy by stab incision (separate procedure), with transfixion as for ins bombe	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
66605	Indectomy, with corneoscleral or corneal section; with cyclectomy	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
66700	Ciliary body destruction; diathermy	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
66920	Removal of lens material, intracapsular	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
67250	Scleral reinforcement (separate procedure), without graft	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
67334	Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
67340	Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	

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67350	Biopsy of extraocular muscle	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
67415	Fine needle aspiration of orbital contents	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
67430	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein), with removal of foreign body	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
67440	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein), with drainage	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
67599	Unlisted procedure, orbit	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
67906	Repair of blepharoptosis, superior rectus technique with fascial sling (includes obtaining fascia)	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
68500	Excision of lacrimal gland (dacryoadenectomy), except for tumor; total	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
68505	Excision of lacrimal gland (dacryoadenectomy), except for tumor; partial	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
68510	Biopsy of lacrimal gland	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
68540	Excision of lacrimal gland tumor; frontal approach	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
68550	Excision of lacrimal gland tumor; involving osteotomy	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
68745	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity), without tube	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
68770	Closure of lacrimal fistula (separate procedure)	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
69155	Radical excision external auditory canal lesion; with neck dissection	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69300	Otoplasty, protruding ear, with or without size reduction	24	PLASTIC AND RECONSTRUCTIVE SURGERY	OTOLARYNGOLOGY	04	*
69320	Reconstruction external auditory canal for congenital atresia, single stage	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69405	Eustachian tube catheterization, transtympanic	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69501	Transmastoid antrotomy (simple mastoidectomy)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69511	Mastoidectomy; radical	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69530	Petrous apicectomy including radical mastoidectomy	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69550	Excision aural glomus tumor; transcanal	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69552	Excision aural glomus tumor; transmastoid	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69554	Excision aural glomus tumor; extended (extratemporal)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69601	Revision mastoidectomy; resulting in complete mastoidectomy	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69602	Revision mastoidectomy; resulting in modified radical mastoidectomy	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69603	Revision mastoidectomy; resulting in radical mastoidectomy	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69604	Revision mastoidectomy; resulting in tympanoplasty	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69605	Revision mastoidectomy; with apicectomy	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69650	Stapes mobilization	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69670	Mastoid obliteration (separate procedure)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69676	Tympanic neurectomy	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69700	Closure postauricular fistula, mastoid (separate procedure)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	18	OPHTHALMOLOGY	OTOLARYNGOLOGY	04	*
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	20	ORTHOPEDIC SURGERY	OTOLARYNGOLOGY	04	*
69725	Decompression facial nerve, intratemporal, including medial to geniculate ganglion	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69740	Suture facial nerve, intratemporal, with or without graft or decompression, lateral to geniculate ganglion	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	

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69745	Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69802	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); with mastoidectomy	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69805	Endolymphatic sac operation, without shunt	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69820	Fenestration semicircular canal	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69840	Revision fenestration operation	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69905	Labyrinthectomy, transcanal	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69915	Vestibular nerve section, translabyrinthine approach	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69950	Vestibular nerve section, transcranial approach	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69955	Total facial nerve decompression and/or repair (may include graft)	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69960	Decompression internal auditory canal	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
69970	Removal of tumor, temporal bone	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)			DIAGNOSTIC RADIOLOGY	30	
74235	Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
74440	Vasography, vesiculography, or epididymography, radiological supervision and interpretation	34	UROLOGY	UROLOGY	34	
74445	Corpora cavernosography, radiological supervision and interpretation	34	UROLOGY	UROLOGY	34	
74710	Pelvimetry, with or without placental localization	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
75803	Lymphangiography, extremity only, bilateral, radiological supervision and interpretation	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
75805	Lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
75807	Lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
75810	Splenoportography, radiological supervision and interpretation	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
75840	Venography, adrenal, unilateral, selective, radiological supervision and interpretation	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
75880	Venography, orbital, radiological supervision and interpretation	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
76150	Xeroradiography	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20	
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	16	OB-GYN	OB-GYN	16	
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording, follow-up or repeat study	16	OB-GYN	OB-GYN	16	
76885	Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
76886	Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician manipulation)	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
76940	Ultrasound guidance for, and monitoring of, visceral tissue ablation	48	PODIATRY	DIAGNOSTIC RADIOLOGY	30	*
76941	Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	34	UROLOGY	OB-GYN	16	*
76945	Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation	16	OB-GYN	OB-GYN	16	
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	16	OB-GYN	OB-GYN	16	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
78135	Red cell survival study, differential organ/tissue kinetics, (eg, splenic and/or hepatic sequestration)	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
78160	Plasma radioiron disappearance (turnover) rate			DIAGNOSTIC RADIOLOGY	30	
78170	Radioiron red cell utilization	20	ORTHOPEDIC SURGERY	NUCLEAR MEDICINE	36	*
78230	Salivary gland imaging;	30	DIAGNOSTIC RADIOLOGY	NUCLEAR MEDICINE	36	*
78231	Salivary gland imaging, with serial images	30	DIAGNOSTIC RADIOLOGY	NUCLEAR MEDICINE	36	*
78232	Salivary gland function study	36	NUCLEAR MEDICINE	NUCLEAR MEDICINE	36	
78351	Bone density (bone mineral content) study, one or more sites; dual photon absorptometry, one or more sites			DIAGNOSTIC RADIOLOGY	30	
78647	Cerebrospinal fluid flow, imaging (not including introduction of material), tomographic (SPECT)	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
78890	Generation of automated data interactive process involving nuclear physician and/or allied health professional personnel, simple manipulations and interpretation, not to exceed 30 minutes			NUCLEAR MEDICINE	36	
78891	Generation of automated data interactive process involving nuclear physician and/or allied health professional personnel, complex manipulations and interpretation, exceeding 30 minutes			NUCLEAR MEDICINE	36	
79200	Radiopharmaceutical therapy, by intracavitary administration	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
79440	Radiopharmaceutical therapy, by intra-articular administration	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30	
88125	Cytopathology, forensic (eg, sperm)	22	PATHOLOGY	PATHOLOGY	22	
88349	Electron microscopy; scanning	22	PATHOLOGY	PATHOLOGY	22	
88355	Morphometric analysis, skeletal muscle	22	PATHOLOGY	PATHOLOGY	22	
89132	Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology, after stimulation			GASTROENTEROLOGY	10	
89135	Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); one hour			GASTROENTEROLOGY	10	
89136	Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study), two hours	22	PATHOLOGY	GASTROENTEROLOGY	10	*
89140	Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study), two hours including gastric stimulation (eg, histalog, pentagastrin)	69	INDEPENDENT LABORATORY	GASTROENTEROLOGY	10	*
90829	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services	26	PSYCHIATRY	PSYCHIATRY	26	
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy), approximately 20-30 minutes			PSYCHIATRY	26	
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy), approximately 45-50 minutes			PSYCHIATRY	26	
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes			PSYCHIATRY	26	
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient			PSYCHIATRY	26	
91060	Gastric saline load test	29	PULMONARY DISEASE	GASTROENTEROLOGY	10	
91133	Electrogastrography, diagnostic, transcutaneous; with provocative testing	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10	
92015	Determination of refractive state	18	OPHTHALMOLOGY	OPTOMETRY	41	*

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	41	OPTOMETRY	OPTOMETRY	41	
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician, corneal lens, both eyes except for aphakia			OPTOMETRY	41	
92316	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician, corneal lens for aphakia, both eyes	41	OPTOMETRY	OPTOMETRY	41	
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal scleral lens	18	OPHTHALMOLOGY	OPTOMETRY	41	*
92335	Prescription of ocular prosthesis (artificial eye) and direction of fitting and supply by independent technician, with medical supervision of adaptation	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18	
92340	Fitting of spectacles, except for aphakia, monofocal			OPTOMETRY	41	
92341	Fitting of spectacles, except for aphakia; bifocal			OPTOMETRY	41	
92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal			OPTOMETRY	41	
92352	Fitting of spectacle prosthesis for aphakia; monofocal			OPTOMETRY	41	
92353	Fitting of spectacle prosthesis for aphakia; multifocal			OPTOMETRY	41	
92354	Fitting of spectacle mounted low vision aid, single element system			OPTOMETRY	41	
92355	Fitting of spectacle mounted low vision aid, telescopic or other compound lens system			OPTOMETRY	41	
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)			OPTOMETRY	41	
92370	Repair and refitting spectacles; except for aphakia			OPTOMETRY	41	
92371	Repair and refitting spectacles, spectacle prosthesis for aphakia			OPTOMETRY	41	
92573	Lombard test	64	AUDIOLOGIST (BILLING INDEPENDENTLY)	AUDIOLOGIST (BILLING INDEPENDENTLY)	64	
92596	Ear protector attenuation measurements	64	AUDIOLOGIST (BILLING INDEPENDENTLY)	AUDIOLOGIST (BILLING INDEPENDENTLY)	64	
92601	Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming	64	AUDIOLOGIST (BILLING INDEPENDENTLY)	AUDIOLOGIST (BILLING INDEPENDENTLY)	64	
92602	Diagnostic analysis of cochlear implant, patient under 7 years of age; subsequent reprogramming	64	AUDIOLOGIST (BILLING INDEPENDENTLY)	AUDIOLOGIST (BILLING INDEPENDENTLY)	64	
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient, each additional 30 minutes (List separately in addition to code for primary procedure)	13	NEUROLOGY	OTOLARYNGOLOGY	04	*
92613	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording, physician interpretation and report only			OTOLARYNGOLOGY	04	
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording,	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04	
92615	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; physician interpretation and report only			OTOLARYNGOLOGY	04	
92617	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; physician interpretation and report only			OTOLARYNGOLOGY	04	
92970	Cardioassist-method of circulatory assist, internal	06	CARDIOLOGY	CARDIOLOGY	06	
92977	Thrombolysis, coronary; by intravenous infusion	06	CARDIOLOGY	CARDIOLOGY	06	
92990	Percutaneous balloon, valvuloplasty, pulmonary valve	06	CARDIOLOGY	CARDIOLOGY	06	
92992	Atrial septectomy or septostomy, transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)	06	CARDIOLOGY	CARDIOLOGY	06	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
92993	Atrial septectomy or septostomy, blade method (Park septostomy) (includes cardiac catheterization)	06	CARDIOLOGY	CARDIOLOGY	06	
92997	Percutaneous transluminal pulmonary artery balloon angioplasty, single vessel	06	CARDIOLOGY	CARDIOLOGY	06	
92998	Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	06	CARDIOLOGY	CARDIOLOGY	06	
93581	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	06	CARDIOLOGY	CARDIOLOGY	06	
93615	Esophageal recording of atrial electrogram with or without ventricular electrogram(s)	06	CARDIOLOGY	CARDIOLOGY	06	
93890	Transcranial Doppler study of the intracranial arteries, vasoreactivity study			NEUROLOGY	13	
94150	Vital capacity, total (separate procedure)			PULMONARY DISEASE	29	
95071	Inhalation bronchial challenge testing (not including necessary pulmonary function tests), with antigens or gases, specify	03	ALLERGY/IMMUNOLOGY	ALLERGY/IMMUNOLOGY	03	
95130	Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract, single stinging insect venom	03	ALLERGY/IMMUNOLOGY	ALLERGY/IMMUNOLOGY	03	
95132	Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract, three stinging insect venoms	03	ALLERGY/IMMUNOLOGY	ALLERGY/IMMUNOLOGY	03	
95858	Tensilon test for myasthenia gravis, with electromyographic recording	13	NEUROLOGY	NEUROLOGY	13	
95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)	13	NEUROLOGY	NEUROLOGY	13	
95965	Magnetoencephalography (MEG), recording and analysis, for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	13	NEUROLOGY	NEUROLOGY	13	
95966	Magnetoencephalography (MEG), recording and analysis, for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)	13	NEUROLOGY	NEUROLOGY	13	
96000	Comprehensive computer-based motion analysis by video-taping and 3-D kinematics;	20	ORTHOPEDIC SURGERY	PHYSICAL THERAPIST (INDEP. PRACTICE)	65	*
96003	Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle	30	DIAGNOSTIC RADIOLOGY	PHYSICAL THERAPIST (INDEP. PRACTICE)	65	*
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	83	HEMATOLOGY/ONCOLOGY	HEMATOLOGY/ONCOLOGY	83	
96571	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10	
96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality			DERMATOLOGY	07	
97010	Application of a modality to one or more areas; hot or cold packs			PHYSICAL THERAPIST (INDEP. PRACTICE)	65	
98943	Chiropractic manipulative treatment (CMT), extraspinal, one or more regions	35	CHIROPRACTIC	CHIROPRACTIC	35	
99141	Sedation with or without analgesia (conscious sedation), intravenous, intramuscular or inhalation			PEDIATRIC MEDICINE	37	
99142	Sedation with or without analgesia (conscious sedation), oral, rectal and/or intranasal			PEDIATRIC MEDICINE	37	
99170	Anogenital examination with colposcopic magnification in childhood for suspected trauma	16	OB-GYN	PEDIATRIC MEDICINE	37	*
99175	Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	08	FAMILY PRACTICE	FAMILY PRACTICE	08	
99186	Hypothermia; total body	13	NEUROLOGY	NEUROLOGY	13	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
99290	Critical care services delivered by a physician, face-to-face, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or less; each additional 30 minutes (List separately in addition to code for primary service)	11	INTERNAL MEDICINE	PEDIATRIC MEDICINE	37	*
99293	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	37	PEDIATRIC MEDICINE	PEDIATRIC MEDICINE	37	
99296	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less	37	PEDIATRIC MEDICINE	PEDIATRIC MEDICINE	37	
99298	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)	37	PEDIATRIC MEDICINE	PEDIATRIC MEDICINE	37	
99299	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)	08	FAMILY PRACTICE	PEDIATRIC MEDICINE	37	*
99374	Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 15-29 minutes			INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99375	Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more			INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99377	Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 15-29 minutes			INTERNAL MEDICINE/FAMILY MEDICINE	11/08	

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
99378	Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more			INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99379	Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes			INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99380	Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more			INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/nsk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; infant (age under 1 year)			PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/nsk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)			PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/nsk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)			PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec. Medicare ID	Change
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)			PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years			PEDIATRIC MEDICINE/FAMILY MEDICINE	11/08	
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years			PEDIATRIC MEDICINE/FAMILY MEDICINE	11/08	
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 65 years and over			PEDIATRIC MEDICINE/FAMILY MEDICINE	11/08	
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient, infant (age under 1 year)			PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)			PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)			PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)			PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 18-39 years	11	INTERNAL MEDICINE	INTERNAL MEDICINE/FAMILY MEDICINE	11/08	

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CPT Code	CPT Descriptor	Dominant Medicare ID	Dominant Specialty Per 2003 Medicare Data	Recommended Specialty for PLI Methodology	Rec Medicare ID	Change
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/nsk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years	11	INTERNAL MEDICINE	INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/nsk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 65 years and over	11	INTERNAL MEDICINE	INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99401	Preventive medicine counseling and/or nsk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	11	INTERNAL MEDICINE	INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99402	Preventive medicine counseling and/or nsk factor reduction intervention(s) provided to an individual (separate procedure), approximately 30 minutes			INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99403	Preventive medicine counseling and/or nsk factor reduction intervention(s) provided to an individual (separate procedure), approximately 45 minutes			INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99404	Preventive medicine counseling and/or nsk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes			INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99411	Preventive medicine counseling and/or nsk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes			INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99412	Preventive medicine counseling and/or nsk factor reduction intervention(s) provided to individuals in a group setting (separate procedure), approximately 60 minutes			INTERNAL MEDICINE/FAMILY MEDICINE	11/08	
99431	History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries )	08	FAMILY PRACTICE	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	*
99432	Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s)			PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	
99433	Subsequent hospital care, for the evaluation and management of a normal newborn, per day	08	FAMILY PRACTICE	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	*
99435	History and examination of the normal newborn infant, including the preparation of medical records (This code should only be used for newborns assessed and discharged from the hospital or birthing room on the same date )	08	FAMILY PRACTICE	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	*
99436	Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn	37	PEDIATRIC MEDICINE	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	*
99440	Newborn resuscitation provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	08	FAMILY PRACTICE	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08	*

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2004

**Anesthesia for Incomplete or Missed Abortion**

The CPT Editorial Panel created two new codes, 01965 *Anesthesia for incomplete or missed abortion procedures* and 01966 *Anesthesia for induced abortion procedures*, to differentiate between anesthesia for two distinct categories of abortion procedures - induced and spontaneous. CPT Code 01964 *Anesthesia for abortion procedures* (Base Unit = 4), was valued by the RUC in April 2001.

**01965 and 01966**

The RUC reviewed survey data from nearly 40 anesthesiologists who indicated that the services described in 01965 and 01966 have a similar intensity to that of code 01964. The survey responses on the intensity/complexity measures indicated little variance, with mental effort and judgment; technical skill and physical effort; and psychological stress for reference service code 01964. The society recommended the survey median of 4 base units for both 01965 and 01966. **The RUC recommends a base unit of 4 for CPT codes 01965 and 01966.**

**Practice Expense**

These anesthesia services are 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
01964		Anesthesia for abortion procedures  <del>(01964 has been deleted. To report, see 01965, 01966)</del>	XXX	N/A
•01965	A1	Anesthesia for incomplete or missed abortion procedures	XXX	4
•01966	A2	Anesthesia for induced abortion procedures	XXX	4

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
ANESTHESIA SUMMARY OF RECOMMENDATION

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**CPT Code: 01965 Tracking Number: A1 Global Period: XXX Recommended Base Unit Value: 4**

**CPT Descriptor: Anesthesia for incomplete or missed abortion procedures**

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**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 24-year-old female presents with a positive pregnancy test and heavy vaginal bleeding which started one day prior. By the last menstrual period, she should be 10-weeks pregnant. She denies passing tissue but has had large clots. On exam, she has a dilated cervical os with tissue at the os. The patient undergoes surgical treatment of incomplete abortion.

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

Two respondents did not feel that the vignette described their typical patient. One indicated that the typical patient would be morbidly obese, hypertensive, have a history of drug use, HIV and be positive for hepatitis. The other respondent noted that his/her typical patient would not be actively bleeding.

**Description of Pre-Service Work:** The patient was seen in the pre-operative holding area after being admitted through the emergency department. She was a healthy appearing young woman who was pale and somewhat anxious. Her past medical history was unremarkable; she was on no medications and had no known drug allergies. She had never had a general anesthetic, and knew of no family history of problems with anesthesia. Her last oral intake was 7 hrs earlier. She weighed 60kg, and her airway was a Mallampati Class I. Her vital signs demonstrated tachycardia at 106 and a blood pressure of 90/60. Her hemoglobin was slightly low at 10.1. The anesthetic options and risks were discussed as well as the remote possibility of blood transfusions. She chose to have a general anesthetic. Consent was obtained for the anesthesia procedure.

**Description of Intra-Service Work:** An 18gauge intravenous (IV) catheter was inserted in her left forearm. After a fluid bolus of crystalloid fluid, which corrected her tachycardia, she was given 2mg of midazolam and 10mg of metoclopramide and taken to the operating room (OR). After moving to the OR table, EKG, non-invasive blood pressure and pulse oximetry monitors were attached. She breathed 100% oxygen by mask, and anesthesia was induced with 100mcg of fentanyl and 150mg of propofol. Desflurane was added to the inspired oxygen, and she was ventilated by hand. After approximately 60 seconds, a # laryngeal mask airway (LMA) was inserted. Proper positioning was assured by chest movement and a satisfactory wave form and numerical value on the end-tidal CO2 monitor. The patient was gently ventilated by hand for an additional 4 to 5 minutes before spontaneous respirations resumed.

The patient was put in the lithotomy position, and after a vaginal prep, the procedure commenced. At the request of the surgeon, 20 units of pitocin were added to the Ringer's Lactate solution that was infusing via the IV. Also, as prophylaxis against nausea, 4 mg of ondansetron was given IV.

The procedure lasted 20 minutes. Estimated blood loss was 150cc. At the conclusion of the procedure, the patient was taken out of the lithotomy position. The desflurane had been discontinued as the surgeon announced that she was through; the patient was still breathing spontaneously and the LMA was removed a minute or two later.

The patient was moved to a recovery stretcher and taken to the Post Anesthesia Care Unit (PACU). Report was given to the PACU nurse as the monitors were being applied. After assuring that the patient's condition was satisfactory, the anesthesiologist transferred care to the PACU nurse. A hemoglobin was obtained, demonstrating a slight additional drop to 9.5. After discussion with the surgeon, the decision was made to manage the patient's anemia conservatively.

**Description of Post-Service Work:** The patient was seen approximately an hour and a half later in the second stage recovery area. She was awake, alert and oriented, and except for some mild cramping, she had no complaints. She was judged ready for discharge.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>		James D. Grant, MD, Brenda S. Lewis, DO			
<b>Specialty(s):</b>		American Society of Anesthesiologists			
<b>CPT Code:</b>		01965			
<b>Sample Size:</b>	83	<b>Resp n:</b>	38	<b>Resp %:</b> 46%	
<b>Sample Type:</b> Combination Panel and Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey Base Unit Values:</b>	4	4	4	4	5
<b>Pre-Anesthesia Time:</b>	5	10	15	28	60
<b>Intra-op Anesthesia Time:</b>	15	21	30	44	90
<b>Post-Anesthesia Time:</b>			10		

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>
01964	XXX	4

CPT Descriptor Anesthesia for abortion procedures.

**KEY MPC COMPARISON CODES:**

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

**Not applicable for anesthesia codes.**

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

Other Reference CPT Code                      Global    Base Unit Value

CPT Descriptor

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

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

**Number of respondents who choose Key Reference Code: 33**

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 01965	Key Reference CPT Code: 01964
Median Pre-Service Time	15.00	10.00
Median Intra-Service Time	30.00	30.00
Median Post-service Time	10.00	10.00
<b>Median Total Time</b>	<b>55.00</b>	<b>50.00</b>

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	2.36	2.30
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.24	2.15
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Urgency of medical decision making	2.58	2.42
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.58	2.55
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Physical effort required	2.45	2.39
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.67	2.61
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Outcome depends on the skill and judgement of physician	2.64	2.55
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Estimated risk of malpractice suit with poor outcome	3.33	3.33
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**INTENSITY/COMPLEXITY MEASURES**

CPT Code	Reference
<b>01965</b>	<b>Service 1</b>

**Time Segments (Mean)**

Pre-Anesthesia intensity/complexity	2.45	2.33
Intra-Op Anesthesia intensity/complexity	2.70	2.70
Post-Anesthesia intensity/complexity	2.27	2.21

**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.*

Code 01964 – *Anesthesia for abortion procedures*, was valued by the RUC in 2001. It was a new code in 2002 CPT. Code 01964 has 4 base units – a value that is reasonable and fair. The reason behind the request to delete code 01964 and replace it with two codes (this one and another to describe anesthesia for induced abortion procedures) was not because we had concerns about the work value. It was a coverage issue.

We anticipated that the surveys would show that the work for new code 01965 to be very similar to the work . 01964. Our survey results were very much in line with that expectation. Almost all respondents selected code 01964 to serve as their reference service. Of all 38 respondents, 34 of them valued new code 01965 at 4 base units and four of them valued it at 5 base units. Pre-, intra- and post-anesthesia time estimates and the intensity/complexity measures for the new code were remarkably similar to those 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) 01964 – Anesthesia for abortion procedures.

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

Specialty 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?  
 About 10-15% of pregnancies end in a miscarriage. Given the national birthrate of 13.9/1000 females between the ages of 15 and 44 and a corresponding population in that demographic group of 60 million, the estimated number of spontaneous abortions range from about 83,000 to 125,000/year. The number of these cases requiring surgical intervention is approximately 30% for a surgical frequency of 25,000 – 37,000 per year.

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

Specialty Anesthesiology                      Frequency Sometimes                      Percentage      100%

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 Anesthesiology                      Frequency Rarely                                      Percentage      100%

Specialty    Frequency    Percentage

Specialty    Frequency    Percentage

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
ANESTHESIA SUMMARY OF RECOMMENDATION

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**CPT Code:01966 Tracking Number: A2 Global Period: XXX Recommended Base Unit Value: 4**

**CPT Descriptor:** Anesthesia for induced abortion procedures

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**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 30 year old female is pregnant. At thirteen weeks gestation, an ultrasound reveals that her fetus has anencephaly. She consults her obstetrician about a termination of pregnancy. Except for some seasonal reactive airway disease, she is in otherwise good health.

**Percentage of Survey Respondents who found Vignette to be Typical:** 97%. Only one respondent disagreed. This anesthesiologist commented that this often includes a patient at a greater gestational age.

**Description of Pre-Service Work:** The patient was seen in the pre-operative holding area of an out patient day surgery center before surgery. She was a healthy appearing young woman who was somewhat anxious. Her past medical history was unremarkable; she was on no medications and had no known drug allergies. She had never had a general anesthetic, and knew of no family history of problems with anesthesia. Her last oral intake was at 2200hrs the previous day. She weighed 60kg, and her airway was a Mallampati Class I. The anesthetic options and risks were discussed, and she chose to have a general anesthetic. Consent was obtained for the anesthesia service.

**Description of Intra-Service Work:** An 18gauge intravenous (IV) catheter was inserted in her left forearm; she was given 2mg of midazolam and 10mg of metoclopramide and taken to the operating room (OR). After moving to the OR table, EKG, non-invasive blood pressure and pulse oximetry monitors were attached. She breathed 100% oxygen by mask, and anesthesia was induced with 100mcg of fentanyl and 150mg of propofol. Desflurane was added to the inspired oxygen, and she was ventilated by hand. After approximately 60 seconds, a #3 laryngeal mask airway (LMA) was inserted. Proper positioning was assured by chest movement and a satisfactory wave form and numerical value on the end-tidal CO2 monitor. The patient was gently ventilated by hand for an additional 4 to 5 minutes before spontaneous respirations resumed.

The patient was put in the lithotomy position, and after a vaginal prep, the procedure commenced. At the request of the surgeon, 20 units of pitocin were added to the Ringer's Lactate solution that was infusing via the IV. Also, as prophylaxis against nausea, 4 mg of ondansetron was given IV.

The procedure lasted 20 minutes; at the conclusion of the procedure, the patient was taken out of the lithotomy position. The desflurane had been discontinued as the surgeon announced that she was through; the patient was still breathing spontaneously and the LMA was removed a minute or two later, when the patient began to respond to verbal stimuli.

The patient was moved to a recovery stretcher and taken to the Post Anesthesia Care Unit (PACU). Report was given to the PACU nurse as the monitors were being applied. After assuring that the patient's condition was satisfactory, the anesthesiologist transferred care to the PACU nurse.

**Description of Post-Service Work:** The patient was seen approximately an hour and a half later in the second stage recovery area. She was awake, alert and oriented, and except for some mild cramping, she had no complaints. She was judged ready for discharge.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	James D. Grant, MD, Brenda S. Lewis, DO				
<b>Specialty(s):</b>	American Society of Anesthesiologists				
<b>CPT Code:</b>	01966				
<b>Sample Size:</b>	83	<b>Resp n:</b>	36	<b>Resp %:</b> 43%	
<b>Sample Type:</b>	Combination Panel and Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey Base Unit Values:</b>	3	4	4	4	5
<b>Pre-Anesthesia Time:</b>	5	10	15	26	45
<b>Intra-op Anesthesia Time:</b>	15	20	35	45	120
<b>Post-Anesthesia Time:</b>			10		

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>
01964	XXX	4

CPT Descriptor Anesthesia for abortion procedures

**KEY MPC COMPARISON CODES:**

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

**Not applicable for Anesthesia codes**

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

Other Reference CPT Code                      Global    Base Unit Value

CPT Descriptor

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

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

**Number of respondents who choose Key Reference Code: 30**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 01966</b>	<b>Key Reference CPT Code: 01964</b>
Median Pre-Service Time	15.00	10.00
Median Intra-Service Time	35.00	30.00
Median Post-service Time	10.00	10.00
<b>Median Total Time</b>	<b>60.00</b>	<b>50.00</b>

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	2.43	2.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.20	2.17
Urgency of medical decision making	2.50	2.57

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

Technical skill required	2.63	2.60
Physical effort required	2.43	2.43

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.67	2.50
Outcome depends on the skill and judgement of physician	2.67	2.60
Estimated risk of malpractice suit with poor outcome	3.43	3.33

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

Pre-Anesthesia intensity/complexity	2.50	2.30
Intra-Op Anesthesia intensity/complexity	2.73	2.70
Post-Anesthesia intensity/complexity	2.17	2.20

**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.*

Code 01964 – *Anesthesia for abortion procedures*, was valued by the RUC in 2001. It was a new code in 2002 CPT. Code 01964 has 4 base units – a value that is reasonable and fair. The reason behind the request to delete code 01964 and replace it with two codes (this one and another to describe anesthesia for incomplete or missed abortion procedures) was not because we had concerns about the work value. It was a coverage issue.

The responses we received varied only slightly from those received for code 01965 – *Anesthesia for incomplete or missed abortion procedures*. Out of our 36 respondents, 28 valued the service at 4 base units; seven valued it at 5 base units and one valued it at 3 base units. The reported time was a total of 10 minutes higher than the reference service as the median pre-service and the median intra-service times were five minutes higher. The intensity/complexity measures for these time segments were higher for the new code than for the reference service. These differences would be expected since the reference service described all abortion procedures and the new code describes induced procedures performed for fetal abnormality requiring anesthesia care. While there are some differences between these patients and those receiving care for an incomplete or missed abortion, we agree with the majority of our respondents, and recommend that code 01966 be valued at 4 base units.

**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)

01964 – Anesthesia for abortion procedures

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

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

Specialty Anesthesiology                      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?

It is difficult to provide precise numbers since the percentage of induced procedures requiring anesthesia has not been reported. The numbers should be low. For example, the reported incidence of anencephaly is about 1/1000 pregnancies.

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

Specialty Anesthesiology                      Frequency Rarely                      Percentage      100%

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 Anesthesiology                      Frequency Rarely                      Percentage      100%

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 2005

**Free Skin Grafts**

In response to requests from the CPT Editorial Panel to clarify the reporting of CPT codes 15400 and 15401 *Application of xenograft, skin*, specifically and the entire free skin graft section of CPT more generically, the American Burn Association developed a coding proposal encompassing 45 new and revised CPT codes. The current codes in *CPT 2005* do not describe the many new methods that have become available for the treatment and healing of extensive burn and skin wounds. These new and revised CPT codes will describe the various application techniques that are available today.

A survey was mailed to sixty burn surgeons and podiatrists. The specialty societies then developed recommendations using this survey data and physician time for presentation to the RUC. In general, the society presented the 25<sup>th</sup> percentile of the survey results for the work value and the RUC agreed that the relationships established in the survey results should be utilized to value these services. A summary of each code and the physician time (based on the survey median) is attached to this summary. The RUC reviewed work value recommendations and direct practice expense inputs for each of the following services:

15000 (FF1) *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or one percent of body area of infants and children*

The RUC agreed that the CPT changes were editorial in nature and recommends no change to the work relative value. This recommendation is also supported by the 25<sup>th</sup> percentile of the survey results. **The RUC recommends a work value of 3.99.**

15001 (FF2) *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)*

The RUC agreed that the CPT changes were editorial in nature and recommends no change to the work relative value. This recommendation is also supported by the 25<sup>th</sup> percentile of the survey results. **The RUC recommends a work value of 1.00.**

15040 (FF3) *Harvest of skin for tissue cultured skin autograft; 100 sq cm or less*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. This service describes the harvesting of normal skin, which is then sent to an institution to be cultured into thin epidermal autografts to later be applied to large burn areas. Previously there was no way to report this service. The RUC also agreed that the valuation appears appropriate in comparison to the work of 15000 *FF1* (work rvu = 3.99), as 15000 includes 30 minutes of intra-service time, compared to 15 minutes for 15040 *FF3*. The difference in time accounts for the smaller size of harvested skin in 15040 and fewer passes of the dermatome needed to harvest. Also, there is less need to provide hemostasis in 15040 than 15000. **The RUC recommends a work value of 2.00.**

15110 (FF4) *Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. This service was compared to 15100 *Split graft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children* (work relative value = 9.04, LOS – 4 days, 4.5 office visits) in technique, hospital, and office visits. This service is considered more intense because of the increased difficulty in harvesting ultra thin (.006 of an inch) epidermal grafts and in obtaining 100 sq cm as a single sheet graft. In addition, these extremely fragile grafts require two to three dressing changes within a week of the surgery. **The RUC recommends a work value of 9.50.**

15111 (FF5) *Epidermal autograft, 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. This service is comparable to 15101 *Split graft, trunk, arms, legs; each additional 100 sq cm, or one percent of body area of infants and children* (work relative value = 1.72), with increased intensity related to the harvesting of ultra thin epidermal grafts and obtaining 100 sq cm as a single sheet graft. **The RUC recommends a work value of 1.85.**

15115 (FF6) *Epidermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. This service was compared to 15100 *Split graft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children* (work relative value = 9.04, LOS – 4 days, 4.5 office visits) in technique, hospital, and office visits. This service is considered more intense because of the

increased difficulty in harvesting ultra thin (.006 of an inch) epidermal grafts and in obtaining 100 sq cm as a single sheet graft. In addition, these extremely fragile grafts require two to three dressing changes within a week of the surgery. The RUC also agreed that this service should be more work than 15110 *FF4* due to the additional complexity needed to preserve critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 9.81.**

15116 (FF7) *Epidermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)*

The specialty and the RUC reviewed the survey 25<sup>th</sup> percentile (work value 1.25) and felt that the increased complexity needed to preserve the critical structures of the face and other anatomic areas listed in this descriptor should lead to a higher value than 15111 *FF5* (work relative value = 1.85). Accounting for the additional intra-service time of 10 minutes and the increased intensity of this service, the RUC estimated a work value of 2.50 for this service. **The RUC recommends a work value of 2.50.**

15130 (FF8) *Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. This service involves removing an epidermal split thickness graft off of a donor site, removing the dermal graft from underneath, and then putting the epidermal graft back down. The dermal autograft is then transferred to the recipient site. 15130 *FF8* is more work than CPT 14020 *Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less* (work rvu = 6.58), as 14020 is primarily an outpatient procedure, including four typical office visits, but no hospital work as included in 15130. **The RUC recommends a work value of 7.00**

15131 (FF9) *Dermal autograft, 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. CPT code 15131 *FF9* is less work than 15101 *Split graft, trunk, arms, legs; each additional 100 sq cm, or one percent of body area of infants and children* (work relative value = 1.72), with less intra-service time. This service is expected to be rarely reported (fewer than 100 times per year to Medicare patients). **The RUC recommends a work value of 1.50**

15135 (FF10) *Dermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey median, as the increased complexity needed to preserve the critical structures of the face and other anatomic areas listed in this descriptor should lead to a higher value than 15130 *FF8* (work relative value = 7.00). This service involves removing an epidermal split thickness graft off of a donor site, removing the dermal graft from underneath, and then putting the epidermal graft back down. The dermal autograft is then transferred to the recipient site. **The RUC recommends a work value of 10.50.**

15136 (FF11) *Dermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. Although this service is more intense than 15131 *FF9* (work value 1.50), the survey intra-service time for this service is a few minutes shorter than 15131. This is related to the limited coverage to small areas with exposed critical structures. In addition, the RUC noted that the increment in the base codes of 15130 *FF8* and 15135 *FF10* sufficiently incorporate the increased complexity of the patient. This service is expected to be rarely reported (fewer than 100 times per year to Medicare patients). **The RUC recommends a work value of 1.50.**

15150 (FF12) *Tissue cultured epidermal autograft, trunk, arms, legs; first 25 sq cm or less*

The RUC agreed with the specialty's recommendation of the survey median. This service involves tissue that has been sent off and cultured and has been retrieved to be applied. This tissue comes in 25 sq cm units. Each 25 sq cm must be applied separately. The tissue usually requires one month to culture. It was noted again that this base code incorporates all of the visits, rather than allocating any to the add-on services 15151 *FF13* or 15152 *FF14*. The RUC agreed that the intra-operative work of 15150 *FF12* is similar to 15100 (work relative value = 9.00) in that each graft must be secured to the recipient site. However, 15150 represents overall less work than 15100 as the graft is smaller (25 sq cm versus 100 sq cm) and there is no need for harvesting. **The RUC recommends a work value of 8.25.**



15151 (FF13) *Tissue cultured epidermal autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) (do not report more than once)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The intra-operative work of 15151 *FF13* is similar to 15101 (work relative value = 1.72). **The RUC recommends a work value of 2.00.**

15152 (FF14) *Tissue cultured epidermal autograft, 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that 15152 *FF14* should be valued higher than 15151 *FF13* as the size of the autograft is larger (additional 1 sq cm to 75 sq cm in 15151 compared to each additional 100 sq cm in 15152). **The RUC recommends a work value of 2.50.**

15155 (FF15) *Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 25 sq cm or less*

The survey data for this service did not reflect the appropriate relationship between 15155 *FF15* and 15150 *FF 12* (work relative value = 8.25). The RUC agreed that the specialty's recommended value of 9.00 reflects the appropriate relationship to 15150 *FF12*, as the incremental increase is required to account for increased complexity in preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 9.00.**

15156 (FF16) *Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) (do not report more than once)*

The survey data for this service did not reflect the appropriate relationship between 15156 *FF16* and 15151 *FF 13* (work relative value = 2.00). The RUC agreed that the specialty's recommended value of 2.75 reflects the appropriate relationship to 15151 *FF13*, as the incremental increase is required to account for increased complexity in preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 2.75.**

15157 (FF17) *Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that the specialty's recommended value of 3.00 reflects the appropriate relationship to 15152 *FF14* (work relative value = 2.50) as the incremental increase is required to account for increased complexity in preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 3.00.**

15170 (FF18) *Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this service is more work than CPT code 15350 *Application of allograft, skin; 100 sq cm or less* (work relative value = 3.99) as there is extra care necessary to secure the packaged product and to provide complete single layer coverage (without overlapping) of the recipient site as the packaged product will become part of the permanent coverage. Three hospital visits are required to represent the work involved with dressing changes prior to the recipient areas being covered with permanent skin grafts. No office visits are required as these visits will be included in the permanent skin graft code. **The RUC recommends a work value of 5.00.**

15171 (FF19) *Acellular dermal replacement, 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that 15171 *FF19* reflects more work than 15351 *Application of allograft, skin; each additional 100 sq cm* (work relative value = 1.00) as there is extra care necessary to secure the packaged product and to provide complete single layer coverage (without overlapping) of the recipient site as the packaged product will become part of the permanent coverage. **The RUC recommends a work value of 1.55.**

15175 (FF20) *Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed that this service involves more work than CPT code 15350 *Application of allograft, skin; 100 sq cm or less* (work relative value = 3.99) as extra care is necessary to secure the packaged product and to provide complete single layer



coverage (without overlapping) of the recipient site as the packaged product will become part of the permanent coverage. Three hospital visits are required to represent the work involved with dressing changes prior to the recipient areas being covered with permanent skin grafts. No office visits are required as these visits will be included in the permanent skin graft code. The RUC agreed with the specialty society's determination that an increment of work above 15170 *FF18* (work relative value = 5.00) to reflect the increased intensity of preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 7.00.**

15176 (FF21) *Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that 15176 *FF21* reflects more work than 15351 *Application of allograft, skin; each additional 100 sq cm* (work relative value = 1.00) as extra care is necessary to secure the packaged product and to provide complete single layer coverage (without overlapping of the recipient site as the packaged product will become part of the permanent coverage. In addition, the RUC agreed that the increment of work above 15171 *FF19* is appropriate to reflect the increased intensity of preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 2.45.**

15300 (FF22) *Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. CPT code 15300 *FF22* describes the same work as the existing code 15350 *Application of allograft, skin; 100 sq cm or less* (work relative value = 3.99). **The RUC recommends a work value of 3.99.**

15301 (FF23) *Allograft skin for temporary wound closure, 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. CPT code 15301 *FF23* describes the same work as the existing code 15351 *Application of allograft, skin; each additional 100 sq cm* (work relative value = 1.00). **The RUC recommends a work value of 1.00.**

15320 (FF24) *Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that the additional increment of work above 15300 *FF22* was appropriate to reflect the increased intensity in preserving critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 4.70.**

15321 (FF25) *Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that the additional increment of work above 15301 *FF23* was appropriate to reflect the increased intensity in preserving critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 1.50.**

15330 (FF26) *Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. This service describes application of a prepared product that cannot stand alone and is placed under a flap or graft. Therefore, this service is always reported on the same date as another service with a -51 modifier. CPT code 15330 *FF26* describes the same work as the existing code 15350 *Application of allograft, skin; 100 sq cm or less* and 15300 *FF22* (work relative value = 3.99). **The RUC recommends a work value of 3.99.**

15331 (FF27) *Acellular dermal allograft, 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. CPT code 15331 *FF27* describes the same work as the existing code 15351 *Application of allograft, skin; each additional 100 sq cm* and 15301 *FF23* (work relative value = 1.00). **The RUC recommends a work value of 1.00.**

15335 (FF28) *Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The specialty society presented and the RUC agreed that the value should incorporate an appropriate increment of work for the increased intensity of preserving critical structures of the face and other anatomic areas listed in this descriptor and, therefore, recommended 4.50, a slight increase above 15330 *FF26* (work relative value = 3.99). This service describes application of a prepared product that cannot stand alone and is placed under a flap or graft. Therefore, this service is always reported on the same date as another service with a -51 modifier. This service is slightly less work than 15320 *FF24* the hospital work is included in other services. **The RUC recommends a work value of 4.50.**

15336 (FF29) *Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this represents an appropriate increment of work above 15331 *FF27* (work relative value = 1.00) to reflect the increased intensity of preserving the critical structures of the face and other anatomic areas listed in this descriptor. This service is slightly less work than 15321 *FF25* the hospital work is included in other services. **The RUC recommends a work value of 1.43.**

15340 (FF30) *Tissue cultured allogeneic skin substitute; first 25 sq cm or less*

The typical patient for this service is a Type II Diabetic with a non-infected full thickness ulceration of the heel. The intra-work of this service includes: local anesthesia, debridement, achieve adequate hemostasis, measuring the wound, obtaining graft material, applying the material, and suturing. The survey results were not utilized for this service as at the time of the survey, CPT had not yet indicated that debridement was included in this service. CPT has since clarified that debridement (currently reported with CPT codes 15000, 11040 – 11042) is no longer separately reported. The specialty presented a recommendation based on the following building block:

Pre-Service Evaluation and Positioning	15 minutes x .0224 = 0.34
Pre-Service Scrub, Dress, and Wait	10 minutes x .0081 = 0.08
Intra-Service Work (20 min survey + 8 minutes of debridement)	28 minutes x .0520 = 1.46
Immediate Post-Service Time	15 minutes x .0224 = 0.34
½ day discharge day 99238	0.64
Two, 99212 office visits (10 day global)	<u>0.86</u>
Calculated Work Relative Value	<b>3.72</b>

**The RUC recommends a work value of 3.72.**

15341 (FF31) *Tissue cultured allogeneic skin substitute; each additional 25 sq cm*

The RUC agreed with the specialty's recommendation of the survey median. This service also includes any additional debridement required. It was noted that the IWPUT (0.033) represented in this recommendation approximates the current IWPUT for E/M services. **The RUC recommends a work value of 0.50.**

15360 (FF32) *Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC considered this to be slightly less work than 15350 and 15300 FF22 (work relative values = 3.99). However, it was noted that office visits should be assigned to this code as this service is considered as the final management of the wound and extra care in application is necessary. **The RUC recommends a work value of 3.87.**

15361 (FF33) *Tissue cultured allogeneic dermal substitute, 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. This represents slightly more work than 15351 and 15301 FF23 as this coverage is considered as the final management of the wound and extra care in application is necessary. **The RUC recommends a work value of 1.15.**

15365 (FF34) *Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that a work value of 4.15 represented the appropriate increment of increased work above 15360 FF32 to justify the increased complexity in preserving the critical structure of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 4.15**

15366 (FF35) *Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that a work value of 1.45 represented the appropriate increment of increased work above 15361 FF33 to justify the increased complexity in preserving the critical structure of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 1.45.**

15400 (FF36) *Xenograft, skin (dermal) for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this service should be valued the same as existing code 15400 *Application of xenograft, skin; 100 sq cm or less (work relative value = 3.99)*. **The RUC recommends a work value of 3.99.**

15401 (FF37) *Xenograft; skin (dermal) for temporary wound closure, 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this service should be valued the same as existing code 15401 *Application of xenograft, skin; each additional 100 sq cm (work relative value = 1.00)*. **The RUC recommends a work value of 1.00.**

15420 (FF38) *Xenograft skin (dermal) for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this service should be valued more than existing code 15400 *Application of xenograft, skin; 100 sq cm or less (work relative value = 3.99)* and new code 15400 *FF36* to account for the increased intensity in preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 4.50.**

15421 (FF39) *Xenograft skin (dermal) for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this service should be more than the existing code 15401 *Application of xenograft, skin; each additional 100 sq cm (work relative value = 1.00)* to account for the increased intensity in preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 1.50.**

15430 (FF40) *Acellular xenograft implant; first 100 sq cm or less, or one percent of body area of infants and children*

The intra-work of this service includes: debridement, achieve adequate hemostasis, measuring the wound, obtaining graft material, and application of the material. The survey results were not utilized for this service as at the time of the survey, CPT had not yet indicated that debridement was included in this service. CPT has since clarified that debridement (15000, 11040 – 11042) is no longer separately reported. In addition, the RUC understands that the patient is seen back in the office each 10 days during the ninety day global period for reapplication of the acellular xenograft implant, to include any required debridement. The specialty presented a recommendation based on the following building block:

Pre-Service Evaluation and Positioning	15 minutes x .0224 = 0.34
Pre-Service Scrub, Dress, and Wait	10 minutes x .0081 = 0.08
Intra-Service Work	15 minutes x .0400 = 0.60
Immediate Post-Service Time	10 minutes x .0224 = 0.22

½ day discharge day 99238	0.64
Nine, 99212 office visits (1 each 10 days of 90 day global)	<u>3.87</u>
Calculated Work Relative Value	5.75

**The RUC recommends a work value of 5.75.**

15431 (FF41) *Acellular xenograft implant; 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)*

The presenting specialty societies indicated that their members do not use this product for large burns/wounds. However, the presenters noted that this service may be provided by some trauma surgeons. **The RUC recommend that this service be carrier priced in 2006.**

16020 (FF42) *Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agrees that the CPT revisions clarified the current reporting of these services. **The RUC recommends a work value of 0.80.**

16025 (FF43) *Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (e.g., whole face or whole extremity, or 5 to 10% total body surface area)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agrees that the CPT revisions clarified the current reporting of these services. **The RUC recommends a work value of 1.85.**

16030 (FF44) *Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (e.g., more than one extremity, or greater than 10% total body surface area)*

The RUC agreed with the specialty's recommendation of the survey 25<sup>th</sup> percentile. The RUC agrees that the CPT revisions clarified the current reporting of these services. **The RUC recommends a work value of 2.08.**

### Work Neutrality

The RUC acknowledges that the relative value recommendations for these services are not work neutral. Based on the best estimates on projected utilization, the overall increase in work values for the entire family of services is 6%. The RUC recommends that any minor adjustment that would be necessary be made to the overall budget neutrality adjustment to the conversion factor, rather than to these codes. The RUC agreed that compelling evidence was presented by the specialties that the new codes do describe new technology for burns and chronic wounds. In addition, the current valuation of codes 15342 and 15343 *Application of bilaminar skin substitute/neodermis* is not based on any survey data or input from the specialties providing this service. These product applications have never been clearly defined. The new codes and the corresponding valuation incorporates the major differences in the application of the skin substitutes, include: application techniques; patient population; site-of-service; physician time; and length of stay.

### Global Period Assignment

The RUC evaluated each of these services based on the historical global periods for this family and the global periods assigned by CMS for the new/revised CPT codes. However, the RUC is concerned that the assignment of a 90 day global period for these codes and other codes typically reported for patients with burns and chronic wounds may be problematic and we urge CMS to consider this issue. The typical patient would receive services over the course of several weeks and months that would each be assigned 90 day global periods. The RUC is concerned that the current reporting mechanism leads to a duplication in the number of post-operative visits included in these codes, as there is no reduction in payment for staged procedures (CPT modifier -58). In addition, a burn patient may have wounds on many anatomical areas, sometimes treated over different days. Again, a duplication in payment for post-service care would occur under the current coding system. The RUC would be interested in re-reviewing these services, if the specialty and CMS conclude that a change in global period assignment is warranted. The RUC would also note that analyses such as IWP/UT are not effective for these codes, as the number of visits for the typical patient are included in the base code, even though the add-on code describes the larger burns/wounds. The RUC did not assign any pre or post service work to the add-on (ZZZ) codes. However, the work in these codes reflect the increased intensity of the larger burn/wound.

### Practice Expense

The RUC made several modifications to the direct practice expense recommendations to reflect a relationship of 2/3 nurse time to physician time for assisting the physician when the service is performed in the non-facility. In addition, the direct practice expense inputs were modified to reflect consistency with the physician time data post-operative office visits. Minor revisions were also made to the medical supplies and equipment, including a clarification that the skin substitute/grafts should be reported separately, as described in the CPT preamble to these codes: *“When services are performed in office, the supply of the skin substitute/graft should be reported separately. Routine dressing supplies are not reported separately.”* The direct practice expense recommendations are attached to this recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Identify by size and location of the defect (recipient area) and the type of graft <u>or skin substitute</u>; includes simple debridement of granulations <u>tissue</u> or recent avulsion.</p> <p>When a primary procedure such as orbitectomy, radical mastectomy, or deep tumor removal requires a skin graft for definitive closure, see the appropriate anatomical subsection for the primary procedure and this section for the skin graft <u>or skin substitute</u>.</p> <p>Use 15000-<u>15001</u> for initial wound/<u>recipient site</u> preparation.</p> <p>Use 15100-15261 for <u>autologous autogenous</u> skin grafts. For <del>autogenous</del> <u>autologous</u> tissue-cultured <u>epidermal skin</u> grafts, use <del>15100-15121</del> <u>15150-15157</u>. For harvesting of autologous keratinocytes and dermal tissue for tissue-cultured skin grafts, use 15040. Procedures are coded by recipient site. Use codes <del>15342 and 15343</del> for application of skin substitute/neodermis <u>15170-15176 for acellular dermal replacement</u>. Use modifier 58 for staged application procedure(s).</p> <p>Repair of donor site requiring skin graft or local flaps is to be added as an additional procedure.</p> <p>Codes 15000; <u>and 15001, 15350, 15351, 15400, 15401</u> describe burn and wound preparation <del>and management procedures or incisional or excisional release of scar contracture resulting in an open wound requiring a skin graft</del>. <u>Codes 15100-15431 describe the application of skin replacements and skin substitutes</u>. The following definition should be applied to codes <u>15000, 15001, 15100, 15101, 15110, 15111, 15115, 15116, 15120, 15121, 15130, 15131, 15135, 15136, 15150 – 15152, 15157, 15170-15176, 15300-15366, and 15360-15431</u> when determining the involvement of body size. The measurement of 100 sq cm is applicable to adults and children age 10 and over, percentages <u>of body surface area</u> apply to infants and children under the age of 10.</p> <p><u>These codes are not intended to be reported for simple graft application alone or application stabilized with dressings (eg, by simple gauze wrap), without surgical fixation of the skin substitute/graft. The skin substitute/graft is anchored using the surgeon's choice of fixation. When services are performed in office, the supply of the skin substitute/graft should be reported separately. Routine dressing supplies are not reported separately.</u></p>				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 15000	FF1	<p>Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), <u>or incisional release of scar contracture</u>; first 100 sq cm or one percent of body area of infants and children</p> <p>(For appropriate skin grafts <u>or replacements</u>, see 15050-15261, <u>15330-15336</u>; list the free graft <u>or replacement</u> separately by its procedure number when the graft, immediate or delayed, is applied)</p>	000	3.99 (No Change)
▲ +15001	FF2	<p>each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)</p> <p>(Use 15001 in conjunction with 15000)</p> <p>(For excision to prepare or create recipient site with <u>alloplastic dressings or materials not listed below</u>, use 15000, 15001 only)</p> <p>(For excision with immediate skin grafting, use 15000, 15001 in conjunction with 15050-15261)</p> <p>(For excision with immediate allograft <u>skin</u> placement, use 15000, 15001 in conjunction with <del>15350</del> <u>15300-15366</u>)</p> <p>(For excision with immediate <del>xenograft</del> <u>xenogeneic dermis</u> placement, use 15000, 15001 in conjunction with 15400-15431)</p>	ZZZ	1.00 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●15040	FF3	Harvest of skin for tissue cultured skin autograft; 100 sq cm or less	000	2.00
15050		<i>Pinch graft, single or multiple, to cover small ulcer, tip of digit or other minimal open area (except on face), up to defect size 2 cm diameter</i>	090	4.29 (No Change)
▲15100		<del>Split-thickness autograft- graft</del> , trunk, arms, legs; first 100sq cm or less, or one percent of body area of infants and children (except 15050)	090	9.04 (No Change)
▲+15101		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)  (Use 15101 in conjunction with 15100)	ZZZ	1.72 (No Change)
●15110	FF4	Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	9.50
●+15111	FF5	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)  (Use 15111 in conjunction with 15110)	ZZZ	1.85

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●15115	FF6	Epidermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	9.81
●+15116	FF7	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)  (Use 15116 in conjunction with 15115)	ZZZ	2.50
▲15120		<del>Split-thickness autograft-graft</del> , face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)	090	9.82 (No Change)
▲+15121		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)  (Use 15121 in conjunction with 15120)	ZZZ	2.67 (No Change)
●15130	FF8	Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	7.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•+15131	FF9	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)  (Use 15131 in conjunction with 15130)	ZZZ	1.50
•15135	FF10	Dermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	10.50
•+15136	FF11	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)  (Use 15136 in conjunction with 15135)	ZZZ	1.50
•15150	FF12	Tissue cultured epidermal autograft, trunk, arms, legs; first 25 sq cm or less	090	8.25
•+15151	FF13	additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)  (Do not report 15151 more than once per session)  (Use 15151 in conjunction with 15150)	ZZZ	2.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•+15152	FF14	<p>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)</p> <p>(Use 15152 in conjunction with 15151)</p>	ZZZ	2.50
•15155	FF15	Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 25 sq cm or less	090	9.00
•+15156	FF16	<p>additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)</p> <p>(Do not report 15156 more than once per session)</p> <p>(Use 15156 in conjunction with 15155)</p>	ZZZ	2.75
•+15157	FF17	<p>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)</p> <p>(Use 15157 in conjunction with 15156)</p>	ZZZ	3.00
•15170	FF18	Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	5.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•+15171	FF19	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)  (Use 15171 in conjunction with 15170)	ZZZ	1.55
•15175	FF20	Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	7.00
•+15176	FF21	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)  (Use 15176 in conjunction with 15175)	ZZZ	2.45
<u>Application of a non-autologous human skin graft (ie, homograft) from a donor to a part of the recipient's body to resurface an area damaged by burns, traumatic injury, soft-tissue infection and/or tissue necrosis or surgery.</u>				
•15300	FF22	Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	3.99

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•+15301	FF23	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)  (Use 15301 in conjunction with 15300)	ZZZ	1.00
•15320	FF24	Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	4.70
•+15321	FF25	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)  (Use 15321 in conjunction with 15320)	ZZZ	1.50
•15330	FF26	Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	3.99
•+15331	FF27	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)  (Use 15331 in conjunction with 15330)	ZZZ	1.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●15335	FF28	Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	4.50
●+15336	FF29	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)  (Use 15336 in conjunction with 15335)	ZZZ	1.43
●15340	FF30	Tissue cultured allogeneic skin substitute; first 25 sq cm or less	010	3.72
●+15341	FF31	each additional 25 sq cm  (Use 15341 in conjunction with 15340)  (Do not report 15340, 15341 with 15000, 11040-11042)	ZZZ	0.50
D 15342		<del>Application of bilaminar skin substitute/neodermis; 25 sq cm</del> (15342 has been deleted. See 15170, 15175, 15340, 15360, 15365)	010	N/A
D +15343		<del>each additional 25 sq cm (List separately in addition to code for primary procedure)</del> (15343 has been deleted. See 15171, 15176, 15341, 15361, 15366)	ZZZ	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 15350		<del>Application of allograft; 100 sq cm or less</del> (15350 has been deleted. To report, use 15300, 15320, 15330, and 15335))	090	N/A
D +15351		<del>each additional 100 sq cm (List separately in addition to code for primary procedure)</del> (15351 has been deleted. To report, use 15301, 15321, 15331, and 15336)	ZZZ	N/A
•15360	FF32	Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	3.87
•+15361	FF33	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)  (Use 15361 in conjunction with 15360)	ZZZ	1.15
•15365	FF34	Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	4.15
•+15366	FF35	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)  (Use 15366 in conjunction with 15365)	ZZZ	1.45

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<u>Application of a non-human skin graft or biologic wound dressing (eg, porcine tissue or pigskin) to a part of the recipient's body to resurface an area damaged by burns, traumatic injury, soft-tissue infection and/or tissue necrosis or surgery.</u>				
▲●15400	FF36	<del>Application of xenograft, skin; 100 sq cm or less</del> Xenograft; skin (dermal) for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	3.99 (No Change)
▲+15401	FF37	each additional 100 sq cm, or each additional <u>one percent of body area of infants and children, or part thereof</u> (List separately in addition to code for primary procedure)  (Use 15401 in conjunction with 15400)	ZZZ	1.00 (No Change)
●15420	FF38	Xenograft skin (dermal) for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	4.50
●+15421	FF39	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)  (Use 15421 in conjunction with 15420)	ZZZ	1.50
●15430	FF40	Acellular xenograft implant, first 100 sq cm or less, or one percent of body area of infants and children	090	5.75

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●+15431	FF41	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)  (Use 15431 in conjunction with 15430)  (Do not report 15430, 15431 with 15000, 11040-11042)	ZZZ	Carrier Price
16000		<i>Initial treatment, first degree burn, when no more than local treatment is required</i>	000	0.89  (No Change)
D 16010		<del>Dressings and/or debridement, initial or subsequent; under anesthesia, small</del>	000	N/A
D 16015		<del>under anesthesia, medium or large, or with major debridement</del> (16010 and 16015 have been deleted. To report, see 16020 – 16030)	000	N/A
▲16020	FF42	Dressings and/or debridement of partial-thickness burns, initial or subsequent; <del>without anesthesia, office or hospital small (less than 5% total body surface area)</del>	000	0.80  (No Change)
▲16025	FF43	<del>without anesthesia</del> medium (eg, whole face or whole extremity, <u>or 5 to 10% total body surface area</u> )	000	1.85  (No Change)
▲16030	FF44	<del>without anesthesia</del> large (eg, more than one extremity, <u>or greater than 10% total body surface area</u> )	000	2.08  (No Change)

Free Skin grafts

Tracking Number	CPT Code	Global Period	2005 Work RVU	RUC Work RVU Rec	Median Time (min)											
					Pre	Intra	Immed Post	99231	99232	99238	99211	99212	99213			
				IWPUT RVU	0.0224	0.0224	0.0081			0.0224	0.64	1.06	1.28	0.17	0.43	0.65
FF1	15000	0		3.99	15	15	10	40	30	20						
FF2	15001	ZZZ		1.00					15							
FF3	15040	0		2.00	15	10	10	35	15	10						
Torso 1st 100 sq cm																
<i>Harvard</i>	15100	90	9.04	9.04				64	73	29	2.5		1			4.5
FF4	15110	90		9.50	20	20	10	50	28	20		4	1		3	
FF8	15130	90		7.00	10	10	10	30	25	18		1	1		4	
FF12	15150	90		8.25	30	25	15	70	20	30		3	1		3	
Torso ea additional 100 sq cm																
<i>Harvard</i>	15101	ZZZ	1.72	1.72					29							
FF5	15111	ZZZ		1.85					25							
FF9	15131	ZZZ		1.50					18							
FF13	15151	ZZZ		2.00					20							
FF14	15152	ZZZ		2.50					20							
Face 1st 100 sq cm																
<i>Harvard</i>	15120	90	9.82	9.82				56	102	25	0.5		1			4
FF6	15115	90		9.81	20	20	15	55	35	20		4	1		3	
FF10	15135	90		10.50	13	12	10	35	28	18		1	1		4	
FF15	15155	90		9.00	30	30	15	75	25	30		3	1		3	
Face ea additional 100 sq cm																
<i>Harvard</i>	15121	ZZZ	2.67	2.67					64							
FF7	15116	ZZZ		2.50					35							
FF11	15136	ZZZ		1.50					15							
FF16	15156	ZZZ		2.75					20							
FF17	15157	ZZZ		3.00					30							
Acellular Derm replacement 1st 100																
<i>RUC May 98</i>	15350	90	3.99					40	20							
FF18	15170	90		5.00	20	20	10	50	30	20		3				
FF32	15360	90		3.87	20	15	10	45	30	15			1		3	
FF22	15300	90		3.99	15	18	15	48	20	18		2				

Free Skin Grafts

FF26	15330	90		3.99	15	15	13	43	18	18						
RUC May 98	15400	90	3.99					35	20	18	5		1	1	2	1
FF36	15400	90		3.99	15	10	13	38	25	15		1			3	
Acellular Derm replacement ea add 100																
RUC May 98	15351	ZZZ	1.00						15							
FF19	15171	ZZZ		1.55					15							
FF33	15361	ZZZ		1.15					13							
FF23	15301	ZZZ		1.00					15							
FF27	15331	ZZZ		1.00					13							
RUC May 98	15401	ZZZ	1.00						15							
FF37	15401	ZZZ		1.00					20							
RUC May 98	15350	90	3.99					40	20							
FF20	15175	90		7.00	18	20	10	30	30	20		3				
FF34	15365	90		4.15	15	15	10	40	25	15			1		3	
FF24	15320	90		4.70	15	20	15	50	40	18		2				
FF28	15335	90		4.50	15	15	10	40	30	15						
RUC May 98	15400	90	3.99					35	20	18	5		1	1	2	1
FF38	15420	90		4.50	15	15	15	45	30	15		1			3	
RUC May 98	15351	ZZZ	1.00						15							
FF21	15176	ZZZ		2.45					28							
FF35	15366	ZZZ		1.45					15							
FF25	15321	ZZZ		1.50					20							
FF29	15336	ZZZ		1.43					25							
RUC May 98	15401	ZZZ	1.00						15							
FF39	15421	ZZZ		1.50					20							
FF30	15340	10		3.72	10	5	10	25	28	15			0.5		2	
FF31	15341	ZZZ		0.5					15							
FF40	15430	90		5.75	10	5	10	25	15	10			0.5		9	
FF42	16020	0		0.8	10	5	5	20	10	10						
FF43	16025	0		1.85	10	5	8	23	20	15						
FF44	16030	0		2.08	15	5	10	30	35	13						

## Compelling Evidence for New Work Related to Application of Skin Substitutes

- History of Codes for “Bilaminate/neodermis” skin substitutes
  - Initially assigned G-codes by CMS approximately 5 years ago
  - No single vignette was developed that adequately described all of the procedures now included in the 15342-15343 codes
  - The codes were never formally surveyed by specialty societies, therefore there have been assumptions made as to work valuation
  - Product applications have never been clearly defined
  - New products have become available for the treatment of different types of wounds
  - These issues have led to confusion as to which codes to apply to application of the various new skin substitutes
  - ABA/ASPS requested to clarify for *CPT Assistant*
  
- Current status of product applications
  - **Coding has not kept pace with new technology (for burns and chronic wounds).**
    - Some products improve wound healing, some serve as temporary wound covers, while products are permanent skin replacements
    - The current codes were initially assigned 10 day global periods while other skin grafts have typically been assigned 90 days
    - Applications in burn care are more appropriately coded in 100 cm<sup>2</sup> increments (with the exception of cultured autologous skin, which is typically supplied in 25 cm<sup>2</sup> units)
    - Debridement codes are now bundled into Codes 15340, 15341, 15430, and 15431
  
  - **The procedures and diagnoses associated with the application of newer skin substitutes differ in patient acuity and the complexity of wound closure.**
  
  - **Other major differences in the application of skin substitutes:**
    - **Application techniques**
    - **Patient populations**
    - **Site of service**
    - **Length of stay**
    - **Physician work**
  
  - **A wide variety of skin substitutes are now relegated to 15342-15343**

## Free Skin Grafts Tab 6 Work Neutrality Analysis

CPT Code	Tracking #	2005 Work RVU	SS Work RVU	2003 Medicare Utilization	Projected Utilization	Previously Reported Code	Pool of 2005 Work RVUs	Pool of Requested Work RVUs	Reviewed by RUC
15000	FF1	3.99	3.99	43,753	32,758	15000	174,574	130,704	May-98
15001	FF2	1.00	1.00	30,900	30,900	15001	30,900	30,900	May-98
								<b>-25%</b>	
15040	FF3		2.00		1,000	unlisted		2,000	
15100		9.04	9.04	22,277	20,777	15100	201,384	187,824	May-98
15101		1.72	1.72	22,074	18,724	15101	37,967	32,205	May-98
15110	FF4		9.50		500	15100		4,750	
15111	FF5		1.85		2,000	15101		3,700	
15130	FF8		7.00		500	15100		3,500	
15131	FF9		1.50		100	15101		150	
15150	FF12		8.25		250	15100		2,063	
15151	FF13		2.00		250	15101		500	
15152	FF14		2.50		1,000	15101		2,500	
15155	FF15		9.00		250	15100		2,250	
<b>Total Pool of Work RVUs for Family</b>							239,351	239,442	
<b>% Increase</b>								0%	
15120		9.82	9.82	10,987	8,737	15120	107,892	85,797	May-98
15121		2.67	2.67	1,767	67	15121	4,718	179	May-98
15115	FF6		9.81		2,000	15120		19,620	
15116	FF7		2.50		730	15121		1,825	
15135	FF10		10.50		250	15120		2,625	
15136	FF11		1.50		100	15121		150	
15156	FF16		2.75		500	15121		1,375	
15157	FF17		3.00		370	15121		1,110	
<b>Total Pool of Work RVUs for Family</b>							112,610	112,681	
<b>% Increase</b>								0%	
15342		1.00		16,261	deleted		16,261		CMS - 2001
15343		0.25		13,362	deleted		3,341		CMS - 2001
15170	FF18		5.00		1,000	15342		5,000	
15171	FF19		1.55		2,000	15343		3,100	
15175	FF20		7.00		511	15342		3,577	
15176	FF21		2.45		1,000	15343		2,450	
15340	FF30		3.72		11,000	15342		40,920	
15341	FF31		0.50		6,000	15343		3,000	
15360	FF32		3.87		2,250	15342		8,708	
15361	FF33		1.15		3,362	15343		3,866	
15365	FF34		4.15		1,500	15342		6,225	
15366	FF35		1.45		1,000	15343		1,450	
<b>Total Pool of Work RVUs for Family</b>							19,602	78,296	
<b>% Increase</b>								299%	

## Free Skin Grafts Tab 6 Work Neutrality Analysis

CPT Code	Tracking #	2005 Work RVU	SS Work RVU	2003 Medicare Utilization	Projected Utilization	Previously Reported Code	Pool of 2005 Work RVUs	Pool of Requested Work RVUs	Reviewed by RUC
15350		3.99		5,551	deleted		22,148		May-98
15351		1.00		8,752	deleted		8,752		May-98
15300	FF22		3.99		1,200	15350		4,788	
15301	FF23		1.00		2,000	15351		2,000	
15320	FF24		4.70		1,822	15350		8,563	
15321	FF25		1.50		2,752	15351		4,128	
15330	FF26		3.99		1,529	15350		6,101	
15331	FF27		1.00		2,000	15351		2,000	
15335	FF28		4.50		1,000	15350		4,500	
15336	FF29		1.43		2,000	15351		2,860	
<b>Total Pool of Work RVUs for Family</b>							30,900	34,940	
<b>% Increase</b>								13%	
15400	FF36	3.99	3.99	18,254	3,254	15400	72,833	12,983	May-98
15401	FF37	1.00	1.00	1,715	1,300	15401	1,715	1,300	May-98
15420	FF38		4.50		1,000	15400		4,500	
15421	FF39		1.50		200	15401		300	
15430	FF40		5.75		14,000	15400		80,500	
15431	FF41				215			0	No Recommendation
<b>Total Pool of Work RVUs for Family</b>							74,548	99,583	
<b>% Increase</b>								34%	
16010		0.87		1,149	deleted	16010	1,000		Never Reviewed
16015		2.35		788	deleted	16015	1,852		Never Reviewed
16020	FF42	0.80	0.80	18,066	19,215	16020/ 16010	14,453	15,372	Never Reviewed
16025	FF43	1.85	1.85	4,048	4,442	16025/ 16015	7,489	8,218	Never Reviewed
16030	FF44	2.08	2.08	1,801	2,380	16030/ 160	3,746	4,950	Never Reviewed
<b>Total Pool of Work RVUs for Family</b>							28,539	28,540	
<b>% Increase</b>								0%	
<b>Total Sum of Work RVUs</b>							711,026	755,087	
<b>% Increase in Work Relative Values Requested</b>								6.20%	

Any of the following codes may be billed at the same time as the surveyed procedure code:

<b>CPT</b>	<b>Global Period</b>	<b>Work RVU</b>	<b>Pre-service Time</b>	<b>Intra-service Time</b>	<b>Post-Service Time</b>
15000	000	3.99	40	30	20
15001	ZZZ	1.0		15	
15100	090	9.04	64	73	180
15101	ZZZ	1.72		29	
15120	090	9.81	56	102	127
15121	ZZZ	2.67		64	
15350	090	3.99	40	20	
15351	ZZZ	1.0		15	
15400	090	3.99	35	20	173
15401	ZZZ	1.0		15	
16020	000	0.8	20	10	10
16025	000	1.85	23	25	15
16030	000	2.08	30	35	13

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

**Recommended Work Relative Value**

CPT Code:15000 Tracking Number: FF1 Global Period: 000

Specialty Society RVU: 3.99

RUC RVU: 3.99

CPT Descriptor: Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or less or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 27-year-old cook was admitted to the burn center with grease scald burns involving the left neck, shoulder, chest, arm, and hand. A total of 25% body surface area was burned full thickness. Under general anesthesia, the left arm and hand burns were excised down to viable subcutaneous tissue; a total of 500 sq cm was excised.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 32%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, the subcutaneous tissue beneath the full-thickness burn is infiltrated with crystalloid solution containing epinephrine in order to minimize blood loss. The eschar is excised down to viable subcutaneous tissue. Hemostasis is obtained with electrocautery, epinephrine soaked laparotomy pads and/or topical thrombin. A total of 100 sq cm is excised in preparation for immediate or staged skin grafting and/or application of a skin substitute/replacement.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care of the operative sites, and preparation of discharge records.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005	
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD	
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons	
<b>CPT Code:</b>	15000	
<b>Sample Size:</b>	60	<b>Response:</b> 51.66 %
	<b>Resp n:</b> 31	
<b>Sample Type:</b>	Panel	

	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	3.99	3.99	4.00	5.00	20.00
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.0		
<b>Intra-Service Time:</b>	5.00	20.00	30.00	53.75	150.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>20.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15000	000	3.99

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
32020	000	3.97

CPT Descriptor 1 Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
64721	090	4.28

CPT Descriptor 2 Neuroplasty and/or transposition; median nerve at carpal tunnel

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 87.1 %**

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 15000	Key Reference CPT Code: 15000
Median Pre-Service Time	40.00	0.00
Median Intra-Service Time	30.00	30.00
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	90.00	30.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.41
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.97	3.00
Urgency of medical decision making	3.33	3.22

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

Technical skill required	3.93	4.63
Physical effort required	3.67	3.78

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.57	3.63
Outcome depends on the skill and judgment of physician	4.00	4.04
Estimated risk of malpractice suit with poor outcome	3.03	3.15

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

Pre-Service intensity/complexity	3.31	3.36
Intra-Service intensity/complexity	3.70	3.59
Post-Service intensity/complexity	3.21	3.07

**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 surveying societies feel that the changes in code 15000X are mostly editorial and therefore are crosswalking values of 15000 the new codes.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15001 Tracking Number: FF2 Global Period: ZZZ

**Recommended Work Relative Value**  
Specialty Society RVU: **1.00**  
RUC RVU: **1.00**

CPT Descriptor: Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 27-year-old cook was admitted to the burn center with grease scald burns involving the left neck, shoulder, chest, arm, and hand. A total of 25% body surface area was burned full thickness. Under general anesthesia, the left arm and hand burns were excised down to viable subcutaneous tissue; a total of 200 sq cm is to be excised. (The first 100 sq cm is reported separately).

Percentage of Survey Respondents who found Vignette to be Typical: 80%

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: After the induction of anesthesia, the subcutaneous tissue beneath the full-thickness burn is infiltrated with crystalloid solution containing epinephrine in order to minimize blood loss. The eschar is excised down to viable subcutaneous tissue. Hemostasis is obtained with electrocautery, epinephrine soaked laparotomy pads and/or topical thrombin. An additional 100 sq cm is excised in preparation for immediate or staged skin grafting and/or application of a skin substitute/replacement. The first 100 sq cm is reported separately.

Description of Post-Service Work:

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	Richard J. Kagan, MD, Keith Brandt, MD				
Specialty(s):	American Burn Association, American Society of Plastic Surgeons				
CPT Code:	15001				
Sample Size:	60	Resp n:	31	Response:	51.66 %
Sample Type:	Panel				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
Survey RVW:		1.00	1.00	1.00	1.50
Pre-Service Evaluation Time:				0.0	
Pre-Service Positioning Time:				0.0	
Pre-Service Scrub, Dress, Wait Time:				0.0	
Intra-Service Time:		2.00	10.00	15.00	30.00
Post-Service	Total Min**	CPT code / # of visits			

<b>Immed. Post-time:</b>	<u><b>0.00</b></u>	
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x <b>0.0</b> 99292x <b>0.0</b>
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x <b>0.0</b> 99232x <b>0.0</b> 99233x <b>0.0</b>
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x <b>0.00</b> 99239x <b>0.00</b>
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x <b>0.0</b> 12x <b>0.0</b> 13x <b>0.0</b> 14x <b>0.0</b> 15x <b>0.0</b>

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15001	ZZZ	1.00

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
45331	000	1.15

CPT Descriptor 1 Sigmoidoscopy, flexible; with biopsy, single or multiple

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
56605	000	1.1

CPT Descriptor 2 Biopsy of vulva or perineum (separate procedure); one lesion

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 87.0 %**

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 15001</u>	<u>Key Reference CPT Code: 15001</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	15.00	20.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	20.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.83	2.96
Urgency of medical decision making	3.27	3.29

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

Technical skill required	3.87	3.96
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Physical effort required	3.57	3.70
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.57	3.59
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Outcome depends on the skill and judgment of physician	4.03	4.07
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Estimated risk of malpractice suit with poor outcome	3.03	3.11
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.17	3.26
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Intra-Service intensity/complexity	3.67	3.63
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Post-Service intensity/complexity	3.07	3.11
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**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 surveying societies feel that the changes in code 15001 are mostly editorial and therefore are crosswalking the value of 15001 to the new code.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15040 Tracking Number: FF3 Global Period: 000  CPT Descriptor: Harvest of skin for tissue cultured skin autograft; 100 sq cm or less	<b>Recommended Work Relative Value</b> Specialty Society RVU: <b>2.00</b> RUC RVU: <b>2.00</b>
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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-year-old boy was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, he was intubated at the scene. He was transported to the nearby emergency room where he was assessed to have 80% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns (the excision is separately reported); however, due to the extent of burn and lack of sufficient donor sites, his remaining excised wounds were covered with cadaveric allograft and/or other skin substitute/skin replacement. As there was inadequate skin graft donor sites available for immediate, permanent wound coverage, a split-thickness skin biopsy was harvested for the preparation of cultured autologous skin grafts to be applied in 3-4 weeks, when available.

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? 14%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; ensuring that the necessary surgical instruments and supplies are present and available in the operative suite as well as the medium for placement and transport of the autologous skin to the laboratory for autologous cultured skin growth.

Description of Intra-Service Work: After the induction of anesthesia, the subcutaneous tissue beneath the donor site is infiltrated with crystalloid solution containing epinephrine in order to minimize blood loss and facilitate donor skin harvesting. A split-thickness skin graft 0.010 – 0.015 inches in depth is harvested using a dermatome. A total of 100 sq cm is recovered. Hemostasis is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. A dressing is applied to the donor site and covered with dry gauze.

Description of Post-Service Work: Postoperative work begins after the application of the donor site dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD		
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons		
<b>CPT Code:</b>	15040		
<b>Sample Size:</b>	60	<b>Response:</b>	%
		<b>Resp n:</b>	21

Sample Type: Panel					
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:	0.50	2.00	3.10	4.25	5.00
Pre-Service Evaluation Time:			15.0		
Pre-Service Positioning Time:			10.0		
Pre-Service Scrub, Dress, Wait Time:			10.0		
Intra-Service Time:	1.00	10.00	15.00	30.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>10.00</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15000	000	3.99

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
32020	000	3.97

CPT Descriptor 1 Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
64721	090	4.28

CPT Descriptor 2 Neuroplasty and/or transposition; median nerve at carpal tunnel

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 66.6 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15040</u>	<u>Key Reference CPT Code: 15000</u>
Median Pre-Service Time	35.00	0.00
Median Intra-Service Time	15.00	30.00
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	60.00	30.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.23	3.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.95	2.86
Urgency of medical decision making	3.55	3.14

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

Technical skill required	2.86	3.50
Physical effort required	2.67	3.29

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.19	3.29
Outcome depends on the skill and judgment of physician	3.24	3.57
Estimated risk of malpractice suit with poor outcome	2.67	2.86

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

Pre-Service intensity/complexity	3.10	2.79
Intra-Service intensity/complexity	2.81	2.93
Post-Service intensity/complexity	2.76	2.64

**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 code 15040X compares favorably to the reference code 15000. The decrease in work value is related to smaller size of harvested skin and the fewer passes of the dermatome needed to harvest. Also there is less need to provide hemostasis.



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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 15101

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**

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CPT Code:15110 Tracking Number: FF4 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **9.50**  
RUC RVU: **9.5**

CPT Descriptor: Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-year-old boy was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, he was intubated at the scene. He was transported to the nearby emergency room where he was assessed to have 80% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns; however, due to the extent of burn and lack of sufficient donor sites available for immediate, permanent wound coverage, his wounds were covered with an acellular dermal replacement (i.e., Integra®). He is returned to the operating room for harvesting of "ultrathin" epidermal skin autografts to be placed on the now vascularized acellular dermal replacement covering his torso, arms, and legs.

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 includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, the subcutaneous tissue beneath the donor site is infiltrated with crystalloid solution containing epinephrine in order to minimize blood loss and facilitate donor skin harvesting. An epidermal skin graft 0.004 – 0.006 inches in depth is harvested using a dermatome. The dermatome is adjusted as necessary during donor skin harvesting to ensure that almost no dermal tissue is harvested. A total of 100 sq cm is recovered and is meshed for expansion prior to placement on the excised wound. Hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The epidermal skin graft is then applied to the trunk and secured to the excised wound with interrupted sutures, surgical staples, and/or fibrin sealant. A dressing is applied to the graft site and secured to prevent mechanical shear. A dressing is applied to the donor site and covered with dry gauze.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

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**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>		Richard J. Kagan, MD, Keith Brandt, MD			
<b>Specialty(s):</b>		American Burn Association, American Society of Plastic Surgeons			
<b>CPT Code:</b>		15110			
<b>Sample Size:</b>	60	<b>Resp n:</b>	26	<b>Response:</b>	%
<b>Sample Type:</b> Panel					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>
<b>Survey RWV:</b>		1.20	9.50	10.00	11.00
<b>Pre-Service Evaluation Time:</b>				20.0	
<b>Pre-Service Positioning Time:</b>				20.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		1.00	12.50	28.00	60.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>		
<b>Immed. Post-time:</b>		<u>20.00</u>			
<b>Critical Care time/visit(s):</b>		<u>0.0</u>	99291x 0.0	99292x 0.0	
<b>Other Hospital time/visit(s):</b>		<u>120.0</u>	99231x 0.0	99232x 4.0	99233x 0.0
<b>Discharge Day Mgmt:</b>		<u>36.0</u>	99238x 1.00	99239x 0.00	
<b>Office time/visit(s):</b>		<u>45.0</u>	99211x 0.0	12x 3.0	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>
15100	090	9.04

CPT Descriptor Split graft, trunk, arms, legs; first 100sq cm or less, or one percent of body area of infants and children (except 15050)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
14060	090	8.49

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
44950	090	9.99

CPT Descriptor 2 Appendectomy;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 100.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15110</u>	<u>Key Reference CPT Code: 15100</u>
Median Pre-Service Time	50.00	39.00
Median Intra-Service Time	28.00	73.00
Median Immediate Post-service Time	20.00	29.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	120.0	47.50
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	45.0	103.50
Median Total Time	299.00	328.00
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	3.81	3.46
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.46	3.19
--	------	------

Urgency of medical decision making	3.65	3.46
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.38	3.88
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Physical effort required	3.84	3.81
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.08	3.69
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Outcome depends on the skill and judgment of physician	4.35	4.00
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Estimated risk of malpractice suit with poor outcome	3.35	3.27
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.77	3.50
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Intra-Service intensity/complexity	4.15	3.65
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Post-Service intensity/complexity	3.73	3.42
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**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 code 15110 compares favorably with reference code 15100 in the technique, hospital and office visits. 7 extra work value is justified because of the increased difficulty harvesting "ultra thin epidermal grafts" and the difficulty obtaining 100 sq cm as a single sheet graft. Also, extra time is needed during dressing changes, because of the extra fragile nature of the ultra thin graft. The 4-99232 hospital visits and 4-99212 office visits are added to represent the time needed to perform dressing changes of the grafted area.



Specialty

Frequency 0

Percentage 0.00 %

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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15111 Tracking Number: FF5 Global Period: ZZZ

**Recommended Work Relative Value**  
Specialty Society RVU: **1.85**  
RUC RVU: **1.85**

CPT Descriptor: Epidermal autograft, 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-year-old boy was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, he was intubated at the scene. He was transported to the nearby emergency room where he was assessed to have 80% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns; however, due to the extent of burn and lack of sufficient donor sites available for immediate, permanent wound coverage, his wounds were covered with an acellular dermal replacement (i.e., Integra®). He is returned to the operating room for harvesting of "ultrathin" epidermal skin autografts to be placed on the now vascularized acellular dermal replacement covering his torso, arms, and legs.

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:**

Description of Intra-Service Work: After the induction of anesthesia, the subcutaneous tissue beneath the donor site is infiltrated with crystalloid solution containing epinephrine in order to minimize blood loss and facilitate donor skin harvesting. An epidermal skin graft 0.004 – 0.006 inches in depth is harvested using a dermatome. The dermatome is adjusted as necessary during donor skin harvesting to ensure that almost no dermal tissue is harvested. An additional 400 sq cm is recovered and is meshed for expansion prior to placement on the excised wound. Hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The epidermal skin graft is then applied to the trunk and arm and secured to the excised wound with interrupted sutures, surgical staples, and/or fibrin sealant. A dressing is applied to the graft site and secured to prevent mechanical shear. A dressing is applied to the donor site and covered with dry gauze.

**Description of Post-Service Work:****SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15111				
<b>Sample Size:</b>	60	<b>Resp n:</b>	26	<b>Response:</b>	43.33 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	1.85	2.00	2.63	5.99

Pre-Service Evaluation Time:				0.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0		
Intra-Service Time:		5.00	10.00	25.00	33.75	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>0.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15101	ZZZ	1.72

CPT Descriptor 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)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
11441	010	1.48

CPT Descriptor 1 Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
11043	010	2.38

CPT Descriptor 2 Debridement; skin, subcutaneous tissue and muscle

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 100.0 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 15111	Key Reference CPT Code: 15101
Median Pre-Service Time	12.00	0.00
Median Intra-Service Time	25.00	29.00
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	37.00	29.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.42	2.92
Urgency of medical decision making	3.67	3.23

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

Technical skill required	4.32	3.73
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Physical effort required	3.92	3.62
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.00	3.50
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Outcome depends on the skill and judgment of physician	4.28	3.81
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Estimated risk of malpractice suit with poor outcome	3.32	4.23
--	------	------

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

Pre-Service intensity/complexity	3.77	3.50
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Intra-Service intensity/complexity	4.20	3.69
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Post-Service intensity/complexity	3.76	3.46
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**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 code 15111 compares favorably with reference code 15101 in the technique, hospital and office visits. The extra work value is justified because of the increased difficulty harvesting "ultra thin epidermal grafts" and the difficulty obtaining 100 sq cm as a single sheet graft. Also, extra time is needed during dressing changes, because of the extra fragile nature of the ultra thin graft.

## 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 attached table

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 15101

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

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

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

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

2,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Plastic surgery Frequency 1000 Percentage 50.00 %

Specialty General surgery Frequency 1000 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? 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**

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CPT Code:15115 Tracking Number: FF6 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **9.81**  
RUC RVU: **9.81**

CPT Descriptor: Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-year-old boy was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, he was intubated at the scene. He was transported to the nearby emergency room where he was assessed to have 80% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns; however, due to the extent of burn and lack of sufficient donor sites available for immediate, permanent wound coverage, his wounds were covered with an acellular dermal replacement (i.e., Integra®). He is returned to the operating room for harvesting of "ultrathin" epidermal skin autografts to be placed on the now vascularized acellular dermal replacement covering his hands.

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? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, the subcutaneous tissue beneath the donor site is infiltrated with crystalloid solution containing epinephrine in order to minimize blood loss and facilitate donor skin harvesting. An epidermal skin graft 0.004 – 0.006 inches in depth is harvested using a dermatome. The dermatome is adjusted as necessary during donor skin harvesting to ensure that almost no dermal tissue is harvested. A total of 100 sq cm is recovered and is meshed for expansion prior to placement on the excised wound. Hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The epidermal skin graft is then applied to the hands and secured to the excised wound with interrupted sutures, surgical staples, and/or fibrin sealant. A dressing is applied to the graft site and secured to prevent mechanical shear. A dressing is applied to the donor site and covered with dry gauze.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

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**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD					
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons					
<b>CPT Code:</b>	15115					
<b>Sample Size:</b>	60	<b>Resp n:</b>	24	<b>Response:</b>	%	
<b>Sample Type:</b> Panel						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		1.00	9.81	11.00	12.99	15.00
<b>Pre-Service Evaluation Time:</b>				20.0		
<b>Pre-Service Positioning Time:</b>				20.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15.0		
<b>Intra-Service Time:</b>		1.00	18.75	35.00	41.25	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>20.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>120.0</u>	99231x 0.0	99232x 4.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>45.0</u>	99211x 0.0	12x 3.0	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>
15120	090	9.81

CPT Descriptor Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
14060	090	8.49

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
44950	090	9.99

CPT Descriptor 2 Appendectomy;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 95.8 %

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 15115	Key Reference CPT Code: 15120
Median Pre-Service Time	55.00	31.00
Median Intra-Service Time	35.00	102.00
Median Immediate Post-service Time	20.00	25.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	120.0	9.50
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	45.0	92.00
Median Total Time	311.00	295.50
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.77	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.45	2.91
Urgency of medical decision making	3.68	3.13

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

Technical skill required	4.55	3.82
Physical effort required	3.95	3.39

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.32	3.70
Outcome depends on the skill and judgment of physician	4.55	3.96
Estimated risk of malpractice suit with poor outcome	3.59	3.26

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

Pre-Service intensity/complexity	3.78	3.43
Intra-Service intensity/complexity	4.48	3.91
Post-Service intensity/complexity	3.82	3.43

**ADDITIONAL RATIONALE**

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

The new code 15115 compares favorably with reference code 15100 in the technique, hospital and office visits. The extra work value is justified because of the increased difficulty harvesting "ultra thin epidermal grafts" and the difficulty obtaining 100 sq cm as a single sheet graft. Also, extra time is needed during dressing changes, because of the extra fragile nature of the ultra thin graft. The 4-99232 hospital visits and 4-99212 office visits are added to represent the time needed to perform dressing changes of the grafted area. The extra value of 15115 compared to 15110 is justified by the extra intensity and complexity needed to preserve critical structures of the face.



Specialty                                      Frequency 0                                      Percentage 0.00 %

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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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



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

CPT Code:15116 Tracking Number: FF7 Global Period: ZZZ

**Recommended Work Relative Value**  
Specialty Society RVU: **2.5**  
RUC RVU: **2.5**

CPT Descriptor: Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-year-old boy was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, he was intubated at the scene. He was transported to the nearby emergency room where he was assessed to have 80% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns; however, due to the extent of burn and lack of sufficient donor sites available for immediate, permanent wound coverage, his wounds were covered with an acellular dermal replacement (i.e., Integra®). He is returned to the operating room for harvesting of "ultrathin" epidermal skin autografts to be placed on the now vascularized acellular dermal replacement covering both of his hands. The first 100 sq cm will be coded separately.

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? 0%

s conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

Description of Intra-Service Work: After the induction of anesthesia, the subcutaneous tissue beneath the donor site is infiltrated with crystalloid solution containing epinephrine in order to minimize blood loss and facilitate donor skin harvesting. An epidermal skin graft 0.004 – 0.006 inches in depth is harvested using a dermatome. The dermatome is adjusted as necessary during donor skin harvesting to ensure that almost no dermal tissue is harvested. Two hundred is recovered and is meshed for expansion prior to placement on the excised wound. Hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The epidermal skin graft is then applied to the hands and secured to the excised wound with interrupted sutures, surgical staples, and/or fibrin sealant. A dressing is applied to the graft site and secured to prevent mechanical shear. A dressing is applied to the donor site and covered with dry gauze.

## Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15116				
<b>Sample Size:</b>	60	<b>Resp n:</b>	24	<b>Response:</b>	40.00 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>

<b>Survey RVW:</b>	1.00	1.25	3.00	3.50	7.99
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	15.00	35.00	56.25	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>0.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15121	ZZZ	2.67

CPT Descriptor Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
11043	010	2.38

CPT Descriptor 1 Debridement; skin, subcutaneous tissue and muscle

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
64721	090	4.28

CPT Descriptor 2 Neuroplasty and/or transposition; median nerve at carpal tunnel

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 95.8 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 15116	Key Reference CPT Code: 15121
Median Pre-Service Time	3.50	0.00
Median Intra-Service Time	35.00	64.00
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	38.50	64.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.85	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	2.82
Urgency of medical decision making	3.76	3.00

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

Technical skill required	4.59	3.91
Physical effort required	4.09	3.48

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.27	3.65
Outcome depends on the skill and judgment of physician	4.54	3.96
Estimated risk of malpractice suit with poor outcome	3.72	3.30

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

Pre-Service intensity/complexity	3.78	3.26
Intra-Service intensity/complexity	4.43	3.61
Post-Service intensity/complexity	3.82	3.43

**ADDITIONAL RATIONALE**

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

The new code 15116X compares favorably with reference code 15101 in the technique, hospital and office visits. extra work value is justified because of the increased difficulty harvesting "ultra thin epidermal grafts" and the difficulty obtaining 100 sq cm as a single sheet graft. Also, extra time is needed during dressing changes, because of the extra fragile nature of the ultra thin graft. The 99232 hospital visit and 99212 office visit are added to represent the time needed to perform dressing changes of the grafted area. The extra value of 15115X compared to 15110X is justified by the extra intensity and complexity needed to preserve critical structures of the face..



Specialty                                      Frequency 0                                      Percentage 0.00 %

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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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



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

CPT Code:15130 Tracking Number: FF8 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **7.0**  
RUC RVU: **7.0**

CPT Descriptor: Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 62 y/o male has recurrent metastatic cancer to his left popliteal fossa. He has previously had radiation therapy to this area and undergoes surgical exploration. The popliteal artery is exposed and has evidence of radiation injury.

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 includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, the subcutaneous tissue beneath the donor site is infiltrated with crystalloid solution containing epinephrine in order to minimize blood loss and facilitate donor skin harvesting. A split-thickness skin graft 0.010 – 0.015 inches in depth is raised but not removed from the underlying dermal bed using a dermatome. The dermatome is adjusted to facilitate removal of the graft from the device. A second pass of the dermatome is made over the freshly created donor site at a depth of 0.010 inches for the recovery of the dermal graft. A total of 100 sq cm of dermal autograft tissue is recovered. Hemostasis of the donor site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The split-thickness skin graft that was originally raised is then applied to the donor site and secured with interrupted sutures, surgical staples, and/or fibrin sealant. The dermal graft is then secured to the surgically prepared wound in the popliteal fossa. Dressings are applied to both the grafted donor site and the surgically prepared wound in the popliteal fossa and both are secured to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD

<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15130				
<b>Sample Size:</b>	60	<b>Resp n:</b>	6	<b>Response:</b>	%
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.40	7.00	9.50	11.50	12.00
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			10.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.0		
<b>Intra-Service Time:</b>	0.00	0.25	25.00	30.00	45.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>18.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>30.0</u>	99231x 0.0	99232x 1.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>60.0</u>	99211x 0.0	12x 4.0	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>
15100	090	9.04

CPT Descriptor Split graft, trunk, arms, legs; first 100sq cm or less, or one percent of body area of infants and children (except 15050)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
14060	090	8.49

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
44950	090	9.99

CPT Descriptor 2 Appendectomy;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

**Number of respondents who choose Key Reference Code: 5      % of respondents: 83.3 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15130</u>	<u>Key Reference CPT Code: 15100</u>
Median Pre-Service Time	30.00	39.00
Median Intra-Service Time	25.00	73.00
Median Immediate Post-service Time	18.00	29.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	47.50
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	60.0	103.50
Median Total Time	199.00	328.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.80	2.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	2.40
Urgency of medical decision making	3.40	2.40

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

Technical skill required	4.60	2.80
Physical effort required	3.80	2.60
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	3.80	2.40
Outcome depends on the skill and judgment of physician	4.40	3.00
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	3.40	3.00
Intra-Service intensity/complexity	3.80	3.60
Post-Service intensity/complexity	3.40	3.20

**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)

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 attached table

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 15100

How often do physicians 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 Burn Association	How often? Rarely
Specialty American Society of Plastic Surgeons	How often? Rarely

Specialty	How often?
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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? 500  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Plastic surgery	Frequency 250	Percentage 50.00 %
Specialty General surgery	Frequency 250	Percentage 50.00 %
Specialty	Frequency 0	Percentage 0.00 %

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

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-> **Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 14020

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:15131 Tracking Number: FF9 Global Period: ZZZ

**Recommended Work Relative Value**  
Specialty Society RVU: 1.5  
RUC RVU: 1.5

CPT Descriptor: Dermal autograft, 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 62 y/o male has recurrent metastatic cancer to his left popliteal fossa. He has previously had radiation therapy to this area and undergoes surgical exploration. The popliteal artery is exposed and has evidence of radiation injury.

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:

Description of Intra-Service Work: After the induction of anesthesia, the subcutaneous tissue beneath the donor site is infiltrated with crystalloid solution containing epinephrine in order to minimize blood loss and facilitate donor skin harvesting. A split-thickness skin graft 0.010 - 0.015 inches in depth is raised but not removed from the underlying dermal bed using a dermatome. The dermatome is adjusted to facilitate removal of the graft from the device. A second pass of the dermatome is made over the freshly created donor site at a depth of 0.010 inches for the recovery of the dermal graft. Two hundred sq cm of dermal autograft tissue is recovered. Hemostasis of the donor site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The split-thickness skin graft that was originally raised is then applied to the donor site and secured with interrupted sutures, surgical staples, and/or fibrin sealant. The dermal graft is then secured to the surgically prepared wound in the popliteal fossa. The first 100 sq cm is separately reported. Dressings are applied to both the grafted donor site and the surgically prepared wound in the popliteal fossa and both are secured to prevent mechanical shear.

## Description of Post-Service Work:

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	Richard J. Kagan, MD, Keith Brandt, MD				
Specialty(s):	American Burn Association, American Society of Plastic Surgeons				
CPT Code:	15131				
Sample Size:	60	Resp n:	5	Response: 8.33 %	
Sample Type:	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
Survey RVW:	1.40	1.50	2.00	2.00	4.00
Pre-Service Evaluation Time:			0.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		

<b>Intra-Service Time:</b>		0.00	11.25	18.00	20.00	20.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>0.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15101	ZZZ	1.72

CPT Descriptor 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)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
11441	010	1.48

CPT Descriptor 1 Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
11043	010	2.38

CPT Descriptor 2 Debridement; skin, subcutaneous tissue and muscle

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

**Number of respondents who choose Key Reference Code: 4      % of respondents: 80.0 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15131</u>	<u>Key Reference CPT Code: 15101</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	18.00	29.00
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	18.00	29.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.80	2.25
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	2.25
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Urgency of medical decision making	3.40	2.25
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.60	2.75
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Physical effort required	3.60	2.50
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.80	2.25
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Outcome depends on the skill and judgment of physician	4.20	3.00
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Estimated risk of malpractice suit with poor outcome	2.80	2.25
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.40	3.00
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Intra-Service intensity/complexity	3.80	3.75
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Post-Service intensity/complexity	3.40	3.00
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**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 code compares favorably to the reference code 15101. The additional work value is justified, because of additional passes of the dermatome and the need to fixate the dermal graft at the recipient site and the split graft at the donor site. This technique is typically limited to coverage of small areas with exposed critical structures. Therefore, the need for use of 15131 will be limited and therefore no additional hospital or office visits are requested.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**Specialty Society RVU: **10.50**RUC RVU: **10.5**

CPT Code:15135 Tracking Number: FF10 Global Period: 090

CPT Descriptor: Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 62 y/o male has recurrent metastatic cancer to his left neck. He has previously had radiation therapy to this area and undergoes surgical exploration with radical neck dissection. The carotid artery is exposed and has evidence of radiation injury.

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 includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, the subcutaneous tissue beneath the donor site is infiltrated with crystalloid solution containing epinephrine in order to minimize blood loss and facilitate donor skin harvesting. A split-thickness skin graft 0.010 – 0.015 inches in depth is raised but not removed from the underlying dermal bed using a dermatome. The dermatome is adjusted to facilitate removal of the graft from the device. A second pass of the dermatome is made over the freshly created donor site at a depth of 0.010 inches for the recovery of the dermal graft. A total of 100 sq cm of dermal autograft tissue is recovered. Hemostasis of the donor site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The split-thickness skin graft that was originally raised is then applied to the donor site and secured with interrupted sutures, surgical staples, and/or fibrin sealant. The dermal graft is then secured to the surgically prepared wound in the neck. Dressings are applied to both the grafted donor site and the surgically prepared wound on the trunk and both are secured to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD

<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15135				
<b>Sample Size:</b>	60	<b>Resp n:</b>	6	<b>Response:</b>	%
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.40	8.50	<b>10.50</b>	12.50	15.00
<b>Pre-Service Evaluation Time:</b>			<b>13.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>12.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.0</b>		
<b>Intra-Service Time:</b>	20.00	21.25	<b>28.00</b>	41.25	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b><u>18.00</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b><u>30.0</u></b>	99231x 0.0	99232x 1.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b><u>36.0</u></b>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b><u>60.0</u></b>	99211x 0.0	12x 4.0	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>
15120	090	9.81

CPT Descriptor Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
14060	090	8.49

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
44950	090	9.99

CPT Descriptor 2 Appendectomy;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 100.0 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 15135	Key Reference CPT Code: 15120
Median Pre-Service Time	35.00	56.00
Median Intra-Service Time	28.00	102.00
Median Immediate Post-service Time	18.00	25.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	8.50
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	60.0	92.00
Median Total Time	207.00	319.50
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.83	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	2.50
Urgency of medical decision making	3.33	2.50

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

Technical skill required	4.33	3.17
Physical effort required	3.83	2.67

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.00	2.83
Outcome depends on the skill and judgment of physician	4.00	3.33
Estimated risk of malpractice suit with poor outcome	2.67	2.50

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

Pre-Service intensity/complexity	3.50	3.17
Intra-Service intensity/complexity	3.83	4.00
Post-Service intensity/complexity	3.33	3.17

**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 code compares favorably to the reference code 15120. The additional work value is justified, because of the additional passes of the dermatome and the need to fixate the dermal graft at the recipient site and the split graft at the donor site. The additional hospital visits are justified because of the critical structures covered at the recipient site. The extra value of 15135 compared to 15130 is justified by the extra intensity and complexity needed to preserve critical structures of the face.



Specialty

Frequency 0

Percentage 0.00 %

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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15136 Tracking Number: FF11 Global Period: ZZZ

**Recommended Work Relative Value**  
Specialty Society RVU: **1.50**

**RUC RVU: 1.50**

CPT Descriptor: Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 62 y/o male has recurrent metastatic cancer to his left neck. He has previously had radiation therapy to this area and undergoes surgical exploration with radical neck dissection. The carotid artery is exposed and has evidence of radiation injury.

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:**

Description of Intra-Service Work: After the induction of anesthesia, the subcutaneous tissue beneath the donor site is infiltrated with crystalloid solution containing epinephrine in order to minimize blood loss and facilitate donor skin harvesting. A split-thickness skin graft 0.010 – 0.015 inches in depth is raised but not removed from the underlying dermal bed using a dermatome. The dermatome is adjusted to facilitate removal of the graft from the device. A second pass of the dermatome is made over the freshly created donor site at a depth of 0.010 inches for the recovery of the dermal graft. Two hundred sq cm of dermal autograft tissue is recovered. The first 100 sq cm is coded separately. Hemostasis of the donor site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The split-thickness skin graft that was originally raised is then applied to the donor site and secured with interrupted sutures, surgical staples, and/or fibrin sealant. The dermal graft is then secured to the surgically prepared wound in the neck. Dressings are applied to both the grafted donor site and the surgically prepared wound on the trunk and both are secured to prevent mechanical shear.

**Description of Post-Service Work:**

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Richard J. Kagan, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15136				
<b>Sample Size:</b>	60	<b>Resp n:</b>	6	<b>Response:</b>	10.00 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.40	1.75	2.25	2.50	4.50
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		0.00	7.50	<b>15.00</b>	22.50	30.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u><b>0.00</b></u>					
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15121	ZZZ	2.67

CPT Descriptor Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
11043	010	2.38

CPT Descriptor 1 Debridement; skin, subcutaneous tissue, and muscle

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
32020	000	3.97

CPT Descriptor 2 Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

**Number of respondents who choose Key Reference Code: 5      % of respondents: 83.3 %**

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 15136	Key Reference CPT Code: 15121
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	15.00	64.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>15.00</b>	<b>64.00</b>
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.83	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	2.40
Urgency of medical decision making	3.50	2.40

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

Technical skill required	4.50	2.80
Physical effort required	3.83	2.40

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.00	2.00
Outcome depends on the skill and judgment of physician	4.00	2.60
Estimated risk of malpractice suit with poor outcome	2.67	2.20

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

Pre-Service intensity/complexity	3.50	3.20
Intra-Service intensity/complexity	3.83	4.00
Post-Service intensity/complexity	3.33	3.20

**ADDITIONAL RATIONALE**

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

This technique is typically limited to coverage of small areas with exposed critical structures. Therefore, the need use of 15131 will be limited and therefore no additional hospital or office visits are requested. 15136 compares to 15131 as the extra intensity and complexity needed to preserve critical structures of the face.



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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 15001

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**Specialty Society RVU: **8.25**RUC RVU: **8.25**

CPT Code:15150 Tracking Number: FF12 Global Period: 090

CPT Descriptor: Tissue cultured epidermal autograft, trunk, arms, legs; first 25 sq cm or less

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-year-old boy was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, he was intubated at the scene. He was transported to the nearby emergency room where he was assessed to have 80% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns; however, due to the extent of burn and lack of sufficient donor sites, his remaining excised wounds were covered with cadaveric allograft and/or other skin substitute/skin replacement. As there were inadequate skin graft donor sites available for immediate, permanent wound coverage, a small split-thickness skin graft was harvested for the preparation of cultured autologous skin grafts 3-4 weeks previously. He is now returned to the operating room for the application of cultured autologous epidermal autografts to his torso and lower extremities.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

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 includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The tissue cultured epidermal autografts are removed from the transport medium and a total of 25 sq cm is applied to the trunk and secured to the excised wound with interrupted sutures, surgical staples, and/or fibrin sealant. A dressing is applied to the graft site and secured to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	04/2005
Presenter(s):	Richard J. Kagan, MD, Keith Brandt, MD

<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15150				
<b>Sample Size:</b>	60	<b>Resp n:</b>	15	<b>Response:</b>	%
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	4.12	8.25	11.50	12.00
<b>Pre-Service Evaluation Time:</b>			30.0		
<b>Pre-Service Positioning Time:</b>			25.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			15.0		
<b>Intra-Service Time:</b>	2.00	15.00	20.00	30.00	150.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>30.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>90.0</u>	99231x 0.0	99232x 3.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>45.0</u>	99211x 0.0	12x 3.0	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>
15100	090	9.04

CPT Descriptor Split graft, trunk, arms, legs; first 100sq cm or less, or one percent of body area of infants and children (except 15050)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
32020	000	3.97

CPT Descriptor 1 Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
64721	090	4.28

CPT Descriptor 2 Neuroplasty and/or transposition; median nerve at carpal tunnel

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 73.3 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 15150	Key Reference CPT Code: 15100
Median Pre-Service Time	70.00	64.00
Median Intra-Service Time	20.00	73.00
Median Immediate Post-service Time	30.00	29.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	90.0	47.50
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	45.0	103.50
Median Total Time	291.00	353.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.36	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.45
Urgency of medical decision making	4.21	3.55

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

Technical skill required	4.50	3.82
Physical effort required	4.14	3.64

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.36	3.55
Outcome depends on the skill and judgment of physician	4.57	3.73
Estimated risk of malpractice suit with poor outcome	3.64	3.36

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

Pre-Service intensity/complexity	4.13	3.64
Intra-Service intensity/complexity	4.60	3.91
Post-Service intensity/complexity	4.40	3.82

**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 intra-operative work of 15150X is similar to the reference code 15100 in that each graft must be secured to recipient site. The reduced work value represents the smaller graft (25 sq cm versus 100 sq cm) and the fact that there is no need for harvesting. The hospital and office visits represent the extra time needed during dressing changes, because of the extra fragile nature of the cultured graft.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**

CPT Code:15151 Tracking Number: FF13 Global Period: ZZZ

Specialty Society RVU: **2.00**RUC RVU: **2.00**

CPT Descriptor: Tissue cultured epidermal autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) (do not report more than once)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-year-old boy was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, he was intubated at the scene. He was transported to the nearby emergency room where he was assessed to have 80% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns; however, due to the extent of burn and lack of sufficient donor sites, his remaining excised wounds were covered with cadaveric allograft and/or other skin substitute/skin replacement. As there were inadequate skin graft donor sites available for immediate, permanent wound coverage, a small split-thickness skin graft was harvested for the preparation of cultured autologous skin grafts 3-4 weeks previously. He is now returned to the operating room for the application of cultured autologous epidermal autografts to his torso and lower extremities.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

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:

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The tissue cultured epidermal autografts are removed from the transport medium. Additional grafts measuring 100 sq cm (the first 25 sq cm will be coded separately) are applied to the trunk and secured to the excised wound with interrupted sutures, surgical staples, and/or fibrin sealant. A dressing is applied to the graft site and secured to prevent mechanical shear.

Description of Post-Service Work:

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	Richard J. Kagan, MD, Keith Brandt, MD				
Specialty(s):	American Burn Association, American Society of Plastic Surgeons				
CPT Code:	15151				
Sample Size:	60	Resp n:	15	Response: 25.00 %	
Sample Type:	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:	1.50	2.00	2.50	2.63	9.00
Pre-Service Evaluation Time:			0.0		
Pre-Service Positioning Time:			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		4.00	10.00	<b>20.00</b>	30.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u><b>0.00</b></u>					
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15101	ZZZ	1.72

CPT Descriptor 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)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
11441	010	1.48

CPT Descriptor 1 Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
11043	010	2.38

CPT Descriptor 2 Debridement; skin, subcutaneous tissue, and muscle

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 66.6 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15151</u>	<u>Key Reference CPT Code: 15101</u>
Median Pre-Service Time	40.00	0.00
Median Intra-Service Time	20.00	29.00
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	29.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.36	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.40
Urgency of medical decision making	4.21	3.50

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

Technical skill required	4.50	3.70
Physical effort required	4.14	3.60

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.36	3.60
Outcome depends on the skill and judgment of physician	4.57	3.70
Estimated risk of malpractice suit with poor outcome	3.64	3.50

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

Pre-Service intensity/complexity	4.07	3.60
Intra-Service intensity/complexity	4.53	3.90
Post-Service intensity/complexity	4.33	3.80

**ADDITIONAL RATIONALE**

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

The intra-operative work of 15151 is similar to the reference code 15101 in that each graft must be secured to recipient site.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**

CPT Code:15152 Tracking Number: FF14 Global Period: ZZZ

Specialty Society RVU: 2.50

RUC RVU: 2.50

CPT Descriptor: Tissue cultured epidermal autograft, 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-year-old boy was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, he was intubated at the scene. He was transported to the nearby emergency room where he was assessed to have 80% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns; however, due to the extent of burn and lack of sufficient donor sites, his remaining excised wounds were covered with cadaveric allograft and/or other skin substitute/skin replacement. As there were inadequate skin graft donor sites available for immediate, permanent wound coverage, a small split-thickness skin graft was harvested for the preparation of cultured autologous skin grafts 3-4 weeks previously. He is now returned to the operating room for the application of cultured autologous epidermal autografts to his torso, lower extremities, and hands.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

s 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:**

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The tissue cultured epidermal autografts are removed from the transport medium. Two hundred sq cm (the first 100 sq cm will be coded separately) of grafts are applied to the trunk and secured to the excised wound with interrupted sutures, surgical staples, and/or fibrin sealant. A dressing is applied to the graft site and secured to prevent mechanical shear.

**Description of Post-Service Work:****SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15152				
<b>Sample Size:</b>	60	<b>Resp n:</b>	14	<b>Response:</b>	23.33 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.50	2.50	2.55	4.00	4.00
<b>Pre-Service Evaluation Time:</b>			0.0		

<b>Pre-Service Positioning Time:</b>				<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		5.00	12.00	<b>20.00</b>	30.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u><b>0.00</b></u>					
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15101	ZZZ	1.72

CPT Descriptor 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)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
11043	010	2.38
<u>CPT Descriptor 1</u> Debridement; skin, subcutaneous tissue, and muscle		

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
11642	010	2.59

CPT Descriptor 2 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 71.4 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 15152	Key Reference CPT Code: 15101
Median Pre-Service Time	40.00	0.00
Median Intra-Service Time	20.00	29.00
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	29.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.31	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.40
Urgency of medical decision making	4.15	3.50

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

Technical skill required	4.46	3.70
Physical effort required	4.08	3.60

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.38	3.60
Outcome depends on the skill and judgment of physician	4.54	3.70
Estimated risk of malpractice suit with poor outcome	3.54	3.50

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

Pre-Service intensity/complexity	4.00	3.70
Intra-Service intensity/complexity	4.50	4.00
Post-Service intensity/complexity	4.29	3.90

**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 intra-operative work of 15152 is similar to the reference code 15101 in that each graft must be secured to recipient site.



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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 15121

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**Specialty Society RVU: **9.00**RUC RVU: **9.00**

CPT Code:15155 Tracking Number: FF15 Global Period: 090

CPT Descriptor: Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 25 sq cm or less

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-year-old boy was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, he was intubated at the scene. He was transported to the nearby emergency room where he was assessed to have 80% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns; however, due to the extent of burn and lack of sufficient donor sites, his remaining excised wounds were covered with cadaveric allograft and/or other skin substitute/skin replacement. As there were inadequate skin graft donor sites available for immediate, permanent wound coverage, a small split-thickness skin graft was harvested for the preparation of cultured autologous skin grafts 3-4 weeks previously. He is now returned to the operating room for the application of cultured autologous epidermal autografts to hands.

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 includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The tissue cultured epidermal autografts are removed from the transport medium and a total of 25 sq cm is applied to the hand and secured to the excised wound with interrupted sutures, surgical staples, and/or fibrin sealant. A dressing is applied to the graft site and secured to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
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<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD					
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons					
<b>CPT Code:</b>	15155					
<b>Sample Size:</b>	60	<b>Resp n:</b>	13	<b>Response:</b>	%	
<b>Sample Type:</b>	Panel					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		1.20	4.90	12.00	15.00	15.00
<b>Pre-Service Evaluation Time:</b>				30.0		
<b>Pre-Service Positioning Time:</b>				30.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15.0		
<b>Intra-Service Time:</b>		2.00	15.00	25.00	35.00	40.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>30.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>90.0</u>	99231x 0.0	99232x 3.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>45.0</u>	99211x 0.0	12x 3.0	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>
15120	090	9.81

CPT Descriptor Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
44950	090	9.99

CPT Descriptor 1 Appendectomy;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
42200	090	11.98

CPT Descriptor 2 Palatoplasty for cleft palate, soft and/or hard palate only

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 84.6 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15155</u>	<u>Key Reference CPT Code: 15120</u>
Median Pre-Service Time	75.00	56.00
Median Intra-Service Time	25.00	102.00
Median Immediate Post-service Time	30.00	25.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	90.0	9.50
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	45.0	92.00
Median Total Time	301.00	320.50
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.36	3.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.45
Urgency of medical decision making	4.09	3.64

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

Technical skill required	4.55	4.09
Physical effort required	4.00	3.63

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.55	3.73
Outcome depends on the skill and judgment of physician	4.36	3.91
Estimated risk of malpractice suit with poor outcome	3.36	3.55

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.15	3.64
Intra-Service intensity/complexity	4.69	4.09
Post-Service intensity/complexity	4.46	3.73

**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.*

The intra-operative work of 15155 is similar to the reference code 15100 in that each graft must be secured to recipient site. The reduced work value represents the smaller graft (25 sq cm versus 100 sq cm) and the fact that there is no need for harvesting. The extra value of 15155 compared to 15150 is justified by the extra intensity and complexity needed to preserve critical structures of the face. The hospital and office visits represent the extra time needed during dressing changes, because of the extra fragile nature of the cultured graft.



Specialty

Frequency 0

Percentage 0.00 %

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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**

CPT Code:15156 Tracking Number: FF16 Global Period: ZZZ

Specialty Society RVU: **2.75**RUC RVU: **2.75**

CPT Descriptor: Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) (do not report more than once)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-year-old boy was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, he was intubated at the scene. He was transported to the nearby emergency room where he was assessed to have 80% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns; however, due to the extent of burn and lack of sufficient donor sites, his remaining excised wounds were covered with cadaveric allograft and/or other skin substitute/skin replacement. As there were inadequate skin graft donor sites available for immediate, permanent wound coverage, a small split-thickness skin graft was harvested for the preparation of cultured autologous skin grafts 3-4 weeks previously. He is now returned to the operating room for the application of cultured autologous epidermal autografts to his hands.

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:**

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The tissue cultured epidermal autografts are removed from the transport medium. Grafts measuring 100 sq cm (the first 25 sq cm will be coded separately) are applied to the hand and secured to the excised wound with interrupted sutures, surgical staples, and/or fibrin sealant. A dressing is applied to the graft site and secured to prevent mechanical shear.

**Description of Post-Service Work:****SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15156				
<b>Sample Size:</b>	60	<b>Resp n:</b>	13	<b>Response:</b>	21.66 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.30	3.00	4.00	4.25	12.00
<b>Pre-Service Evaluation Time:</b>			0.0		

Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		4.00	12.50	20.00	40.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>0.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15121	ZZZ	2.67

CPT Descriptor Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
11642	010	2.59

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
32020	000	3.97

CPT Descriptor 2 Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 76.9 %**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15156</u>	<u>Key Reference CPT Code: 15121</u>
Median Pre-Service Time	55.00	0.00
Median Intra-Service Time	20.00	64.00
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	75.00	64.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.36	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.40
Urgency of medical decision making	4.09	3.60

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

Technical skill required	4.55	4.00
Physical effort required	4.00	3.60

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.55	3.80
Outcome depends on the skill and judgment of physician	4.36	3.90
Estimated risk of malpractice suit with poor outcome	3.36	3.70

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

Pre-Service intensity/complexity	4.08	3.60
Intra-Service intensity/complexity	4.62	4.00
Post-Service intensity/complexity	4.38	3.70

**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.*

The intra-operative work of 15156 is similar to the reference code 15101 in that each graft must be secured to recipient site. The extra value of 15156 compared to 15151 is justified by the extra intensity and complexity needed to preserve critical structures of the face.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**

CPT Code:15157 Tracking Number: FF17 Global Period: ZZZ

Specialty Society RVU: 3.00

**RUC RVU: 3.00**

CPT Descriptor: Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-year-old boy was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, he was intubated at the scene. He was transported to the nearby emergency room where he was assessed to have 80% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns; however, due to the extent of burn and lack of sufficient donor sites, his remaining excised wounds were covered with cadaveric allograft and/or other skin substitute/skin replacement. As there were inadequate skin graft donor sites available for immediate, permanent wound coverage, a small split-thickness skin graft was harvested for the preparation of cultured autologous skin grafts 3-4 weeks previously. He is now returned to the operating room for the application of cultured autologous epidermal autografts to hands.

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:**

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The tissue cultured epidermal autografts are removed from the transport medium. Two hundred sq cm of grafts (the first 100 sq cm will be coded separately) are applied to the hands and fingers and secured to the excised wound with interrupted sutures, surgical staples, and/or fibrin sealant. A dressing is applied to the graft site and secured to prevent mechanical shear.

**Description of Post-Service Work:****SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15157				
<b>Sample Size:</b>	60	<b>Resp n:</b>	13	<b>Response:</b>	21.66 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RWV:</b>	2.60	3.00	4.00	5.25	7.00
<b>Pre-Service Evaluation Time:</b>			0.0		

Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0		
Intra-Service Time:		0.00	15.00	30.00	40.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>0.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15121	ZZZ	2.67

CPT Descriptor Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
11642	010	2.59

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
32020	000	3.97

CPT Descriptor 2 Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 76.9 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15157</u>	<u>Key Reference CPT Code: 15121</u>
Median Pre-Service Time	32.50	0.00
Median Intra-Service Time	30.00	64.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>62.50</b>	<b>64.00</b>
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.36	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.40
Urgency of medical decision making	4.09	3.60

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

Technical skill required	4.55	4.00
Physical effort required	4.00	3.60

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.55	3.80
Outcome depends on the skill and judgment of physician	4.36	3.90
Estimated risk of malpractice suit with poor outcome	3.36	3.70

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

Pre-Service intensity/complexity	4.08	3.60
Intra-Service intensity/complexity	4.62	4.00
Post-Service intensity/complexity	4.38	3.70

**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.*

The intra-operative work of 15157 is similar to the reference code 15101 in that each graft must be secured to recipient site. The extra value of 15157 compared to 15152 is justified by the extra intensity and complexity needed to preserve critical structures of the face.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15170 Tracking Number: FF18 Global Period: 090

**Recommended Work Relative Value**Specialty Society RVU: **5.00**RUC RVU: **5.00**

CPT Descriptor: Acellular dermal replacement trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45-year-old man was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, the patient was intubated at the scene. He was transported to the nearby burn center where he was assessed to have 75% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He underwent bilateral upper extremity escharotomies for circumferential full-thickness burns and his wounds were subsequently dressed with a topical antimicrobial agent and gauze. He required continuous ventilatory support, enteral nutrition, and continued intravenous fluid administration due to his inability to eat. Five days postburn, he underwent excision and split-thickness autografting for full-thickness burns of his hands and upper extremities with meshed skin grafts. He is now being returned to the operating room for excision of the full-thickness burns of his posterior trunk with simultaneous application of an acellular dermal replacement.

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? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; supervising the preparation of the acellular dermal replacement; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The acellular dermal replacement is removed from the rinsing solution and a total of 100 sq cm is applied to the trunk and secured to the excised wound with interrupted sutures or surgical staples. A net dressing is applied and expanded over the graft site and secured with staples to prevent mechanical shear. The wound is then covered with gauze dressings and secured with a bulky dressing to further prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Postoperative work also includes frequent monitoring of the acellular dermal replacement for signs of infection and neovascularization and replacement of the surgical netting or dressings as necessary until autologous skin grafting is possible. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD					
<b>Specialty(s):</b>	American Burn Association					
<b>CPT Code:</b>	15170					
<b>Sample Size:</b>	60	<b>Resp n:</b>	17	<b>Response:</b>	%	
<b>Sample Type:</b>	Panel					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		2.00	5.00	7.00	9.01	15.00
<b>Pre-Service Evaluation Time:</b>				20.0		
<b>Pre-Service Positioning Time:</b>				20.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0		
<b>Intra-Service Time:</b>		5.00	15.00	30.00	30.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>20.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>90.0</u>	99231x 0.0	99232x 3.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15342	010	1.00

CPT Descriptor Application of bilaminate skin substitute/neodermis; 25 sq cm

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
64721	090	4.28

CPT Descriptor 1 Neuroplasty and/or transposition; median nerve at carpal tunnel

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15350	090	3.99

CPT Descriptor Application of allograft, skin; 100 sq cm or less

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 47.0 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 15170</b>	<b>Key Reference CPT Code: 15342</b>
Median Pre-Service Time	50.00	0.00
Median Intra-Service Time	30.00	0.00
Median Immediate Post-service Time	20.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	90.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>190.00</b>	<b>0.00</b>
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.94	3.88
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.50
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Urgency of medical decision making	3.94	4.25
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.06	4.38
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Physical effort required	3.88	4.13
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.00	4.00
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Outcome depends on the skill and judgment of physician	4.18	4.13
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Estimated risk of malpractice suit with poor outcome	3.25	3.25
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.82	3.75
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Intra-Service intensity/complexity	4.06	4.25
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Post-Service intensity/complexity	3.88	3.75
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**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 intraservice work is similar to 15350 (homograft, 100 sq cm or less). However, extra care is necessary to secure the Integra and to provide complete single layer coverage (without overlapping) of the recipient site as the Integra will become part of the permanent coverage. This justifies the slightly higher work value requested for 15170. Three hospital visits are requested to represent the work involved with dressing changes prior to the recipient areas being covered with permanent skin grafts. No office visits are requested as these will be included in the permanent skin graft code.



Specialty                                      Frequency 0                                      Percentage 0.00 %

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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 15350

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:15171 Tracking Number: FF19 Global Period: ZZZ

Specialty Society RVU: **1.55**RUC RVU: **1.55**

CPT Descriptor: Acellular dermal replacement 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45-year-old man was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, the patient was intubated at the scene. He was transported to the nearby burn center where he was assessed to have 75% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He underwent bilateral upper extremity escharotomies for circumferential full-thickness burns and his wounds were subsequently dressed with a topical antimicrobial agent and gauze. He required continuous ventilatory support, enteral nutrition, and continued intravenous fluid administration due to his inability to eat. Five days postburn, he underwent excision and split-thickness autografting for full-thickness burns of his hands and upper extremities with meshed skin grafts. He is now being returned to the operating room for excision of the full-thickness burns of his posterior trunk with simultaneous application of an acellular dermal replacement.

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? 6%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The acellular dermal replacement is removed from the rinsing solution. Two hundred sq cm (the first 100 sq cm will be coded separately) is applied to the trunk and secured to the excised wound with interrupted sutures or surgical staples. A net dressing is applied and expanded over the graft site and secured with staples to prevent mechanical shear. The wound is then covered with gauze dressings and secured with a bulky dressing to further prevent mechanical shear.

**Description of Post-Service Work:****SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15171				
<b>Sample Size:</b>	60	<b>Resp n:</b>	17	<b>Response:</b>	28.33 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	1.55	2.00	2.63	6.00
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		0.00	8.00	<b>15.00</b>	45.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u><b>0.00</b></u>					
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15343	ZZZ	0.25

CPT Descriptor Application of bilaminar skin substitute/neodermis; each additional 25 sq cm (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
45330	000	.96

CPT Descriptor 1 Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
56605	000	1.10

CPT Descriptor 2 Biopsy of vulva or perineum (separate procedure); one lesion

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 41.1 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 15171	Key Reference CPT Code: 15343
Median Pre-Service Time	3.50	0.00
Median Intra-Service Time	15.00	0.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	18.50	0.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.43
Urgency of medical decision making	3.88	4.14

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

Technical skill required	4.06	4.29
Physical effort required	3.88	4.14

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.06	4.00
Outcome depends on the skill and judgment of physician	4.12	4.14
Estimated risk of malpractice suit with poor outcome	3.41	3.29

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

Pre-Service intensity/complexity	3.59	3.71
Intra-Service intensity/complexity	3.94	4.00
Post-Service intensity/complexity	3.71	3.71

**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 intraservice work is similar to 15351 (homograft, each additional 100 sq cm). However, extra care is necessary to secure the Integra and to provide complete single layer coverage (without overlapping) of the recipient site as the Integra will become part of the permanent coverage. This justifies the slightly higher work value requested for 15171.



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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 15001

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:15175 Tracking Number: FF20 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **7.00**  
RUC RVU: **7.00**

CPT Descriptor: Acellular dermal replacement face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45-year-old man was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, the patient was intubated at the scene. He was transported to the nearby burn center where he was assessed to have 75% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He underwent bilateral upper extremity escharotomies for circumferential full-thickness burns and his wounds were subsequently dressed with a topical antimicrobial agent and gauze. He required continuous ventilatory support, enteral nutrition, and continued intravenous fluid administration due to his inability to eat. Five days postburn, he underwent excision and split-thickness autografting for full-thickness burns of his hands and upper extremities with meshed skin grafts. He is now being returned to the operating room for excision of the full-thickness burns of his hands with simultaneous application of an acellular dermal replacement.

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? 25%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; supervising the preparation of the acellular dermal replacement; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The acellular dermal replacement is removed from the rinsing solution and a total of 100 sq cm is applied to the hands and secured to the excised wound with interrupted sutures or surgical staples. A net dressing is applied and expanded over the graft site and secured with staples to prevent mechanical shear. The wound is then covered with gauze dressings and secured with a bulky dressing to further prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Postoperative work also includes frequent monitoring of the acellular dermal replacement for signs of infection and neovascularization and replacement of the surgical netting or dressings as necessary until autologous skin grafting is possible. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>		Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>		American Burn Association				
<b>CPT Code:</b>		15175				
<b>Sample Size:</b>	60	<b>Resp n:</b>	16	<b>Response:</b>	%	
<b>Sample Type:</b> Panel						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		2.00	7.75	9.81	10.25	18.00
<b>Pre-Service Evaluation Time:</b>				18.0		
<b>Pre-Service Positioning Time:</b>				20.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0		
<b>Intra-Service Time:</b>		15.00	20.00	30.00	45.00	120.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>		<u>20.00</u>				
<b>Critical Care time/visit(s):</b>		<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>		<u>90.0</u>	99231x 0.0	99232x 3.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>		<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>		<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15120	090	9.81

CPT Descriptor Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
56605	000	1.10

CPT Descriptor 1 Biopsy of vulva or perineum (separate procedure); one lesion

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
11441	010	1.48

CPT Descriptor 2 Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15351	ZZZ	1.00

CPT Descriptor Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)

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

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

**Number of respondents who choose Key Reference Code: 7      % of respondents: 43.7 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15175</u>	<u>Key Reference CPT Code: 15120</u>
Median Pre-Service Time	47.50	56.00
Median Intra-Service Time	30.00	102.00
Median Immediate Post-service Time	20.00	25.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	90.0	9.50
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	0.0	92.00
<b>Median Total Time</b>	<b>187.50</b>	<b>320.50</b>
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.19	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.43
Urgency of medical decision making	4.00	3.71

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

Technical skill required	4.63	4.00
Physical effort required	4.00	3.57

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.44	3.86
Outcome depends on the skill and judgment of physician	4.56	3.86
Estimated risk of malpractice suit with poor outcome	3.94	3.29

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

Pre-Service intensity/complexity	4.06	3.43
Intra-Service intensity/complexity	4.50	3.71
Post-Service intensity/complexity	4.25	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 intraservice work is similar to 15350 (homograft, 100 sq cm or less). However, extra care is necessary to set the Integra and to provide complete single layer coverage (without overlapping) of the recipient site as the Integra will become part of the permanent coverage. This justifies the slightly higher work value requested for 15175. In addition, the extra value of 15175 compared to 15170 is justified by the extra intensity and complexity needed to preserve critical structures of the face. Three hospital visits are requested to represent the work involved with dressing changes prior to



Specialty Plastic Surgery                      Frequency 125                      Percentage 50.00 %

Specialty    Frequency 0    Percentage 0.00 %

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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 14020

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**Specialty Society RVU: **2.45**

CPT Code:15176 Tracking Number: FF21 Global Period: ZZZ

**RUC RVU: 2.45**

CPT Descriptor: Acellular dermal replacement face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45-year-old man was rescued from a burning building. Due to altered mental status and suspicion of inhalation injury, the patient was intubated at the scene. He was transported to the nearby burn center where he was assessed to have 75% total body surface area burns. Intravenous fluid resuscitation was initiated and ventilatory support maintained. He underwent bilateral upper extremity escharotomies for circumferential full-thickness burns and his wounds were subsequently dressed with a topical antimicrobial agent and gauze. He required continuous ventilatory support, enteral nutrition, and continued intravenous fluid administration due to his inability to eat. Five days postburn, he underwent excision and split-thickness autografting for full-thickness burns of his hands and upper extremities with meshed skin grafts. He is now being returned to the operating room for excision of the full-thickness burns of his posterior hands with simultaneous application of an acellular dermal replacement.

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? 18%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. The acellular dermal replacement is removed from the rinsing solution. Two hundred sq cm (the first 100 sq cm is coded separately) is applied to the hands and fingers and secured to the excised wound with interrupted sutures or surgical staples. A net dressing is applied and expanded over the graft site and secured with staples to prevent mechanical shear. The wound is then covered with gauze dressings and secured with a bulky dressing to further prevent mechanical shear.

**Description of Post-Service Work:****SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15176				
<b>Sample Size:</b>	60	<b>Resp n:</b>	16	<b>Response:</b>	%
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	2.45	3.00	3.63	6.99
<b>Pre-Service Evaluation Time:</b>			0.0		

Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		5.00	13.75	28.00	61.25	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>0.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15343	ZZZ	0.25

CPT Descriptor Application of bilaminate skin substitute/neodermis; each additional 25 sq cm (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
56605	000	1.10

CPT Descriptor 1 Biopsy of vulva or perineum (separate procedure); one lesion

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
11441	010	1.48

CPT Descriptor 2 Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15351	ZZZ	1.00

CPT Descriptor Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)

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

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

**Number of respondents who choose Key Reference Code: 7      % of respondents: 43.7 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15176</u>	<u>Key Reference CPT Code: 15343</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	28.00	0.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>28.00</b>	<b>0.00</b>
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.07	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.29
Urgency of medical decision making	4.00	4.29

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

Technical skill required	4.50	4.43
Physical effort required	4.13	4.14
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.38	4.29
Outcome depends on the skill and judgment of physician	4.50	4.71
Estimated risk of malpractice suit with poor outcome	3.94	3.57

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

Pre-Service intensity/complexity	4.00	4.00
Intra-Service intensity/complexity	4.56	4.29
Post-Service intensity/complexity	4.25	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.*

The intraservice work is similar to 15351 (homograft, each additional 100 sq cm). However, extra care is necessary to secure the Integra and to provide complete single layer coverage (without overlapping) of the recipient site as the Integra will become part of the permanent coverage. This justifies the slightly higher work value requested for 15176. In addition, the extra value of 15176 compared to 15171 is justified by the extra intensity and complexity needed to preserve critical structures of the face.



Specialty

Frequency 0

Percentage 0.00 %

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

Time

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 15121

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:15300 Tracking Number: FF22 Global Period: 090

**Recommended Work Relative Value**

Specialty Society RVU: 3.99

RUC RVU: 3.99

CPT Descriptor: Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 74-year-old mechanic was admitted to the burn center with burns of both legs, lower back, and abdomen after his gasoline-saturated clothing was ignited from a spark. The burns involved 40% body surface area. During the first operative session, the patient underwent surgical excision of the burn tissue from the left lower leg beginning at the ankle and extending to the popliteal area (reported separately). After excision and hemostasis, allografts were obtained from the skin bank. Approximately 100 sq cm of allograft skin was then grafted to the excised surface on the left lower leg and secured with interrupted absorbable sutures. The graft was dressed with a low adherent dressing and reinforced with absorbent dressing and secured with net dressing.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 4%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; supervising the preparation of the acellular dermal replacement; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. Human allograft skin is obtained from the skin bank. A total of 100 sq cm is applied to the leg and secured to the excised wound with interrupted sutures or surgical staples. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons

<b>CPT Code:</b> 15300X					
<b>Sample Size:</b> 60	<b>Resp n:</b> 25	<b>Response:</b> %			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	3.99	4.00	6.50	9.04
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			18.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			15.0		
<b>Intra-Service Time:</b>	5.00	13.75	20.00	37.50	140.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>18.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>60.0</u>	99231x 0.0	99232x 2.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15350	090	3.99

CPT Descriptor Application of allograft, skin; 100 sq cm or less

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 72.0 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 15300X	Key Reference CPT Code: 15350
Median Pre-Service Time	48.00	40.00
Median Intra-Service Time	20.00	20.00
Median Immediate Post-service Time	18.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	60.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	146.00	60.00
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	3.54	3.28
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.21	2.83
Urgency of medical decision making	3.63	3.11

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

Technical skill required	3.54	3.11
Physical effort required	3.46	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.63	3.10
Outcome depends on the skill and judgment of physician	3.67	3.17
Estimated risk of malpractice suit with poor outcome	3.09	2.56

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

Pre-Service intensity/complexity	3.54	3.06
Intra-Service intensity/complexity	3.58	3.22
Post-Service intensity/complexity	3.50	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.*

The application of allograft to the trunk and extremities is similar to the currently existing code 15350.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15301 Tracking Number: FF23 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: 1.00

RUC RVU: 1.00

CPT Descriptor: Allograft skin for temporary wound closure, 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 74-year-old mechanic was admitted to the burn center with burns of both legs, lower back, and abdomen after his gasoline-saturated clothing was ignited from a spark. The burns involved 40% body surface area. During the first operative session, the patient underwent surgical excision of the burn tissue from the lower legs beginning at the ankle and extending to the popliteal area (reported separately). After excision and hemostasis, allografts were obtained from the skin bank. Approximately 200 sq cm of allograft skin was then grafted to the excised surface on the lower legs and secured with interrupted absorbable sutures and surgical staples (the first 100 sq cm is reported separately). The graft was dressed with a low adherent dressing and reinforced with absorbent dressing and secured with net dressing.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 4%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. Human allograft skin is obtained from the skin bank. An additional 400 sq cm is applied to the legs secured to the excised wound with interrupted sutures or surgical staples. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15301				
<b>Sample Size:</b>	60	<b>Resp n:</b>	25	<b>Response:</b>	41.66 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.25	1.00	1.20	1.72	5.00
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		

Intra-Service Time:		0.00	10.00	15.00	20.00	140.00
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>
15351	ZZZ	1.00

CPT Descriptor Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 68.0 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 15301</b>	<b>Key Reference CPT Code: 15351</b>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	15.00	15.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	15.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.50	2.88
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.21	2.71
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Urgency of medical decision making	3.63	3.06
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.50	3.00
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Physical effort required	3.54	3.00
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.58	3.00
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Outcome depends on the skill and judgment of physician	3.63	3.06
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Estimated risk of malpractice suit with poor outcome	3.08	2.47
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.48	2.76
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Intra-Service intensity/complexity	3.54	3.18
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Post-Service intensity/complexity	3.43	2.71
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**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 application of allograft to the trunk and extremities is similar to the currently existing code 15351.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15320 Tracking Number: FF24 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **4.70**  
RUC RVU: **4.70**

CPT Descriptor: Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 74-year-old mechanic was admitted to the burn center with burns of both hands and feet after his gasoline-saturated clothing was ignited from a spark. The burns involved 40% body surface area. During the first operative session, the patient underwent surgical excision of the burn tissue from the left hand beginning at the wrist (reported separately). After excision and hemostasis, allografts were obtained from the skin bank. Approximately 100 sq cm of allograft skin was then grafted to the excised surface on the left hand and secured with interrupted absorbable sutures. The graft was dressed with a low adherent dressing and reinforced with absorbent dressing and secured with net dressing.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 4%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; supervising the preparation of the acellular dermal replacement; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. Human allograft skin is obtained from the skin bank. A total of 100 sq cm is applied to the hands and fingers secured to the excised wound with interrupted sutures or surgical staples. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD
<b>Specialty(s):</b>	American Burn Association

<b>CPT Code:</b> 15320					
<b>Sample Size:</b> 60	<b>Resp n:</b> 25	<b>Response:</b> %			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	4.70	6.00	9.81	10.99
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			20.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			15.0		
<b>Intra-Service Time:</b>	0.00	15.00	40.00	48.75	140.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>18.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>60.0</u>	99231x 0.0	99232x 2.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15350	090	3.99

CPT Descriptor Application of allograft, skin; 100 sq cm or less**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 52.0 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15320</u>	<u>Key Reference CPT Code: 15350</u>
Median Pre-Service Time	50.00	40.00
Median Intra-Service Time	40.00	20.00
Median Immediate Post-service Time	18.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	60.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	168.00	60.00
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	3.63	3.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	2.84
Urgency of medical decision making	3.67	3.23

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

Technical skill required	4.04	3.38
Physical effort required	3.96	3.38

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.92	3.31
Outcome depends on the skill and judgment of physician	3.96	3.38
Estimated risk of malpractice suit with poor outcome	3.33	2.92

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

Pre-Service intensity/complexity	3.58	3.00
Intra-Service intensity/complexity	3.83	3.15
Post-Service intensity/complexity	3.50	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.*

The application of allograft to the face is similar to the currently existing code 15350. The extra value compared 15300 is justified by the extra intensity and complexity needed to preserve critical structures of the face.



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

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- **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**

CPT Code:15321 Tracking Number: FF25 Global Period: ZZZ

Specialty Society RVU: 1.50

RUC RVU: 1.50

CPT Descriptor: Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 74-year-old mechanic was admitted to the burn center with burns of both hands and feet after his gasoline-saturated clothing was ignited from a spark. The burns involved 40% body surface area. During the first operative session, the patient underwent surgical excision of the burn tissue from the hands and feet beginning at the wrist and ankle (reported separately). After excision and hemostasis, allografts were obtained from the skin bank. Approximately 200 sq cm of allograft skin was then grafted to the excised surfaces on the hands and secured with interrupted absorbable sutures and surgical staples (the first 100sq cm is reported separately). The graft was dressed with a low adherent dressing and reinforced with absorbent dressing and secured with net dressing.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 4%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. Human allograft skin is obtained from the skin bank. An additional Two hundred sq cm (the first 100 sq cm is coded separately) is applied to the hands and fingers and secured to the excised wound with interrupted sutures or surgical staples. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

## Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15321				
<b>Sample Size:</b>	60	<b>Resp n:</b>	25	<b>Response:</b> 41.66 %	
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.25	1.50	2.00	2.67	6.00
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		

Intra-Service Time:		0.00	15.00	20.00	40.00	140.00
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>
15351	ZZZ	1.00

CPT Descriptor Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 44.0 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15321</u>	<u>Key Reference CPT Code: 15351</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	20.00	15.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	20.00	15.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.58	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	2.82
Urgency of medical decision making	3.67	3.27

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

Technical skill required	4.04	3.27
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Physical effort required	3.96	3.36
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.92	3.18
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Outcome depends on the skill and judgment of physician	3.96	3.27
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Estimated risk of malpractice suit with poor outcome	3.33	2.91
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.58	3.18
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Intra-Service intensity/complexity	3.92	3.45
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Post-Service intensity/complexity	3.58	3.18
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**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 application of allograft to the face is similar to the currently existing code 15351. The extra value compared 15301 is justified by the extra intensity and complexity needed to preserve critical structures of the face.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15330 Tracking Number: FF26 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **3.99**  
RUC RVU: **3.99**

CPT Descriptor: Acellular dermal allograft trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 20 year-old with history of burns presents with scarring and contracture of the axilla. The patient underwent surgery two years prior with split-thickness skin grafts for burns over 80% of his body. He now has limited range of motion and limited function of his shoulder as a result of the burn. He has failed physical therapy intervention and continues with functional deficits as a result of this contracture.

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 includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; supervising the preparation of the acellular dermal replacement; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. Acellular dermal allograft is removed from the transport package. A total of 100 sq cm is applied to the trunk and secured to the wound with absorbable sutures. The dermal graft is then covered with a local skin flap (separately coded). The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	04/2005
Presenter(s):	Richard J. Kagan, MD, Keith Brandt, MD
Specialty(s):	American Burn Association
CPT Code:	15330

<b>Sample Size:</b> 60	<b>Resp n:</b> 10	<b>Response:</b> %			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RWV:</b>	2.00	3.99	4.00	4.50	5.99
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			13.0		
<b>Intra-Service Time:</b>	10.00	11.25	18.00	30.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>18.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15350	090	3.99

CPT Descriptor Application of allograft, skin; 100 sq cm or less

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 60.0 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15330</u>	<u>Key Reference CPT Code: 15350</u>
Median Pre-Service Time	43.00	40.00
Median Intra-Service Time	18.00	20.00
Median Immediate Post-service Time	18.00	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	79.00	60.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.70	2.67
Urgency of medical decision making	3.30	3.67

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

Technical skill required	3.70	3.50
Physical effort required	3.30	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.90	3.00
Outcome depends on the skill and judgment of physician	3.40	3.50
Estimated risk of malpractice suit with poor outcome	2.50	2.67

**INTENSITY/COMPLEXITY MEASURES**

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

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.40	3.33
Intra-Service intensity/complexity	3.80	3.50
Post-Service intensity/complexity	3.30	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.*

Because the alloderm becomes part of the permanent coverage, the care and work to apply the alloderm is similar to acellular dermal replacements (Integra).



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

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- **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**

CPT Code:15331 Tracking Number: FF27 Global Period: ZZZ

Specialty Society RVU: 1.00

RUC RVU: 1.00

CPT Descriptor: Acellular dermal allograft 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 20 year-old with history of burns presents with scarring and contracture of the axilla. The patient underwent surgery two years prior with split-thickness skin grafts for burns over 80% of his body. He now has limited range of motion and limited function of his shoulder as a result of the burn. He has failed physical therapy intervention and continues with functional deficits as a result of this contracture.

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:**

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. Acellular dermal allograft is removed from the transport package. Two hundred sq cm (the first 100 sq cm is coded separately) is applied to the trunk and secured to the wound with absorbable sutures. The dermal graft is then covered with a local skin flap (separately coded). The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

**Description of Post-Service Work:****SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15331				
<b>Sample Size:</b>	60	<b>Resp n:</b>	9	<b>Response:</b>	%
<b>Sample Type:</b>	Panel				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		1.00	1.00	1.50	2.50
<b>Pre-Service Evaluation Time:</b>				0.0	
<b>Pre-Service Positioning Time:</b>				0.0	
<b>re-Service Scrub, Dress, Wait Time:</b>				0.0	
<b>Intra-Service Time:</b>		0.00	7.00	13.00	37.50
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	0.00				

<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0				
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0			
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00				
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0	

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15351	ZZZ	1.00

CPT Descriptor Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 66.6 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15331</u>	<u>Key Reference CPT Code: 15351</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	13.00	15.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	13.00	15.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.30	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.70	2.67
Urgency of medical decision making	3.20	3.67

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

Technical skill required	3.70	3.33
Physical effort required	3.30	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.90	3.00
Outcome depends on the skill and judgment of physician	3.60	3.83
Estimated risk of malpractice suit with poor outcome	2.60	2.67

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

Pre-Service intensity/complexity	2.88	1.83
Intra-Service intensity/complexity	3.70	3.33
Post-Service intensity/complexity	3.00	1.83

**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.*

Because the alloderm becomes part of the permanent coverage, the care and work to apply the alloderm is similar acellular dermal replacements (Integra).

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.)

- checkboxes for reasons: The surveyed code is an add-on code..., Different specialties work together..., Multiple codes allow flexibility..., Multiple codes are used to maintain consistency..., 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 attached table

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 15351

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

Specialty General Surgery How often? Sometimes
Specialty Plastic Surgery How often? Sometimes

Specialty How often?

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

Table with 3 columns: 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.

Table with 3 columns: Specialty, Frequency 1000, Percentage 50.00 %

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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15335 Tracking Number: FF28 Global Period: 090  
**Recommended Work Relative Value**  
 Specialty Society RVU: **4.50**  
 RUC RVU: **4.50**

CPT Descriptor: Acellular dermal allograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 38-year-old female experienced 2nd and 3rd degree grease burns to the dorsum of her right hand extending to the palmar surface, covering 3% of her total body surface area.

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; supervising the preparation of the acellular dermal replacement; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. Acellular dermal allograft is removed from the transport package. A total of 100 sq cm is applied to the hand and fingers and secured to the wound with absorbable sutures. The dermal graft is then covered with a local skin flap (separately coded). The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	04/2005		
Presenter(s):	Richard J. Kagan, MD, Keith Brandt, MD		
Specialty(s):	American Burn Association		
CPT Code:	15335		
Sample Size:	60	Resp n:	9
		Response:	%
Sample Type:	Panel		

	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:	4.50	4.97	5.00	6.12	10.00
Pre-Service Evaluation Time:			15.0		
Pre-Service Positioning Time:			15.0		
Pre-Service Scrub, Dress, Wait Time:			10.0		
Intra-Service Time:	10.00	15.00	30.00	30.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
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>
15350	090	3.99

CPT Descriptor Application of allograft, skin; 100 sq cm or less

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

**Number of respondents who choose Key Reference Code: 4      % of respondents: 44.4 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 15335</b>	<b>Key Reference CPT Code: 15350</b>
Median Pre-Service Time	40.00	40.00
Median Intra-Service Time	30.00	20.00
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
<b>Median Total Time</b>	<b>85.00</b>	<b>60.00</b>
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.70	2.75
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	3.00
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Urgency of medical decision making	3.33	3.75
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.89	3.50
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Physical effort required	3.44	3.00
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.00	2.75
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Outcome depends on the skill and judgment of physician	3.67	3.75
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Estimated risk of malpractice suit with poor outcome	3.00	3.25
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.33	3.00
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Intra-Service intensity/complexity	4.33	4.50
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Post-Service intensity/complexity	3.44	3.00
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**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.*

Because the alloderm becomes part of the permanent coverage, the care and work to apply the alloderm is similar to acellular dermal replacements (Integra). The extra value of 15335 compared to 15330 is justified by the extra intensity and complexity needed to preserve critical structures of the face.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**Specialty Society RVU: **1.43**RUC RVU: **1.43**

CPT Descriptor: Acellular dermal allograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 38-year-old female experienced 2nd and 3rd degree grease burns to the dorsum of her right hand and fingers extending to the palmar surface, covering 3% of her total body surface area.

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: After the induction of anesthesia, hemostasis of the graft site is obtained with epinephrine soaked laparotomy pads and/or topical thrombin. Acellular dermal allograft is removed from the transport package. Two hundred sq cm (the first 100 sq cm is coded separately) is applied to the hand and fingers and secured to the wound with absorbable sutures. The dermal graft is overgrafted with a split-thickness skin graft which is also secured with interrupted sutures or surgical staples (separately coded). The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work:

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005				
Presenter(s):	Richard J. Kagan, MD, Keith Brandt, MD					
Specialty(s):	American Burn Association, American Society of Plastic Surgeons					
CPT Code:	15336					
Sample Size:	60	Resp n:	9	Response:	%	
Sample Type:	Panel					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
Survey RVW:		1.20	1.43	2.43	4.63	7.00
Pre-Service Evaluation Time:				0.0		
Pre-Service Positioning Time:				0.0		
re-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		10.00	13.75	25.00	37.50	90.00
Post-Service	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>0.00</u>					

<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0				
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0			
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00				
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0	

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15351	ZZZ	1.00

CPT Descriptor Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 4      % of respondents: 44.4 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15336</u>	<u>Key Reference CPT Code: 15351</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	25.00	15.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	25.00	15.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.56	2.75
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	3.00
--	------	------

Urgency of medical decision making	3.33	3.75
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	3.25
--------------------------	------	------

Physical effort required	3.56	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.00	2.75
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Outcome depends on the skill and judgment of physician	3.67	3.75
--	------	------

Estimated risk of malpractice suit with poor outcome	3.00	3.25
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.14	2.00
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Intra-Service intensity/complexity	4.22	3.75
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Post-Service intensity/complexity	3.28	2.50
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**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.*

Because the alloderm becomes part of the permanent coverage, the care and work to apply the alloderm is similar to acellular dermal replacements (Integra). The extra value of 15336 compared to 15331 is justified by the extra intensity and complexity needed to preserve critical structures of the face.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15340 Tracking Number: FF30 Global Period: 010

**Recommended Work Relative Value**  
Specialty Society RVU: **3.72**  
RUC RVU: **3.72**

CPT Descriptor: Tissue cultured allogeneic skin substitute; first 25 sq cm or less

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old male with Type II diabetes presents with a 3 x 3 cm non-infected full-thickness chronic ulceration of the plantar aspect of the right heel. The decision is made to debride the wound and proceed with application of a tissue cultured allogeneic skin substitute.

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? 11%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies, including appropriate graft material, are present and available in the operative suite.

Description of Intra-Service Work: The wound is debrided and after adequate hemostasis has been achieved and administration of anesthesia has occurred, graft materials were obtained. The wound was measured. Approximately 25 sq. cm. of tissue cultured allogeneic skin substitute was fenestrated and then grafted to the excised surface and secured with interrupted sutures

Description of Post-Service Work: Postoperative work begins after skin closure in the operating room and includes application of a low adherent dressing which is reinforced with absorbent and compressive dressings. Postoperative work also include monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders). Discharge management includes the surgeon's final examination of the patient, giving instructions for continuing care of the operative sites, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 10 days after the day of the operation are considered part of the postoperative work for this procedure including removal of sutures, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD, Lloyd Smith, DPM				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons, American Podiatric Medical Association				
<b>CPT Code:</b>	15340				
<b>Sample Size:</b>	60	<b>Resp n:</b>	36	<b>Response:</b>	60.00 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	1.00	1.30	2.35	4.00

Pre-Service Evaluation Time:				10.0		
Pre-Service Positioning Time:				5.0		
Pre-Service Scrub, Dress, Wait Time:				10.0		
Intra-Service Time:		5.00	15.00	28.00	28.50	45.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
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>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>
15342	010	1.00

CPT Descriptor Application of bilaminar skin substitute/neodermis; 25 sq cm

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 24      % of respondents: 66.6 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 15340	Key Reference CPT Code: <u>15342</u>
Median Pre-Service Time	25.00	0.00
Median Intra-Service Time	28.00	0.00
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	18.0	0.00
Median Office Visit Time	30.0	0.00
Median Total Time	116.00	0.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.52	3.29
Urgency of medical decision making	3.05	2.83

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

Technical skill required	3.39	3.17
Physical effort required	2.75	2.54

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.33	3.04
Outcome depends on the skill and judgment of physician	3.56	3.38
Estimated risk of malpractice suit with poor outcome	3.50	3.25

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

Pre-Service intensity/complexity	3.06	3.04
Intra-Service intensity/complexity	3.36	3.38
Post-Service intensity/complexity	2.75	2.58

**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 building block approach was used in developing the RVW for this code since the pre-facilitation committee recommended revising the descriptor to include the wound debridement that is performed prior to application of the tissue cultured allogeneic skin substitute. The surveyed pre-service time of 25 minutes for 15340X was used as was the surveyed immediate post-service time of 15 minutes and the 0.5 day discharge management and two Level II office visits. The intra-service time was adjusted for the wound debridement. The surveyed intra-service time of 20 minutes was used and 25% of the surveyed intra-service time for 15000, which was surveyed as part of this block of codes, was

used. Code 15000 refers to 100 sq cm whereas code 15340 refers to 25 sq cm. The surveyed intra-service time for 15000 is 30 minutes and 25% of that is 7.5 minutes. The 7.5 minutes was added to the surveyed 20 minutes of intra-service time for 15340X for a total intra-service time of 28 minutes. RVWs for each of the different components are:

Pre-service = 0.42 RVWs  
 Intra-service = 1.46 RVUS  
 Post-service = 1.84 RVWs  
 Total RVWs = 3.72  
 IWPUT = .052

The IWPUT was evaluated as well and it was agreed by the presenters that an IWPUT of .052 for this procedure is reasonable.

## 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. Typical scenario: The physician performs an excision of the wound prior to application of the tissue cultured allogeneic skin substitute. Codes that may be reported:
3. 15000 - Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children)  
 Global period: 000 RVW: 3.99 pre-time: 0 intra-time: 30 post-time: 0  
 15001 - Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or one percent of body area of infants and children)  
 Global period: ZZZ RVW: 1.00 pre-time: 0 intra-time: 20 post-time: 0  
 Since the excision codes are 000 day globals and include only intra-service time, there is no duplication of work in the pre- and post-service periods. Additionally, the intra-service time recommended is for the application of the tissue cultured allogeneic skin substitute and does not include time for excision of the wound.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 15342 and 15000

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



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

CPT Code:15341 Tracking Number: FF31 Global Period: ZZZ

**Recommended Work Relative Value**Specialty Society RVU: **.50**RUC RVU: **.50**

CPT Descriptor: Tissue cultured allogeneic skin substitute; each additional 25 sq cm

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old male with Type II diabetes presents with a 6 x 6 cm non-infected full-thickness chronic ulceration of the plantar aspect of the right heel. The decision is made to debride the wound and proceed with application of a tissue cultured allogeneic skin substitute.

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? 22%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

Description of Intra-Service Work: The wound is debrided and after adequate hemostasis has been achieved and administration of anesthesia has occurred, graft materials were obtained. The wound was measured. Approximately 50 sq. cm. of tissue cultured allogeneic skin substitute was fenestrated and then grafted to the excised surface and secured with interrupted sutures.

## Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD, Lloyd Smith, DPM					
<b>Specialty(s):</b>	ABA, APMA, ASPS					
<b>CPT Code:</b>	15341					
<b>Sample Size:</b>	60	<b>Resp n:</b>	36	<b>Response:</b> 60.00 %		
<b>Sample Type:</b>	Panel					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		0.20	0.26	0.50	1.00	4.58
<b>Pre-Service Evaluation Time:</b>				0.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		0.00	10.00	15.00	20.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>0.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			

Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
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\*\*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>
15343	ZZZ	0.25

CPT Descriptor Application of bilaminate skin substitute/neodermis; each additional 25 sq cm

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 63.8 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 15341	Key Reference CPT Code: 15343
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	15.00	0.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	0.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	2.94	2.52
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.52
Urgency of medical decision making	2.91	2.43

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

Technical skill required	3.19	3.00
Physical effort required	2.69	2.57
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	3.14	2.87

Outcome depends on the skill and judgment of physician	3.28	3.13
Estimated risk of malpractice suit with poor outcome	3.17	3.13

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

Pre-Service intensity/complexity	2.74	2.30
Intra-Service intensity/complexity	3.11	2.91
Post-Service intensity/complexity	2.60	2.17

**ADDITIONAL RATIONALE**

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

A consensus panel comprised of representatives from APMA, ASPS and ABA met to discuss the recommendations. It was agreed that a RVW of 0.50, which represents the median would be recommended. No additional pre- or post-service time is required and the panel agreed that 15 minutes of intra-service time is reasonable for applying an additional 25 sq cm of tissue cultured allogeneic skin substitute. The IWPUT for the code is 0.033, which is slightly higher than that for an E/M service, which the panel believes is appropriate since this is a surgical procedure.

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**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. 1. Typical scenario: The physician performs an excision of the wound prior to application of the tissue cultured allogeneic skin substitute. Additionally, since this is an add-on code, the base code of 15340X would also be reported.

Code that will be reported:

3. 15340X - Tissue cultured allogeneic skin substitute; first 25 sq cm or less  
 Global period: 010 RVW (recommended): 1.00 pre-time: 25 intra-time: 20 immediate post-time: 15  
 Since 15341X is an add-on code, no additional time is being recommended for pre- and post-time. The intra-service time is for the application of the additional 25 sq cm of tissue cultured allogeneic skin substitute and no duplication of work is included.

Codes that may be reported:

4. 15000 - Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children)  
 Global period: 000 RVW: 3.99 pre-time: 0 intra-time: 30 post-time: 0  
 15001 - Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or one percent of body area of infants and children)  
 Global period: ZZZ RVW: 1.00 pre-time: 0 intra-time: 20 post-time: 0  
 Since the excision codes are 000 day globals and include only intra-service time, there is no duplication of work in the pre- and post-service periods. Additionally, the intra-service time recommended is for the application of the additional tissue cultured allogeneic skin substitute and does not include time for excision of the wound.
- 

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 15343 + 15000

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

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

Specialty General Surgery How often? Rarely

Specialty Plastic Surgery How often? Rarely



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

CPT Code:15360 Tracking Number: FF32 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **3.87**  
RUC RVU: **3.87**

CPT Descriptor: Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 15-year-old child sustained 20% total body surface area 2nd degree burns. The wounds are superficial and intermediate depth. In an effort to promote healing without the use of topical antibiotic dressings, the patient is taken to the operating room for debridement of the burn wounds and simultaneous application of a tissue cultured allogeneic dermal substitute.

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? 56%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; supervising the preparation of the acellular dermal replacement; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: Hemostasis of the debrided/excised graft site is obtained. The tissue cultured allogeneic dermal substitute is removed from the transport container and a total of 100 sq cm is applied to the trunk and secured to the excised wound with interrupted sutures, surgical staples or steri-strips. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD		
<b>Specialty(s):</b>	American Burn Association		
<b>CPT Code:</b>	15360		
<b>Sample Size:</b>	60	<b>Response n:</b>	9
<b>Sample Type:</b>	Panel	<b>Response:</b>	%

	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
<b>Survey RVW:</b>	3.00	3.87	<b>3.99</b>	4.63	7.00
<b>Pre-Service Evaluation Time:</b>			<b>20.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>15.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.0</b>		
<b>Intra-Service Time:</b>	10.00	13.75	<b>30.00</b>	56.25	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>15.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>45.0</u>	99211x 0.0	12x 3.0	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>
15350	090	3.99

CPT Descriptor Application of allograft, skin; 100 sq cm or less

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

**Number of respondents who choose Key Reference Code: 3      % of respondents: 33.3 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 15360</b>	<b>Key Reference CPT Code: 15350</b>
Median Pre-Service Time	45.00	40.00
Median Intra-Service Time	30.00	20.00
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	36.0	0.00
Median Office Visit Time	45.0	0.00
Median Total Time	171.00	60.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.44	3.00
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.89	2.67
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Urgency of medical decision making	3.22	3.00
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.78	3.67
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Physical effort required	3.22	2.67
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.56	3.00
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Outcome depends on the skill and judgment of physician	3.67	3.67
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Estimated risk of malpractice suit with poor outcome	3.00	2.33
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.13	3.33
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Intra-Service intensity/complexity	3.67	4.00
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Post-Service intensity/complexity	3.00	3.00
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**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.*

Because this coverage is considered as a final management of the wound, extra care in application is necessary. 7 hospital visits and office visits are necessary as this is considered a final management.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**Specialty Society RVU: **1.15**

CPT Code:15361 Tracking Number: FF33 Global Period: ZZZ

**RUC RVU: 1.15**

CPT Descriptor: Tissue cultured allogeneic dermal substitute, 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 15-year-old child sustained 20% total body surface area 2nd degree burns. The wounds are superficial and intermediate depth. In an effort to promote healing without the use of topical antibiotic dressings, the patient is taken to the operating room for debridement of the burn wounds and simultaneous application of a tissue cultured allogeneic dermal substitute.

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? 56%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

Description of Intra-Service Work: Hemostasis of the debrided/excised graft site is obtained. The tissue cultured allogeneic dermal substitute is removed from the transport container. Two hundred sq cm (the first 100 sq cm is coded separately) is applied to the trunk and secured to the excised wound with interrupted sutures, surgical staples or steri-strips. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

## Description of Post-Service Work:

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	Richard J. Kagan, MD, Keith Brandt, MD				
Specialty(s):	American Burn Association, American Society of Plastic Surgeons				
CPT Code:	15361				
Sample Size:	60	Resp n:	9	Response:	15.00 %
Sample Type:	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
Survey RVW:	1.00	1.15	1.35	1.69	2.50
Pre-Service Evaluation Time:			0.0		
Pre-Service Positioning Time:			0.0		
re-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	0.00	5.00	13.00	32.50	60.00
Post-Service	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>0.00</u>				

<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15351	ZZZ	1.00

CPT Descriptor Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

**Number of respondents who choose Key Reference Code: 2      % of respondents: 22.2 %**

**TIME ESTIMATES (Median)**

<b><u>TIME ESTIMATES (Median)</u></b>	<b>New/Revised CPT Code: 15361</b>	<b>Key Reference CPT Code: 15351</b>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	13.00	15.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	13.00	15.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.33	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	3.33	3.50

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

Technical skill required	3.67	4.00
Physical effort required	3.22	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.44	3.50
Outcome depends on the skill and judgment of physician	3.67	3.00
Estimated risk of malpractice suit with poor outcome	3.00	3.50

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

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	3.67	3.50
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.*

Because this coverage is considered as a final management of the wound, extra care in application is necessary similar to acellular dermal replacement.



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

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-> **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15365 Tracking Number: FF34 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **4.15**  
RUC RVU: **4.15**

CPT Descriptor: Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 15-year-old child sustained 20% total body surface area 2nd degree burns. The wounds are superficial and intermediate depth. In an effort to promote healing without the use of topical antibiotic dressings, the patient is taken to the operating room for debridement of the burn wounds and simultaneous application of a tissue cultured allogeneic dermal substitute.

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? 71%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; supervising the preparation of the acellular dermal replacement; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: Hemostasis of the debrided/excised graft site is obtained. The tissue cultured allogeneic dermal substitute is removed from the transport container and a total of 100 sq cm is applied to the hands and fingers and secured to the excised wound with interrupted sutures, surgical staples or steri-strips. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD		
<b>Specialty(s):</b>	American Burn Association		
<b>CPT Code:</b>	15365		
<b>Sample Size:</b>	60	<b>Response n:</b>	7
		<b>Response:</b>	%
<b>Sample Type:</b>	Panel		

	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	3.00	4.15	<b>4.80</b>	6.75	9.00
<b>Pre-Service Evaluation Time:</b>			<b>15.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>15.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.0</b>		
<b>Intra-Service Time:</b>	15.00	20.00	<b>25.00</b>	30.00	35.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b><u>15.00</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b><u>36.0</u></b>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b><u>45.0</u></b>	99211x 0.0	12x 3.0	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>
15342	010	1.00

CPT Descriptor Application of bilaminate skin substitute/neodermis; 25 sq cm

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 2      % of respondents: 28.5 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 15365	Key Reference CPT Code: 15342
Median Pre-Service Time	40.00	0.00
Median Intra-Service Time	25.00	0.00
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	36.0	0.00
Median Office Visit Time	45.0	0.00
Median Total Time	161.00	0.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.57	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	3.50
Urgency of medical decision making	3.29	4.00

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

Technical skill required	3.86	4.00
Physical effort required	3.29	3.50

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.57	4.50
Outcome depends on the skill and judgment of physician	3.29	5.00
Estimated risk of malpractice suit with poor outcome	2.71	4.45

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

Pre-Service intensity/complexity	3.14	3.50
Intra-Service intensity/complexity	3.71	3.50
Post-Service intensity/complexity	3.43	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.*

Because this coverage is considered as a final management of the wound, extra care in application is necessary similar to acellular dermal replacement. The hospital visits and office visits are necessary as this is considered a final management of the wound.

The extra value of 15365 compared to 15360 is justified by the extra complexity needed to preserve critical structure of the face.



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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 15000

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:15366 Tracking Number: FF35 Global Period: ZZZ

**Recommended Work Relative Value**Specialty Society RVU: **1.45**RUC RVU: **1.45**

CPT Descriptor: TTissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 15-year-old child sustained 20% total body surface area 2nd degree burns. The wounds are superficial and intermediate depth. In an effort to promote healing without the use of topical antibiotic dressings, the patient is taken to the operating room for debridement of the burn wounds and simultaneous application of a tissue cultured allogeneic dermal substitute.

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? 71%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

Description of Intra-Service Work: Hemostasis of the debrided/excised graft site is obtained. The tissue cultured allogeneic dermal substitute is removed from the transport container. Two hundred sq cm (the first 100 sq cm is coded separately) is applied to the hands and fingers and secured to the excised wound with interrupted sutures, surgical staples or steri-strips. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

## Description of Post-Service Work:

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	Richard J. Kagan, MD, Keith Brandt, MD				
Specialty(s):	American Burn Association, American Society of Plastic Surgeons				
CPT Code:	15366				
Sample Size:	60	Resp n:	7	Response:	%
Sample Type:	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
Survey RVW:	1.20	1.45	2.00	3.62	9.00
Pre-Service Evaluation Time:			0.0		
re-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	5.00	12.75	15.00	26.25	60.00
Post-Service	Total Min**	CPT code / # of visits			

<b>Immed. Post-time:</b>	<u><b>0.00</b></u>						
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0				
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0			
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00				
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0	

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15343	ZZZ	0.25

CPT Descriptor Application of bilaminate skin substitute/neodermis; each additional 25 sq cm (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 2      % of respondents: 28.5 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15366</u>	<u>Key Reference CPT Code: 15343</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	15.00	0.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	0.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.29	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	3.50
Urgency of medical decision making	3.29	4.00

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

Technical skill required	3.71	3.50
Physical effort required	3.29	3.50

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.43	4.00
Outcome depends on the skill and judgment of physician	3.29	5.00
Estimated risk of malpractice suit with poor outcome	2.71	4.50

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

Pre-Service intensity/complexity	3.00	3.50
Intra-Service intensity/complexity	3.71	3.00
Post-Service intensity/complexity	3.43	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.*

Because this coverage is considered as a final management of the wound, extra care in application is necessary similar acellular dermal replacement. The hospital visits and office visits are necessary as this is considered a final management.

The extra value of 15366 compared to 15361 is justified by the extra complexity needed to preserve critical structure of the face.



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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 15101

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:15400 Tracking Number: FF36 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **3.99**  
RUC RVU: **3.99**

CPT Descriptor: Xenograft; skin (dermal) for temporary wound closure; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 22-year-old mechanic suffered burns of the left shoulder and arm from a radiator scald injury. The burns involved 10% body surface. These burns were deep partial thickness. During the first operative session, the patient underwent surgical preparation of the burn on the left shoulder and arm by excision down to viable dermis (reported separately). After adequate hemostasis had been achieved in the excised surface, 100 sq cm of xenograft skin was then grafted to the excised surface and secured with interrupted sutures. The graft was dressed with a low adherent dressing and reinforced with absorbent dressing and secured with net dressing.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 14%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; supervising the preparation of the acellular dermal replacement; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: Hemostasis of the debrided/excised graft site is obtained. Xenograft skin (dermal) is obtained from the tissue bank. A total of 100 sq cm is applied to the left shoulder and arm and secured to the excised wound with interrupted sutures or surgical staples. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons
<b>CPT Code:</b>	15400

<b>Sample Size:</b> 60	<b>Resp n:</b> 14	<b>Response:</b> %			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.50	3.99	4.00	4.15	5.00
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			10.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			13.0		
<b>Intra-Service Time:</b>	5.00	11.00	25.00	55.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>15.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>30.0</u>	99231x 0.0	99232x 1.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>45.0</u>	99211x 0.0	12x 3.0	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>
15400	090	3.99

CPT Descriptor Application of Xenograft, skin; 100 sq cm or less

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 78.5 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 15400	Key Reference CPT Code: 15400
Median Pre-Service Time	38.00	35.00
Median Intra-Service Time	25.00	20.00
Median Immediate Post-service Time	15.00	18.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	95.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	45.0	60.00
Median Total Time	153.00	264.00
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	3.07	3.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.50	2.54
Urgency of medical decision making	2.79	2.91

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

Technical skill required	3.00	3.18
Physical effort required	2.86	2.91
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	2.64	2.73

Outcome depends on the skill and judgment of physician	3.00	3.09
Estimated risk of malpractice suit with poor outcome	2.57	2.63

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

Pre-Service intensity/complexity	2.79	2.73
Intra-Service intensity/complexity	3.14	3.00
Post-Service intensity/complexity	2.71	2.64

**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 application of xenograft to the trunk and extremity is similar to the currently existing code 15400.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**

CPT Code:15401 Tracking Number: FF37 Global Period: ZZZ

Specialty Society RVU: **1.00**RUC RVU: **1.00**

CPT Descriptor: Xenograft; skin (dermal) for temporary wound closure; 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 22-year-old mechanic suffered burns of the left shoulder, arm, and forearm from a radiator scald injury. The burns involved 10% body surface. These burns were deep partial thickness. During the first operative session, the patient underwent surgical preparation of the burn on the left shoulder, arm, and forearm by excision down to viable dermis (reported separately). After adequate hemostasis had been achieved in the excised surface, xenograft skin was grafted to the excised surface and secured with interrupted sutures and surgical staples. The graft was dressed with a low adherent dressing and reinforced with net dressing. The initial 100sq cm has already been applied (coded separately). A second 100 sq cm is now applied

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 14%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: Hemostasis of the debrided/excised graft site is obtained. Xenograft skin (dermal) is obtained from the tissue bank. Two hundred sq cm (the first 100 sq cm is coded separately) is applied to the left shoulder and arm and secured to the excised wound with interrupted sutures or surgical staples. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15401				
<b>Sample Size:</b>	60	<b>Resp n:</b>	14	<b>Response:</b>	%
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.75	1.00	1.10	1.25	2.00
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	3.50	20.00	37.50	60.00

<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>
<b>Immed. Post-time:</b>	<b><u>0.00</u></b>	
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0 99292x 0.0
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0 99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00 99239x 0.00
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15401	ZZZ	1.00

CPT Descriptor Application of Xenograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 78.5 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15401</u>	<u>Key Reference CPT Code: 15401</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	20.00	15.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	20.00	15.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	2.79	2.91
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.45
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Urgency of medical decision making	2.71	2.82
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.07	3.18
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Physical effort required	2.93	3.00
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.71	2.73
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Outcome depends on the skill and judgment of physician	3.00	3.09
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Estimated risk of malpractice suit with poor outcome	2.57	2.64
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.85	2.55
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Intra-Service intensity/complexity	3.07	2.91
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Post-Service intensity/complexity	2.77	2.45
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**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 application of xenograft to the trunk and extremity is similar to the currently existing code 15401.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15420 Tracking Number: FF38 Global Period: 090

**Recommended Work Relative Value**

Specialty Society RVU: **4.50**

RUC RVU: **4.50**

CPT Descriptor: Xenograft skin (dermal) for temporary wound closure; face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 22-year-old mechanic suffered burns of the face and neck from a radiator scald injury. The burns involved 10% body surface. These burns were deep partial thickness. During the first operative session, the patient underwent surgical preparation of the burns of the face and neck by excision down to viable dermis (reported separately). After adequate hemostasis had been achieved in the excised surface, 100 sq cm of xenograft skin was then grafted to the excised surface and secured with interrupted sutures and surgical staples. The graft was dressed with a low adherent dressing and reinforced with absorbent dressing and secured with net dressing.

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? 15%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; supervising the preparation of the acellular dermal replacement; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: Hemostasis of the debrided/excised graft site is obtained. Xenograft skin (dermal) is obtained from the tissue bank. A total of 100 sq cm is applied to the face and neck and secured to the excised wound with interrupted sutures or surgical staples. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	04/2005
Presenter(s):	Richard J. Kagan, MD, Keith Brandt, MD
Specialty(s):	American Burn Association, American Society of Plastic Surgeons
CPT Code:	15420

<b>Sample Size:</b> 50	<b>Resp n:</b> 13	<b>Response:</b> %			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.50	4.50	<b>4.99</b>	5.00	7.00
<b>Pre-Service Evaluation Time:</b>			<b>15.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>15.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>15.0</b>		
<b>Intra-Service Time:</b>	5.00	14.00	<b>30.00</b>	60.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b><u>15.00</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b><u>30.0</u></b>	99231x 0.0	99232x 1.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b><u>45.0</u></b>	99211x 0.0	12x 3.0	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>
15400	090	3.99

CPT Descriptor Application of Xenograft, skin; 100 sq cm or less

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 53.8 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 15420</u>	<u>Key Reference CPT Code: 15400</u>
Median Pre-Service Time	45.00	35.00
Median Intra-Service Time	30.00	20.00
Median Immediate Post-service Time	15.00	18.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	95.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	45.0	60.00
Median Total Time	165.00	264.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.08	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.62	2.71
Urgency of medical decision making	2.69	2.71

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

Technical skill required	3.54	3.14
Physical effort required	2.92	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.08	3.00
Outcome depends on the skill and judgment of physician	3.38	3.29
Estimated risk of malpractice suit with poor outcome	2.85	2.86

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

Pre-Service intensity/complexity	2.92	2.71
Intra-Service intensity/complexity	3.69	3.00
Post-Service intensity/complexity	2.85	2.57

**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.*

The application of xenograft to the face is similar to the currently existing code 15400. The extra value of 15420 compared to 15400 is justified by the extra complexity needed to preserve critical structures of the face.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**

CPT Code:15421 Tracking Number: FF39 Global Period: ZZZ

Specialty Society RVU: 1.50

**RUC RVU: 1.50**

CPT Descriptor: Xenograft skin (dermal) for temporary wound closure; face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 22-year-old mechanic suffered burns of the face, neck, and hands from a radiator scald injury. The burns involved 10% body surface. These burns were deep partial thickness. During the first operative session, the patient underwent surgical preparation of the burns of the face, neck, and hands by excision down to viable dermis (reported separately). After adequate hemostasis had been achieved in the excised surface, 200 sq cm of xenograft skin was then grafted to the excised surface and secured with interrupted sutures and surgical staples (the first 100 sq cm is reported separately). The graft was dressed with a low adherent dressing and reinforced with absorbent dressing and secured with net dressing.

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? 15%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Description of Intra-Service Work: Hemostasis of the debrided/excised graft site is obtained. Xenograft skin (dermal) is obtained from the tissue bank. Two hundred sq cm (the first 100 sq cm is coded separately) is applied to the hand and fingers and secured to the excised wound with interrupted sutures or surgical staples. The wound is then covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear.

Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	15421				
<b>Sample Size:</b>	60	<b>Resp n:</b>	13	<b>Response:</b>	%
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	1.50	1.50	2.00	3.00
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	5.00	20.00	40.00	60.00

<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>
<b>Immed. Post-time:</b>	<b><u>0.00</u></b>	
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0 99292x 0.0
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0 99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00 99239x 0.00
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15401	ZZZ	1.00

CPT Descriptor Application of Xenograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 61.5 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 15421	Key Reference CPT Code: 15401
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	20.00	15.00
Median Immediate Post-service Time	7.00	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	27.00	15.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.08	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.62	2.75
Urgency of medical decision making	2.69	2.75

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

Technical skill required	3.38	3.00
Physical effort required	2.92	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.23	3.00
Outcome depends on the skill and judgment of physician	3.46	3.25
Estimated risk of malpractice suit with poor outcome	2.92	2.88

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

Pre-Service intensity/complexity	2.92	2.63
Intra-Service intensity/complexity	3.62	2.88
Post-Service intensity/complexity	2.83	2.50

**ADDITIONAL RATIONALE**

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

The application of xenograft to the face is similar to the currently existing code 15401. The extra value of 15421 compared to 15401 is justified by the extra intensity and complexity needed to preserve critical structures of the face.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:15430 Tracking Number: FF40 Global Period: 090

**Recommended Work Relative Value**Specialty Society RVU: **5.75**RUC RVU: **5.75**

CPT Descriptor: Acellular xenograft implant; first 100 sq cm or less, or one percent of body area of infants and children

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72-year-old female presents with a 2 x 2 cm non-infected venous stasis ulceration in the area of the medial malleolus. The decision is made to debride the wound and proceed with application of an acellular xenogeneic implant.

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? 11%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes and interval history and physical exam; reviewing the previous work-up; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include scrubbing and waiting to begin the procedure; supervising the positioning and prepping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available.

Description of Intra-Service Work: The wound is debrided and after adequate hemostasis has been achieved in the excised surface, the acellular xenograft implant was obtained. The wound was measured and the acellular xenograft implant is cut to shape and then grafted to the excised surface and secured.

Description of Post-Service Work: Postoperative work begins after graft application and includes debridement and re-application of the acellular xenograft implant each 7-10 days, which is reinforced with absorbent and compressive dressings. Postoperative work also includes monitoring the patient; writing order; communicating with the family and other health care professionals (including written and oral reports and orders). The physician performs a final examination of the patient, provides instructions for continuing care of the operative sites, and finalizes the medical 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 dressing changes and antibiotic and pain medication adjustments.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005		
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD, Lloyd Smith, DPM			
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons, American Podiatric Medical Association			
<b>CPT Code:</b>	15430			
<b>Sample Size:</b>	60	<b>Response n:</b>	36	<b>Response:</b> 60.00 %
<b>Sample Type:</b>	Panel			
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
				<b>High</b>

<b>Survey RVW:</b>	0.25	1.00	<b>2.45</b>	4.00	8.32
<b>Pre-Service Evaluation Time:</b>			<b>10.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.0</b>		
<b>Intra-Service Time:</b>	1.00	10.00	<b>15.00</b>	21.25	75.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b><u>10.00</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b><u>18.0</u></b>	99238x 0.50	99239x 0.00		
<b>Office time/visit(s):</b>	<b><u>135.0</u></b>	99211x 0.0	12x 9.0	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>
15342	010	1.00

CPT Descriptor Application of bilaminare skin substitute/neodermis; 25 sq cm

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 47.2 %**

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 15430</u>	<u>Key Reference CPT Code: 15342</u>
Median Pre-Service Time	25.00	0.00
Median Intra-Service Time	15.00	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	18.0	0.00
Median Office Visit Time	135.0	0.00
Median Total Time	203.00	0.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.37	3.35
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.16	3.53
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Urgency of medical decision making	3.16	2.88
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.21	3.12
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Physical effort required	2.89	2.53
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.47	3.24
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Outcome depends on the skill and judgment of physician	3.47	3.29
--	------	------

Estimated risk of malpractice suit with poor outcome	3.58	3.24
--	------	------

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

Pre-Service intensity/complexity	2.89	2.94
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Intra-Service intensity/complexity	2.95	3.06
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Post-Service intensity/complexity	2.95	2.65
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**ADDITIONAL RATIONALE**

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

A consensus panel comprised of representatives from APMA, ASPS and ABA met to discuss the recommendations and a building block approach was used. The surveyed pre-service time of 25 minutes, surveyed intra-service time of 10 minutes and surveyed immediate post-service time of 10 minutes were accepted. A 0.5 day of discharge management, along with 9 Level II post-operative visits were accepted. According to the literature, the acellular xenograft implant must be reapplied every 7-10 days and healing typically occurs in 12-20 weeks. Therefore, 9 office visits were included during the 90-day global period. The RVWs for the different components of the service are:

Pre-service = 0.42RVWs  
 Intra-service = 0.60 RVWs  
 Post-service = 4.73 RVWs  
 Total RVWs = 5.75  
 IWPUT = 0.40

The IWPUT was evaluated and it was agreed by the presenters that an IWPUT of .040 for this procedure is reasonable.

## 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. Typical scenario: The physician performs an excision of the wound prior to application of the acellular xenograft implant. Codes that may be reported:
3. 15000 - Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children)  
 Global period: 000 RVW: 3.99 pre-time: 0 intra-time: 30 post-time: 0  
 15001 - Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or one percent of body area of infants and children)  
 Global period: ZZZ RVW: 1.00 pre-time: 0 intra-time: 20 post-time: 0  
 Since the excision codes are 000 day globals and include only intra-service time, there is no duplication of work in the pre- and post-service periods. Additionally, the intra-service times recommended are for the application of the acellular xenograft implant and do not include time for excision of the wound.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 15400 and 15000

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

Specialty Podiatry How often? Sometimes

Specialty How often?

Specialty How often?

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

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 14,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Podiatry	Frequency 14000	Percentage 100.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage %

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

**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 15000

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:16020 Tracking Number: FF42 Global Period: 000

**Recommended Work Relative Value**Specialty Society RVU: **.80**RUC RVU: **.80**

CPT Descriptor: Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 25-year-old firefighter suffered partial-thickness burns of the forehead and right dorsal hand from an open flame. The burns involved 4% of the body surface area. While in the burn outpatient treatment area, he underwent debridement of nonviable, blistered skin and application of a wound dressing. Anesthesia was not required.

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? 23%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: The burn wound is surgically debrided of blisters and non-adherent devitalized tissue. The extent of the debridement is small and involves less than 5% of the total body surface area. The wound is then dressed with a gauze dressing or other skin substitute (separate procedure).

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care of the operative sites, and preparation of discharge records.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	16020				
<b>Sample Size:</b>	60	<b>Resp n:</b>	22	<b>Response:</b>	36.66 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.75	0.80	1.00	1.00	2.20
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			5.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>5.0</b>		
<b>Intra-Service Time:</b>		5.00	10.00	<b>10.00</b>	15.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u><b>10.00</b></u>					
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
16020	000	0.80

CPT Descriptor Dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 81.8 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 16020	Key Reference CPT Code: 16020
Median Pre-Service Time	20.00	0.00
Median Intra-Service Time	10.00	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	40.00	0.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	2.14	2.00
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.91	1.78
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Urgency of medical decision making	2.23	2.00
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.32	2.17
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Physical effort required	2.27	2.11
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.14	2.00
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Outcome depends on the skill and judgment of physician	2.18	2.11
--	------	------

Estimated risk of malpractice suit with poor outcome	2.05	1.83
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.18	2.06
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Intra-Service intensity/complexity	2.23	2.11
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Post-Service intensity/complexity	2.09	1.94
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**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.*

Code 16020 was redefined to describe surface area and reference to anesthesia was dropped.



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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**Specialty Society RVU: **1.85**RUC RVU: **1.85**

CPT Code:16025 Tracking Number: FF43 Global Period: 000

CPT Descriptor: Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5 to 10% total body surface area)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 46-year-old man suffered flame burns as the result of a house fire. He has partial-thickness burns of the face and both hands involving 8% of the body surface area. While in the burn outpatient treatment area, he underwent debridement of nonviable, blistered skin and application of a wound dressing. Anesthesia was not required.

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? 23%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: The burn wound is surgically debrided of blisters and non-adherent devitalized tissue. The debridement involves the entire upper extremity and involves 5 – 10 % of the total body surface area. The wound is then dressed with a gauze dressing or other skin substitute (separate procedure).

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care of the operative sites, and preparation of discharge records.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	Richard J. Kagan, MD, Keith Brandt, MD				
Specialty(s):	American Burn Association, American Society of Plastic Surgeons				
CPT Code:	16025				
Sample Size:	60	Resp n:	22	Response:	36.66 %
Sample Type:	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
Survey RWV:	1.50	1.85	1.95	2.00	2.50
Pre-Service Evaluation Time:			10.0		
Pre-Service Positioning Time:			5.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>8.0</b>		
<b>Intra-Service Time:</b>		8.00	15.00	<b>20.00</b>	30.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>15.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
16025	000	1.85

CPT Descriptor Dressings and/or debridement, initial or subsequent; without anesthesia, medium (eg, whole face or whole extremity)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 81.8 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 16025	Key Reference CPT Code: 16025
Median Pre-Service Time	23.00	0.00
Median Intra-Service Time	20.00	0.00
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	58.00	0.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	2.64	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.36	2.28
Urgency of medical decision making	2.73	2.56

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

Technical skill required	2.73	2.56
Physical effort required	2.73	2.56
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	2.68	2.50

Outcome depends on the skill and judgment of physician	2.77	2.61
Estimated risk of malpractice suit with poor outcome	2.55	2.33

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

Pre-Service intensity/complexity	2.64	2.56
Intra-Service intensity/complexity	3.00	2.83
Post-Service intensity/complexity	2.50	2.39

**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.*

Code 16025 was redefined to describe surface area and reference to anesthesia was dropped.



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

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- **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:16030 Tracking Number: FF44 Global Period: 000

**Recommended Work Relative Value**Specialty Society RVU: **2.08**RUC RVU: **2.08**

CPT Descriptor: Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than one extremity, or greater than 10% total body surface area)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 27-year-old woman suffered grease burns while cooking. She has superficial and deep partial-thickness burns of her hands, forearms, and abdomen involving 15% of the body surface area. She underwent debridement of nonviable, blistered skin and application of a wound dressing. Anesthesia was not required.

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? 41%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include the administration of preoperative antibiotics, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: The burn wound is surgically debrided of blisters and non-adherent devitalized tissue. The debridement involves both upper extremities and involves greater than 10 % of the total body surface area. The wound is then dressed with a gauze dressing or other skin substitute (separate procedure).

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon in the ICU or on a suitable nursing floor. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care of the operative sites, and preparation of discharge records.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005				
<b>Presenter(s):</b>	Richard J. Kagan, MD, Keith Brandt, MD				
<b>Specialty(s):</b>	American Burn Association, American Society of Plastic Surgeons				
<b>CPT Code:</b>	16030				
<b>Sample Size:</b>	60	<b>Resp n:</b>	22	<b>Response:</b>	36.66 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.08	2.08	2.50	2.53	3.30
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			5.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>10.0</b>		
<b>Intra-Service Time:</b>		8.00	19.75	<b>35.00</b>	50.00	110.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>13.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
16030	000	2.08

CPT Descriptor Dressings and/or debridement, initial or subsequent; without anesthesia, large (eg, more than one extremity)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 81.8 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 16030</u>	<u>Key Reference CPT Code: 16030</u>
Median Pre-Service Time	30.00	0.00
Median Intra-Service Time	35.00	0.00
Median Immediate Post-service Time	13.00	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	78.00	0.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.05	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.77	2.50
Urgency of medical decision making	3.00	2.83

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

Technical skill required	4.77	3.06
Physical effort required	3.50	3.22

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.18	2.84
Outcome depends on the skill and judgment of physician	3.14	2.89
Estimated risk of malpractice suit with poor outcome	2.95	2.67

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

Pre-Service intensity/complexity	3.14	2.94
Intra-Service intensity/complexity	3.68	3.39
Post-Service intensity/complexity	3.05	2.78

**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.*

Code 16030 was redefined to describe surface area and reference to anesthesia was dropped.



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

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3. **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  
Non Facility and Facility Direct Inputs**

**FREE SKIN GRAFT CODES**

CPT Code	Descriptor	Global Period	Crosswalk Code
15000	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), <u>or incisional release of scar contracture</u> ; first 100 sq cm or one percent of body area of infants and children	000	15000
+15001	each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)	ZZZ	15000
15040	Harvest of skin for tissue cultured skin autograft; 100 sq cm or less	000	15000
15110	Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	15000
+15111	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)	ZZZ	15000
15115	Epidermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	15000
+15116	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)	ZZZ	15000
15130	Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	15000
+15131	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)	ZZZ	15000
15135	Dermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	15000

**CPT Code: Free Skin Grafts 15000-16030**

+15136	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)	ZZZ	15000
15150	Tissue cultured epidermal autograft, trunk, arms, legs; first 25 sq cm or less	090	15000
+15151	additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) (do not report more than once)	ZZZ	15000
+15152	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)	ZZZ	15000
15155	Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 25 sq cm or less	090	15000
+15156	additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) (do not report more than once)	ZZZ	15000
+15157	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)	ZZZ	15000
15170	Acellular dermal replacement; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	15350
+15171	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)	ZZZ	15350
15175	Acellular dermal replacement; face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	15350
+15176	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)	ZZZ	15350
15300	Allograft skin for temporary wound closure; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	15350
+15301	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)	ZZZ	15350
15320	Allograft skin for temporary wound closure; face, scalp,	090	15350

**CPT Code: Free Skin Grafts 15000-16030**

	eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children		
+15321	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)	ZZZ	15350
15330	Acellular dermal allograft; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	15350
+15331	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)	ZZZ	15350
15335	Acellular dermal allograft; face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	15350
+15336	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)	ZZZ	15350
15340	Tissue cultured allogeneic skin substitute; first 25 sq cm or less	090	15350
+15341	each additional 25 sq cm	ZZZ	15350
15360	Tissue cultured allogeneic dermal substitute; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	15350
+15361	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)	ZZZ	15350
15365	Tissue cultured allogeneic dermal substitute; face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	15350
+15366	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)	ZZZ	15350
15400	Xenograft; skin (dermal) for temporary wound closure; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	090	15400
+15401	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)	ZZZ	15400
15420	Xenograft skin (dermal) for temporary wound closure; face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	090	15400
+15421	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	ZZZ	15400

**CPT Code: Free Skin Grafts 15000-16030**

	procedure)		
15430	Acellular xenograft implant; first 100 sq cm or less, or one percent of body area of infants and children	090	15400
16020	Dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small	000	16020
16025	medium (eg, whole face or whole extremity, <u>or 5 to 10% total body surface area</u> )	000	16020
16030	large (eg, more than one extremity, <u>or greater than 10% total body surface area</u> )	000	16020

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

The direct practice expense inputs provided in the attached spreadsheet were developed by a consensus panel of physicians representing the American Society of Plastic Surgeons, the American Burn Association, and the American Podiatric Medical Association. The new and revised free skin graft codes were divided into appropriate code families and cross-walked to currently existing practice expense values as indicated in the table above.

Please describe the clinical activities of your staff:

**Pre-Service Clinical Labor Activities (prior to procedure day):**

The PEAC standard pre-service times for 90-day, 10-day, and 000-day globals (facility and non-facility) were applied where appropriate.

**Intra-Service Clinical Labor Activities (day of procedure):**

***Pre-Service:***

- Greet patient, escort patient to room, provide gowning, and notify physician that patient is ready; 3 min (PEAC standard)
- Obtain 1-3 vital signs; 3 min
- Prepare room, equipment, and supplies; 2 min (PEAC standard). Note that most codes crosswalked to code 15350 and 15400 have 4 min requested for room preparation.
- Prepare and position patient; 2 min (PEAC standard)
- Sedate/apply anesthesia; 2 min (PEAC standard)

***Intra-Service:***

- Clinical staff assists physician for entire procedure (100% of physician time is requested in most cases).

***Post-Service:***

- Clean room/equipment by physician staff; 3 min (PEAC standard)
- Clean Surgical Instrument Package as indicated [basic for smaller wounds (10 min); medium for larger wounds (15 min)]
- Check dressing and wound/home care instructions/coordinate office visits/prescriptions; 3 min

**Post-Service Clinical Labor Activities:**

**CPT Code: Free Skin Grafts 15000-16030**

- A three minute follow-up phone call is requested for some procedures.

**Supplies and Equipment**

Supplies and equipment necessary to perform the procedures and post-op visits are presented.

	A	B	C	D	E	F	G	H	I
1	Apr-05			<b>Crosswalk Code - 15000 presented Jan 2002 PFAC</b>					
2	<b>Wound excision family</b>	<b>CPT:</b>		<b>15000</b>		<b>15000 - FF1</b>		<b>15001 - FF2</b>	
3		<b>DESCRIPTOR:</b>		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or one percent of body area of infants and children		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or less or		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof	
4		<b>GLOBAL:</b>		10		0		ZZZ	
5		<b>Code</b>	<b>Desc</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
6	<b>TOTAL TIME</b>	L037D	RN/LPN/MA	71	35	69	33	10	0
7	<b>PRE-service time</b>	L037D	RN/LPN/MA	15	35	18	30	0	0
8	<b>SERVICE time</b>	L037D	RN/LPN/MA	56		48	0	10	0
9	<b>POST-service time</b>	L037D	RN/LPN/MA	0	0	3	3	0	0
10	<b>PRE-SERVICE - BEFORE ADMISSION</b>	<b>Code</b>	<b>Desc</b>						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA			5	5		
12	Coordinate pre-surgery services	L037D	RN/LPN/MA			3	10		
13	Schedule space and equipment in facility	L037D	RN/LPN/MA				5		
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MA			7	7		
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MA			3	3		
16	<b>Other Clinical Activity (please specify)</b>								
17	<b>SERVICE PERIOD - ADMISSION TO DISCHARGE</b>	<b>Code</b>	<b>Desc</b>						
18	<b>Pre-service</b>								
19	Review charts	L037D	RN/LPN/MA						
20	Greet patient and provide gowning	L037D	RN/LPN/MA			3			
21	Obtain vital signs	L037D	RN/LPN/MA			3			
22	Provide pre-service education/obtain consent								
23	Prepare room, equipment, supplies	L037D	RN/LPN/MA			2			
24	Setup scope (non facility setting only)								
25	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MA			2			
26	Sedate/apply anesthesia	L037D	RN/LPN/MA			2			
27	<b>Intra-service</b>								
28	Assist physician in performing procedure	L037D	RN/LPN/MA			20		10	
29	<b>Post-service</b>								
30	Monitor pt. //check tubes, monitors, drains	L037D	RN/LPN/MA						
31	Clean room/equipment by physician staff	L037D	RN/LPN/MA			3			
32	Clean Scope								
33	Clean Surgical Instrument Package	L037D	RN/LPN/MA			10			
34	Complete diag forms, lab & X-ray requisitions	L037D	RN/LPN/MA						

	A	B	D	E	F	G	H
1	Apr-05		Crosswalk Code - 15000 presented Jan 2002 PFAC				
2	Wound excision family	CPT:		15000	15000 - FF1	15001 - FF2	
3		DESCRIPTOR:		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or one percent of body area of infants and children	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or less or	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof	
4		GLOBAL:		10	0	ZZZ	
5		Code	Desc	NF	FAC	NF	FAC
35		Review/read X-ray, lab, and pathology reports					
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MA		3		
37	Discharge day mgmt 99238--12 min99239 --15 min	L037D	RN/LPN/MA				
38	Other Clinical Activity (please specify)						
39	<b>POST-SERVICE Period</b>	<b>Code</b>	<b>Desc</b>				
40	Conduct phone calls/call in prescriptions				3	3	
41	99211 16 minutes						
42	99212 27 minutes						
43	99213 36 minutes						
44	99214 53 minutes						
45	99215 63 minutes						
46	<b>Total Office Visit Time:</b>	L037D	RN/LPN/MA	0	0	0	0
47	Other Activity (please specify)						

	A	B	C	D	E	F	G	H	I
1	Apr-05			<b>Crosswalk Code - 15000 presented Jan 2002 PEAC</b>					
2	<b>Wound excision family</b>	<b>CPT:</b>		<b>15000</b>		<b>15000 - FF1</b>		<b>15001 - FF2</b>	
3		<b>DESCRIPTOR:</b>		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or one percent of body area of infants and children		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or less or		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof.	
4		<b>GLOBAL:</b>		10		0		ZZZ	
5		<b>Code</b>	<b>Desc</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
48	<b>MEDICAL SUPPLIES</b>		<b>Code</b>	<b>Desc</b>					
49	pack, minimum multi-specialty visit	SA048	pack	1		1			
50	mask, surgical	SB033	item	2		2			
51	gown, staff, impervious	SB027	item	2		2			
52	cap, surgical	SB001	item			2			
53	gloves, sterile	SB024	pair	2		2			
54	shoe covers, surgical	SB039	pair			1			
55	drape, sterile barrier 16 in X 29 in	SB007	item	1		1			
56	drape, sterile, fenestrated 16 in X 29 in	SB011	item	1		1			
57	povidone soln (Betadine)	SJ041	ml	10		10			
58	syringe-needle 3ml 22-26g	SC064	item	4		4			
59	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	20		20		20	
60	scalpel with blade, surgical (#10-20)	SF033	item	1		1			
61	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1	
62	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item			3			
63	cautery, monopolar, electrode tip	SF016	item	1		1			
64	cautery, patient ground pad w-cord	SF021	item			1			
65	tape, surgical paper 1in (Micropore)	SG079	inch	18		18			
66	dressing, 3inx4in (Telfa, Release)	SG035	item	1		1		1	
67	hydrogen peroxide	SJ028	ml	20		20			
68	dressing, 12-7mm (Gelfoam)	SG033	item	1		1			
69	tray, suturing	SA069	tray	1		1			
70	pack, cleaning, surgical instruments	SA043	pack	1		1			
71	<b>Equipment</b>								
72	light, surgical	EF014		56		1			
73	table, power	EF031		56		1			
74	electrocautery-hyfreator, up to 45 watts	EQ110		56		1			
75	instrument pack, basic (\$500-\$1499)	EQ137				1			
76	instrument pack, medium (\$1500 and up)			56					

	A	B	C	D	E	F	G	H	I
1	Apr-05			Crosswalk Code - 15350					
2	Autografts	CPT:		15100		15040 - FF3		15110 - FF4	
3		DESCRIPTOR:		Split graft, trunk, arms, legs;		Harvest of skin for tissue cultured		Epidermal autograft,	
4		GLOBAL:		90		0		90	
5		Code	Desc	NF	FAC	NF	FAC	NF	FAC
6	<b>TOTAL TIME</b>	L037D	RN/LPN/MA	298	234	56	30	160	153
7	<b>PRE-service time</b>	L037D	RN/LPN/MA	35	60	18	30	35	60
8	<b>SERVICE time</b>	L037D	RN/LPN/MA	101	12	38	0	44	12
9	<b>POST-service time</b>	L037D	RN/LPN/MA	162	162	0	0	81	81
10	<b>PRE-SERVICE - BEFORE ADMISSION</b>	Code	Desc						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA	5	5	5	5	5	5
12	Coordinate pre-surgery services	L037D	RN/LPN/MA	10	20	3	10	10	20
13	Schedule space and equipment in facility	L037D	RN/LPN/MA	0	8		5	0	8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	10	20	7	7	10	20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MA	10	7	3	3	10	7
16	<b>Other Clinical Activity (please specify)</b>			0	0	0	0	0	0
17	<b>SERVICE PERIOD - ADMISSION TO DISCHARGE</b>	Code	Desc						
18	<b>Pre-service</b>								
19	Review charts	L037D	RN/LPN/MA			3		2	
20	Greet patient and provide gowning	L037D	RN/LPN/MA			3		3	
21	Obtain vital signs	L037D	RN/LPN/MA					3	
22	Provide pre-service education/obtain consent					2			
23	Prepare room, equipment, supplies	L037D	RN/LPN/MA					2	
24	Setup scope (non facility setting only)					2			
25	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MA			2		2	
26	Sedate/apply anesthesia	L037D	RN/LPN/MA						
27	<b>Intra-service</b>								
28	Assist physician in performing procedure	L037D	RN/LPN/MA	73		10		19	
29	<b>Post-service</b>								
30	Monitor pt. //check tubes, monitors, drains	L037D	RN/LPN/MA			3		5	
31	Clean room/equipment by physician staff	L037D	RN/LPN/MA					3	
32	Clean Scope					10			
33	Clean Surgical Instrument Package	L037D	RN/LPN/MA						
34	Complete diag forms, lab & X-ray requisitions	L037D	RN/LPN/MA					2	
35	Review/read X-ray, lab, and pathology reports					3			
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MA					3	
37	Discharge day mgmt 99238--12 min99239 --15 min	L037D	RN/LPN/MA						12
38	<b>Other Clinical Activity (please specify)</b>								
39	<b>POST-SERVICE Period</b>	Code	Desc						
40	Conduct phone calls/call in prescriptions								
41	99211 16 minutes								
42	99212 27 minutes							3	3
43	99213 36 minutes								
44	99214 53 minutes								
45	99215 63 minutes								
46	<b>Total Office Visit Time:</b>	L037D	RN/LPN/MA	0	0	0	0	81	81

	A	B	C	D	E	F	G	H	I
1	Apr-05			Crosswalk Code - 15350					
2	Autografts	CPT:		15100		15040 - FF3		15110 - FF4	
3		DESCRIPTOR:		Split graft, trunk, arms, legs;		Harvest of skin for tissue cultured		Epidermal autograft,	
4		GLOBAL:		90		0		90	
5		Code	Desc	NF	FAC	NF	FAC	NF	FAC
47		Other Activity (please specify)							
48	<b>MEDICAL SUPPLIES</b>		Code	Desc					
49	pack, minimum multi-specialty visit	SA048	pack	6	5	1		4	3
50	mask, surgical	SB033	item	2		2		2	
51	gown, staff, impervious	SB027	item	2		2		2	
52	cap, surgical	SB001	item						
53	gloves, sterile	SB024	pair	2		2		2	
54	shoe covers, surgical	SB039	pair						
55	drape, sterile barrier 16 in X 29 in	SB007	item	2		2		2	
56	drape, sterile, fenestrated 16in X 29in	SB011	item	2		2		2	
57	syringe-needle 3ml 22-26g	SC064	item	8		8		8	
58	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	40		40		40	
59	scalpel with blade, surgical (#10-20)	SF033	item	1		1		1	
60	suture, nylon, 3-0 to 6-0, c	SF036	item	6		6		6	
61	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item	1		1		1	
62	Post-op incision care kit (suture removal)	SA031	pack	1	1	1	1	1	1
63	Kling roller bandage, 2 x 131"	SG020	item	2		2		2	
64	dressing, 5in X 9in (Xeroform)	SG041	item	2	2	2	2	2	2
65	dressing, 4in X 4.75in (Tegaderm)	SG037	item	2	1	2	1	2	1
66	gauze, sterile 4in X 4in (10 pack uou)	SG056	item	4	4	4	4	4	4
67	hydrogen peroxide	SJ028	ml	20		20		20	
68	providone soln (Betadine)	SJ041	ml	10		10		10	
69	swab-pad alcohol	SJ053	item	2		2		2	
70	Bacitracin oint ( 15gm uou)	SJ007	item	1	1	1	1	1	1
71	tape, surgical paper 1in (Micropore)	SG079	item	24		24		24	
72	tray, suturing	SA069	tray	1		1		1	
73	blade, dermatome	SF003	item	1		1		1	
74	cautery, monopolar, electrode, needle	SF018	item	1		1		1	
75	cautery, patient ground pad w-cord	SF021	item						
76	pack, cleaning, surgical instruments	SA043	pack	1		1		1	
77	<b>Equipment</b>								
78	light, surgical	EF014		263	162	1		1	1
79	table, power	EF031		263	162	1		1	1
80	mayo stand	EF015							
81	instrument pack, basic (\$1500 and up)	EQ138		101		1		1	
82	dermatome, electric	EQ099		101		1		1	
83	electrocautery-hyfreicator, up to 45 watts	EQ110		101		1		1	
84	camera, digital (12 megapixel)	ED005		27	22			1	1
85	light, exam	EQ168							
86	exam table	EF023							

	A	J	K	L	M	N	O	P	Q
1	<b>Apr-05</b>								
2	<b>Autografts</b>	<b>15111 - FF5</b>		<b>15115 - FF6</b>		<b>15116 - FF7</b>		<b>15130 - FF8</b>	
3		Epidermal autograft, trunk, arms,		Epidermal autograft,		Epidermal autograft,		Dermal autograft, trunk,	
4		<b>ZZZ</b>		<b>90</b>		<b>ZZZ</b>		<b>90</b>	
5		<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
6	<b>TOTAL TIME</b>	<b>17</b>	<b>0</b>	<b>164</b>	<b>153</b>	<b>23</b>	<b>0</b>	<b>185</b>	<b>180</b>
7	<b>PRE-service time</b>	<b>0</b>	<b>0</b>	<b>35</b>	<b>60</b>	<b>0</b>	<b>0</b>	<b>35</b>	<b>60</b>
8	<b>SERVICE time</b>	<b>17</b>	<b>0</b>	<b>48</b>	<b>12</b>	<b>23</b>	<b>0</b>	<b>42</b>	<b>12</b>
9	<b>POST-service time</b>	<b>0</b>	<b>0</b>	<b>81</b>	<b>81</b>	<b>0</b>	<b>0</b>	<b>108</b>	<b>108</b>
10	<b>PRE-SERVICE - BEFORE ADMISSION</b>								
11	Complete pre-service diagnostic & referral forms			5	5			5	5
12	Coordinate pre-surgery services			10	20			10	20
13	Schedule space and equipment in facility			0	8			0	8
14	Provide pre-service education/obtain consent			10	20			10	20
15	Follow-up phone calls & prescriptions			10	7			10	7
16	<b>Other Clinical Activity (please specify)</b>			0	0			0	0
17	<b>SERVICE PERIOD - ADMISSION TO DISCHARGE</b>								
18	<b>Pre-service</b>								
19	Review charts			2				2	
20	Greet patient and provide gowning			3				3	
21	Obtain vital signs			3				3	
22	Provide pre-service education/obtain consent								
23	Prepare room, equipment, supplies			2				2	
24	Setup scope (non facility setting only)								
25	Prepare and position patient/ monitor patient/ set up IV			2				2	
26	Sedate/apply anesthesia								
27	<b>Intra-service</b>								
28	Assist physician in performing procedure	17		23		23		17	
29	<b>Post-service</b>								
30	Monitor pt. //check tubes, monitors, drains			5				5	
31	Clean room/equipment by physician staff			3				3	
32	Clean Scope								
33	Clean Surgical Instrument Package								
34	Complete diag forms, lab & X-ray requisitions			2				2	
35	Review/read X-ray, lab, and pathology reports								
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			3				3	
37	Discharge day mgmt 99238--12 min99239 --15 min				12				12
38	<b>Other Clinical Activity (please specify)</b>								
39	<b>POST-SERVICE Period</b>								
40	Conduct phone calls/call in prescriptions								
41	99211 16 minutes								
42	99212 27 minutes			3	3			4	4
43	99213 36 minutes								
44	99214 53 minutes								
45	99215 63 minutes								
46	<b>Total Office Visit Time:</b>	<b>0</b>	<b>0</b>	<b>81</b>	<b>81</b>	<b>0</b>	<b>0</b>	<b>108</b>	<b>108</b>



	A	R	S	T	U	V	W	X	Y
1	Apr-05								
2	Autografts	15131 - FF9		15135 - FF10		15136 - FF11		15150 - FF12	
3		Dermal autograft, trunk, arms, legs;		Dermal autograft, face,		Dermal autograft, face,		Tissue cultured epidermal autograft,	
4		ZZZ		90		ZZZ		90	
5		NF	FAC	NF	FAC	NF	FAC	NF	FAC
6	<b>TOTAL TIME</b>	12	0	187	180	10	0	154	153
7	<b>PRE-service time</b>	0	0	35	60	0	0	35	60
8	<b>SERVICE time</b>	12	0	44	12	10	0	38	12
9	<b>POST-service time</b>	0	0	108	108	0	0	81	81
10	<b>PRE-SERVICE - BEFORE ADMISSION</b>								
11	Complete pre-service diagnostic & referral forms			5	5			5	5
12	Coordinate pre-surgery services			10	20			10	20
13	Schedule space and equipment in facility			0	8			0	8
14	Provide pre-service education/obtain consent			10	20			10	20
15	Follow-up phone calls & prescriptions			10	7			10	7
16	Other Clinical Activity (please specify)			0	0			0	0
17	<b>SERVICE PERIOD - ADMISSION TO DISCHARGE</b>								
18	<b>Pre-service</b>								
19	Review charts			2				2	
20	Greet patient and provide gowning			3				3	
21	Obtain vital signs			3				3	
22	Provide pre-service education/obtain consent								
23	Prepare room, equipment, supplies			2				2	
24	Setup scope (non facility setting only)								
25	Prepare and position patient/ monitor patient/ set up IV			2				2	
26	Sedate/apply anesthesia								
27	<b>Intra-service</b>								
28	Assist physician in performing procedure	12		19		10		13	
29	<b>Post-service</b>								
30	Monitor pt. //check tubes, monitors, drains			5				5	
31	Clean room/equipment by physician staff			3				3	
32	Clean Scope								
33	Clean Surgical Instrument Package								
34	Complete diag forms, lab & X-ray requisitions			2				2	
35	Review/read X-ray, lab, and pathology reports								
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			3				3	
37	Discharge day mgmt 99238--12 min99239 --15 min				12				12
38	Other Clinical Activity (please specify)								
39	<b>POST-SERVICE Period</b>								
40	Conduct phone calls/call in prescriptions								
41	99211 16 minutes								
42	99212 27 minutes			4	4			3	3
43	99213 36 minutes								
44	99214 53 minutes								
45	99215 63 minutes								
46	<b>Total Office Visit Time:</b>	0	0	108	108	0	0	81	81



	A	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1	Apr-05										
2	Autografts	15151 - FF13		15152 - FF14		15155 - FF15		15156 - FF16		15157 - FF17	
3		Tissue cultured		Tissue cultured		Tissue cultured		Tissue cultured		Tissue cultured	
4		ZZZ		ZZZ		90		ZZZ		ZZZ	
5		NF	FAC								
6		TOTAL TIME	13	0	13	0	158	153	13	0	20
7	PRE-service time	0	0	0	0	35	60	0	0	0	0
8	SERVICE time	13	0	13	0	42	12	13	0	20	0
9	POST-service time	0	0	0	0	81	81	0	0	0	0
10	<b>PRE-SERVICE - BEFORE ADMISSION</b>										
11	Complete pre-service diagnostic & referral forms					5	5				
12	Coordinate pre-surgery services					10	20				
13	Schedule space and equipment in facility					0	8				
14	Provide pre-service education/obtain consent					10	20				
15	Follow-up phone calls & prescriptions					10	7				
16	Other Clinical Activity (please specify)					0	0				
17	<b>SERVICE PERIOD - ADMISSION TO DISCHARGE</b>										
18	<b>Pre-service</b>										
19	Review charts					2					
20	Greet patient and provide gowning					3					
21	Obtain vital signs					3					
22	Provide pre-service education/obtain consent										
23	Prepare room, equipment, supplies					2					
24	Setup scope (non facility setting only)										
25	Prepare and position patient/ monitor patient/ set up IV					2					
26	Sedate/apply anesthesia										
27	<b>Intra-service</b>										
28	Assist physician in performing procedure	13		13		17		13		20	
29	<b>Post-service</b>										
30	Monitor pt. //check tubes, monitors, drains					5					
31	Clean room/equipment by physician staff					3					
32	Clean Scope										
33	Clean Surgical Instrument Package										
34	Complete diag forms, lab & X-ray requisitions					2					
35	Review/read X-ray, lab, and pathology reports										
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					3					
37	Discharge day mgmt 99238--12 min99239 --15 min						12				
38	Other Clinical Activity (please specify)										
39	<b>POST-SERVICE Period</b>										
40	Conduct phone calls/call in prescriptions										
41	99211 16 minutes										
42	99212 27 minutes										
43	99213 36 minutes										
44	99214 53 minutes										
45	99215 63 minutes										
46	<b>Total Office Visit Time:</b>	0	0	0	0	81	81	0	0	0	0





	A	B	C	D	E	F	G	H	I
1	Apr-05		Crosswalk Code - 15350 presented Aug 2003						
2	Acellular dermal replacement	CPT:		15350	15170 - FF18		15171 - FF19		
3		DESCRIPTOR:		Application of allograft, skin;	Acellular dermal replacement,		Acellular dermal		
4		GLOBAL:		90	90		ZZZ		
5		Code	Desc	NF	FAC	NF	FAC	NF	FAC
6									
41	99211	16 minutes							
42	99212	27 minutes							
43	99213	36 minutes		2.5	2.5				
44	99214	53 minutes							
45	99215	63 minutes							
46	<b>Total Office Visit Time:</b>	L037D	RN/LPN/MA	90	90	0	0	0	0
47	Other Activity (please specify)								
48	<b>MEDICAL SUPPLIES</b>	Code	Desc						
49	pack, minimum multi-specialty visit	SA048	pack	3.5	2.5	1			
50	mask, surgical	SB033	item	2		2			
51	gown, staff, impervious	SB027	item						
52	cap, surgical	SB001	item						
53	gloves, sterile	SB024	pair						
54	shoe covers, surgical	SB039	pair						
55	drape, sterile barrier 16 in X 29 in	SB007	item	1		1			
56	syringe-needle 3ml 22-26g	SC064	item	3		3			
57	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	20		20			
58	scalpel with blade, surgical (#10-20)	SF033	item	1		1			
59	suture, nylon, 3-0 to 6-0, c	SF036	item	2		2			
60	Post-op incision care kit (suture removal)	SA054	pack	1		1			
61	Kling roller bandage, 2 x 131"	SG020	item	2		2			
62	dressing, 5in X 9in (Xeroform)	SG041	item	3.5	2.5	1			
63	cotton balls, sterile	SG082	item	5		5			
64	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1			
65	Bacitracin oint ( 0.9gm uou)	SJ007	item	1		1			
66	tray, suturing	SA069	tray	1		1			
67	pack, cleaning, surgical instruments	SA043	pack	1		1			
68	<b>Equipment</b>								
69	light, surgical	EF014		55		1			
70	table, power	EF031		55		1			
71	mayo stand	EF015		55		1			
72	instrument pack, basic (\$500-\$1499)	EQ137		55		1			
73	camera, digital (6 megapixel)	ED004		55		1			
74	light, exam	EQ168		90	90				
75	exam table	EF023		90	90				

	A	J	K	L	M
1	Apr-05				
2	Acellular dermal replacement	15175 - FF20		15176 - FF21	
3		Acellular dermal		Acellular dermal	
4		90		ZZZ	
5		NF	FAC	NF	FAC
6	TOTAL TIME	80	60	19	0
7	PRE-service time	35	60	0	0
8	SERVICE time	45	0	19	0
9	POST-service time	0	0	0	0
10	<b>PRE-SERVICE - BEFORE ADMISSION</b>				
11	Complete pre-service diagnostic & referral forms	5	5		
12	Coordinate pre-surgery services	10	20		
13	Schedule space and equipment in facility	0	8		
14	Provide pre-service education/obtain consent	10	20		
15	Follow-up phone calls & prescriptions	10	7		
16	Other Clinical Activity (please specify)	0	0		
17	<b>SERVICE PERIOD - ADMISSION TO DISCHARGE</b>				
18	<b>Pre-service</b>				
19	Review charts	2			
20	Greet patient and provide gowning	3			
21	Obtain vital signs	3			
22	Provide pre-service education/obtain consent				
23	Prepare room, equipment, supplies	2			
24	Setup scope (non facility setting only)				
25	Prepare and position patient/ monitor patient/ set up IV	2			
26	Sedate/apply anesthesia				
27	<b>Intra-service</b>				
28	Assist physician in performing procedure	20		19	
29	<b>Post-service</b>				
30	Monitor pt. //check tubes, monitors, drains	5			
31	Clean room/equipment by physician staff	3			
32	Clean Scope				
33	Clean Surgical Instrument Package				
34	Complete diag forms, lab & X-ray requisitions	2			
35	Review/read X-ray, lab, and pathology reports				
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	3			
37	Discharge day mgmt 99238--12 min99239 --15 min				
38	Other Clinical Activity (please specify)				
39	<b>POST-SERVICE Period</b>				
40	Conduct phone calls/call in prescriptions				

	A	J	K	L	M
1	Apr-05				
2	<b>Acellular dermal replacement</b>	<b>15175 - FF20</b>		<b>15176 - FF21</b>	
3		<b>Acellular dermal</b>		<b>Acellular dermal</b>	
4		<b>90</b>		<b>ZZZ</b>	
5		<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
41		99211 16 minutes			
42	99212 27 minutes				
43	99213 36 minutes				
44	99214 53 minutes				
45	99215 63 minutes				
46	<b>Total Office Visit Time:</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
47	Other Activity (please specify)				
48	<b>MEDICAL SUPPLIES</b>				
49	pack, minimum multi-specialty visit	<b>1</b>			
50	mask, surgical	<b>2</b>			
51	gown, staff, impervious				
52	cap, surgical				
53	gloves, sterile				
54	shoe covers, surgical				
55	drape, sterile barrier 16 in X 29 in	<b>1</b>			
56	syringe-needle 3ml 22-26g	<b>3</b>			
57	lidocaine 1% w-epi inj (Xylocaine w-epi)	<b>20</b>			
58	scalpel with blade, surgical (#10-20)	<b>1</b>			
59	suture, nylon, 3-0 to 6-0, c	<b>2</b>			
60	Post-op incision care kit (suture removal)	<b>1</b>			
61	Kling roller bandage, 2 x 131"	<b>2</b>			
62	dressing, 5in X 9in (Xeroform)	<b>1</b>			
63	cotton balls, sterile	<b>5</b>			
64	sodium chloride 0.9% irrigation (500-1000ml uou)	<b>1</b>			
65	Bacitracin oint ( 0.9gm uou)	<b>1</b>			
66	tray, suturing	<b>1</b>			
67	pack, cleaning, surgical instruments	<b>1</b>			
68	<b>Equipment</b>				
69	light, surgical	<b>1</b>			
70	table, power	<b>1</b>			
71	mayo stand	<b>1</b>			
72	instrument pack, basic (\$500-\$1499)	<b>1</b>			
73	camera, digital (6 megapixel)	<b>1</b>			
74	light, exam				
75	exam table				



	A	B	C	D	E	F	G	H	I
1	Apr-05			Crosswalk Code - 15350 presented Aug 2003					
2	Allografts	CPT:		15350		15300X - FF22		15301X - FF23	
3		DESCRIPTOR:		Application of allograft, skin;		Allograft skin for temporary		Allograft skin for temporary	
4		GLOBAL:		90		90		ZZZ	
5		Code	Desc	NF	FAC	NF	FAC	NF	FAC
42	99212	27 minutes							
43	99213	36 minutes			2.5	2.5			
44	99214	53 minutes							
45	99215	63 minutes							
46	<b>Total Office Visit Time:</b>	L037D	RN/LPN/MA	90	90	0	0	0	0
47	Other Activity (please specify)								
48	<b>MEDICAL SUPPLIES</b>	<b>Code</b>	<b>Desc</b>						
49	pack, minimum multi-specialty visit	SA048	pack	3.5	2.5	1			
50	mask, surgical	SB033	item	2		2			
51	gown, staff, impervious	SB027	item						
52	cap, surgical	SB001	item						
53	gloves, sterile	SB024	pair						
54	shoe covers, surgical	SB039	pair						
55	drape, sterile barrier 16 in X 29 in	SB007	item	1		1			
56	syringe-needle 3ml 22-26g	SC064	item	3		3			
57	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	20		20			
58	scalpel with blade, surgical (#10-20)	SF033	item	1		1			
59	suture, nylon, 3-0 to 6-0, c	SF036	item	2		2			
60	Post-op incision care kit (suture removal)	SA054	pack	1		1			
61	Kling roller bandage, 2 x 131"	SG020	item	2		2			
62	dressing, 5in X 9in (Xeroform)	SG041	item	3.5	2.5	1			
63	cotton balls, sterile	SG082	item	5		5			
64	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1			
65	Bacitracin oint ( 0.9gm uou)	SJ007	item	1		1			
66	tray, suturing	SA069	tray	1		1			
67	pack, cleaning, surgical instruments	SA043	pack	1		1			
68	<b>Equipment</b>								
69	light, surgical	EF014		55		1			
70	table, power	EF031		55		1			
71	mayo stand	EF015		55		1			
72	instrument pack, basic (\$500-\$1499)	EQ137		55		1			
73	camera, digital (6 megapixel)	ED004		55		1			
74	light, exam	EQ168		90	90				
75	exam table	EF023		90	90				





	A	R	S	T	U
1	Apr-05				
2	Allografts	15335 - FF28		15336 - FF29	
3		Acellular dermal		Acellular dermal	
4		90		ZZZ	
5		NF	FAC	NF	FAC
6		TOTAL TIME	80	60	17
7	PRE-service time	35	60	0	0
8	SERVICE time	45	0	17	0
9	POST-service time	0	0	0	0
10	<b>PRE-SERVICE - BEFORE ADMISSION</b>				
11	Complete pre-service diagnostic & referral forms	5	5		
12	Coordinate pre-surgery services	10	20		
13	Schedule space and equipment in facility	0	8		
14	Provide pre-service education/obtain consent	10	20		
15	Follow-up phone calls & prescriptions	10	7		
16	Other Clinical Activity (please specify)	0	0		
17	<b>SERVICE PERIOD - ADMISSION TO DISCHARGE</b>				
18	<b>Pre-service</b>				
19	Review charts	2			
20	Greet patient and provide gowning	3			
21	Obtain vital signs	3			
22	Provide pre-service education/obtain consent				
23	Prepare room, equipment, supplies	2			
24	Setup scope (non facility setting only)				
25	Prepare and position patient/ monitor patient/ set up IV	2			
26	Sedate/apply anesthesia				
27	<b>Intra-service</b>				
28	Assist physician in performing procedure	20		17	
29	<b>Post-service</b>				
30	Monitor pt. //check tubes, monitors, drains	5			
31	Clean room/equipment by physician staff	3			
32	Clean Scope				
33	Clean Surgical Instrument Package				
34	Complete diag forms, lab & X-ray requisitions	2			
35	Review/read X-ray, lab, and pathology reports				
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	3			
37	Discharge day mgmt 99238--12 min 99239 --15 min				
38	Other Clinical Activity (please specify)				
39	<b>POST-SERVICE Period</b>				
40	Conduct phone calls/call in prescriptions				
41	99211 16 minutes				

	A	R	S	T	U
1	Apr-05				
2	<b>Allografts</b>	<b>15335 - FF28</b>		<b>15336 - FF29</b>	
3		Acellular dermal		Acellular dermal	
4		90		ZZZ	
5		NF	FAC	NF	FAC
42		99212 27 minutes			
43	99213 36 minutes				
44	99214 53 minutes				
45	99215 63 minutes				
46	<b>Total Office Visit Time:</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
47	Other Activity (please specify)				
48	<b>MEDICAL SUPPLIES</b>				
49	pack, minimum multi-specialty visit	1			
50	mask, surgical	2			
51	gown, staff, impervious				
52	cap, surgical				
53	gloves, sterile				
54	shoe covers, surgical				
55	drape, sterile barrier 16 in X 29 in	1			
56	syringe-needle 3ml 22-26g	3			
57	lidocaine 1% w-epi inj (Xylocaine w-epi)	20			
58	scalpel with blade, surgical (#10-20)	1			
59	suture, nylon, 3-0 to 6-0, c	2			
60	Post-op incision care kit (suture removal)	1			
61	Kling roller bandage, 2 x 131"	2			
62	dressing, 5in X 9in (Xeroform)	1			
63	cotton balls, sterile	5			
64	sodium chloride 0.9% irrigation (500-1000ml uou)	1			
65	Bacitracin oint ( 0.9gm uou)	1			
66	tray, suturing	1			
67	pack, cleaning, surgical instruments	1			
68	<b>Equipment</b>				
69	light, surgical	1			
70	table, power	1			
71	mayo stand	1			
72	instrument pack, basic (\$500-\$1499)	1			
73	camera, digital (6 megapixel)	1			
74	light, exam				
75	exam table				

	A	B	C	D	E	F	G	H	I
1	Apr-05			<b>Crosswalk Code - 15350</b>					
2	<b>Tissue Cultured Allografts</b>	<b>CPT:</b>		<b>15350</b>		<b>15340 - FF30</b>		<b>15341 - FF31</b>	
3		<b>DESCRIPTOR:</b>		Application of allograft, skin;		Tissue cultured allogeneic skin		Tissue cultured allogeneic skin	
4		<b>GLOBAL:</b>		90		10		ZZZ	
5		<b>Code</b>	<b>Desc</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
6	<b>TOTAL TIME</b>	L037D RN/LPN/MA	180	156	138	120	10	0	
7	<b>PRE-service time</b>	L037D RN/LPN/MA	35	60	35	60	0	0	
8	<b>SERVICE time</b>	L037D RN/LPN/MA	55	6	49	6	10	0	
9	<b>POST-service time</b>	L037D RN/LPN/MA	90	90	54	54	0	0	
10	<b>PRE-SERVICE - BEFORE ADMISSION</b>	<b>Code</b>	<b>Desc</b>						
11	Complete pre-service diagnostic & referral forms	L037D RN/LPN/MA	5	5	5	5			
12	Coordinate pre-surgery services	L037D RN/LPN/MA	10	20	10	20			
13	Schedule space and equipment in facility	L037D RN/LPN/MA	0	8	0	8			
14	Provide pre-service education/obtain consent	L037D RN/LPN/MA	10	20	10	20			
15	Follow-up phone calls & prescriptions	L037D RN/LPN/MA	10	7	10	7			
16	<b>Other Clinical Activity (please specify)</b>		0	0	0	0			
17	<b>SERVICE PERIOD - ADMISSION TO DISCHARGE</b>	<b>Code</b>	<b>Desc</b>						
18	<b>Pre-service</b>								
19	Review charts	L037D RN/LPN/MA	2		2				
20	Greet patient and provide gowning	L037D RN/LPN/MA	3		3				
21	Obtain vital signs	L037D RN/LPN/MA	3		3				
22	Provide pre-service education/obtain consent								
23	Prepare room, equipment, supplies	L037D RN/LPN/MA	4		2				
24	Setup scope (non facility setting only)								
25	Prepare and position patient/ monitor patient/ set up IV	L037D RN/LPN/MA	2		2				
26	Sedate/apply anesthesia	L037D RN/LPN/MA							
27	<b>Intra-service</b>								
28	Assist physician in performing procedure	L037D RN/LPN/MA	20		19		10		
29	<b>Post-service</b>								
30	Monitor pt. //check tubes, monitors, drains	L037D RN/LPN/MA	5		3				
31	Clean room/equipment by physician staff	L037D RN/LPN/MA	3		3				
32	Clean Scope								
33	Clean Surgical Instrument Package	L037D RN/LPN/MA			10				
34	Complete diag forms, lab & X-ray requisitions	L037D RN/LPN/MA	2		2				
35	Review/read X-ray, lab, and pathology reports								
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D RN/LPN/MA	3						
37	Discharge day mgmt 99238--12 min99239 --15 min	L037D RN/LPN/MA	6	6		6			
38	<b>Other Clinical Activity (please specify)</b>								
39	<b>POST-SERVICE Period</b>	<b>Code</b>	<b>Desc</b>						
40	Conduct phone calls/call in prescriptions								
41	99211 16 minutes								

	A	B	C	D	E	F	G	H	I
1	Apr-05			Crosswalk Code - 15350					
2	Tissue Cultured Allografts	CPT:		15350		15340 - FF30		15341 - FF31	
3		DESCRIPTOR:		Application of allograft, skin;		Tissue cultured allogeneic skin		Tissue cultured allogeneic skin	
4		GLOBAL:		90		10		ZZZ	
5		Code	Desc	NF	FAC	NF	FAC	NF	FAC
42		99212	27 minutes			2	2		
43	99213	36 minutes	2.5	2.5					
44	99214	53 minutes							
45	99215	63 minutes							
46	<b>Total Office Visit Time:</b>	L037D	RN/LPN/MA	90	90	54	54	0	0
47	Other Activity (please specify)								
48	<b>MEDICAL SUPPLIES</b>	Code	Desc						
49	pack, minimum multi-specialty visit	SA048	pack	3.5	2.5	3	2		
50	mask, surgical	SB033	item	2		2			
51	gown, staff, impervious	SB027	item						
52	cap, surgical	SB001	item						
53	gloves, sterile	SB024	pair			2			
54	shoe covers, surgical	SB039	pair						
55	drape, sterile barrier 16 in X 29 in	SB007	item	1		1			
56	syringe-needle 3ml 22-26g	SC064	item	3		1			
57	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	20		5		5	
58	scalpel with blade, surgical (#10-20)	SF033	item	1		1			
59	suture, nylon, 3-0 to 6-0, c	SF036	item	2		1		1	
60	Post-op incision care kit (suture removal)	SA054	pack	1		1			
61	Kling roller bandage, 2 x 131"	SG020	item	2		2		2	
62	dressing, 5in X 9in 9 (Xeroform)	SG041	item			5		5	
63	dressing, 5in X 9in (Xeroform)	SG041	item	3.5	2.5	3	2		
64	cotton balls, sterile	SG082	item	5					
65	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1			
66	Bacitracin oint ( 0.9gm uou)	SJ007	item	1		1			
67	tray, suturing	SA069	tray	1		1			
68	pack, cleaning, surgical instruments	SA043	pack	1		1			
69	<b>Equipment</b>								
70	light, surgical	EF014		55		1			
71	table, power	EF031		55		1	1		
72	mayo stand	EF015		55		1	1		
73	instrument pack, basic (\$500-\$1499)	EQ137		55		1			
74	camera, digital (6 megapixel)	ED004		55					
75	light, exam	EQ168		90	90	1	1		
76	exam table	EF023		90	90				



	A	J	K	L	M	N	O	P	Q
1	Apr-05								
2	<b>Tissue Cultured Allografts</b>	<b>15360X - FF32</b>		<b>15361X - FF33</b>		<b>15365 - FF34</b>		<b>15366 - FF35</b>	
3		Tissue cultured allogeneic dermal		Tissue cultured allogeneic dermal		Tissue cultured		Tissue cultured	
4		90		ZZZ		90		ZZZ	
5		NF	FAC	NF	FAC	NF	FAC	NF	FAC
42		99212 27 minutes	3	3			3	3	
43	99213 36 minutes								
44	99214 53 minutes								
45	99215 63 minutes								
46	<b>Total Office Visit Time:</b>	<b>81</b>	<b>81</b>	<b>0</b>	<b>0</b>	<b>81</b>	<b>81</b>	<b>0</b>	<b>0</b>
47	Other Activity (please specify)								
48	<b>MEDICAL SUPPLIES</b>								
49	pack, minimum multi-specialty visit	4	3			4	3		
50	mask, surgical	2				2			
51	gown, staff, impervious								
52	cap, surgical								
53	gloves, sterile	2				2			
54	shoe covers, surgical								
55	drape, sterile barrier 16 in X 29 in	1				1			
56	syringe-needle 3ml 22-26g	3				3			
57	lidocaine 1% w-epi inj (Xylocaine w-epi)	20				20			
58	scalpel with blade, surgical (#10-20)	1				1			
59	suture, nylon, 3-0 to 6-0, c	2				2			
60	Post-op incision care kit (suture removal)	1				1			
61	Kling roller bandage, 2 x 131"	2		2		2		2	
62	dressing, 5in X 9in 9 (Xeroform)	5				5			
63	dressing, 5in X 9in (Xeroform)	5	4			5	4		
64	cotton balls, sterile	5				5			
65	sodium chloride 0.9% irrigation (500-1000ml uou)	1				1			
66	Bacitracin oint ( 0.9gm uou)	1				1			
67	tray, suturing	1				1			
68	pack, cleaning, surgical instruments	1				1			
69	<b>Equipment</b>								
70	light, surgical	1				1			
71	table, power	1				1			
72	mayo stand	1				1			
73	instrument pack, basic (\$500-\$1499)	1				1			
74	camera, digital (6 megapixel)	1				1			
75	light, exam	1	1			1	1		
76	exam table	1	1			1	1		

	A	B	C	D	E	F	G	H
1			Crosswalk Code - 15400					
2			15400		15400 - FF36		15401 - FF37	
3	Xenografts	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Application of xenograft, skin; 100 sq cm or less		Xenograft, skin (dermal) for temporary wound closure; trunk, arms,		Xenograft, skin (dermal) for temporary wound closure; trunk, arms, legs; each additional 100 sq cm, or	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		90	90	90	90	ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME	RN/LPN/MTA	196	172	168	153	36	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	RN/LPN/MTA	35	60	35	60	0	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	RN/LPN/MTA	55	6	52	12	36	0
9	TOTAL POST-SERV CLINICAL LABOR TIME	RN/LPN/MTA	106	106	81	81	0	0
10	<del>PRE-SERVICE</del>							
11	Start: Following visit when decision for surgery or procedure made							
12	Complete pre-service diagnostic & referral forms	RN/LPN/MTA	5	5	5	5		
13	Coordinate pre-surgery services	RN/LPN/MTA	10	20	10	20		
14	Schedule space and equipment in facility	RN/LPN/MTA	0	8	0	8		
15	Provide pre-service education/obtain consent	RN/LPN/MTA	10	20	10	20		
16	Follow-up phone calls & prescriptions	RN/LPN/MTA	10	7	10	7		
17	Other Clinical Activity (please specify)	RN/LPN/MTA	0	0	0	0		
18	End:When patient enters office/facility for surgery/procedure							
19	<del>SERVICE PERIOD</del>							
20	Start: When patient enters office/facility for surgery/procedure							
21	Pre-service services							
22	Review charts	RN/LPN/MTA	2		2			
23	Greet patient and provide gowning	RN/LPN/MTA	3		3			
24	Obtain vital signs	RN/LPN/MTA	3		3			
25	Provide pre-service education/obtain consent	RN/LPN/MTA						
26	Prepare room, equipment, supplies	RN/LPN/MTA	4		2			
27	Setup scope (non facility setting only)	RN/LPN/MTA						
28	Prepare and position patient/ monitor patient/ set up IV	RN/LPN/MTA	2		2			
29	Sedate/apply anesthesia	RN/LPN/MTA						
30	Intra-service							
31	Assist physician in performing procedure	RN/LPN/MTA	20		17		13	
32	Post-Service							
33	Monitor pt. following service/check tubes, monitors, drains	RN/LPN/MTA	5		5		5	
34	Clean room/equipment by physician staff	RN/LPN/MTA	3		3		3	
35	Clean Scope	RN/LPN/MTA						
36	Clean Surgical Instrument Package	RN/LPN/MTA			10		10	

	A	B	C	D	E	F	G	H
1		<b>Crosswalk Code - 15400</b>						
2			<b>15400</b>		<b>15400 - FF36</b>		<b>15401 - FF37</b>	
3	<b>Xenografts</b>	<b>CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE</b>	<b>Application of xenograft, skin; 100 sq cm or less</b>		<b>Xenograft, skin (dermal) for temporary wound closure; trunk, arms,</b>		<b>Xenograft, skin (dermal) for temporary wound closure; trunk, arms, legs; each additional 100 sq cm, or</b>	
4	<b>LOCATION</b>		<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>		<b>90</b>	<b>90</b>	<b>90</b>	<b>90</b>	<b>ZZZ</b>	<b>ZZZ</b>
37	Complete diagnostic forms, lab & X-ray requisitions	RN/LPN/MTA	<b>2</b>		<b>2</b>		<b>2</b>	
38	Review/read X-ray, lab, and pathology reports	RN/LPN/MTA						
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	RN/LPN/MTA	<b>3</b>		<b>3</b>		<b>3</b>	
40	Discharge day management 99238 --12 minutes 99239 --15 minutes	RN/LPN/MTA	<b>6</b>	<b>6</b>		<b>12</b>		
41	Other Clinical Activity (please specify)	RN/LPN/MTA						
42	<b>End: Patient leaves office</b>							
43	<b>POST-SERVICE PERIOD</b>							
44	<b>Start: Patient leaves office/facility</b>							
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	<b>1</b>	<b>1</b>				
49	99212 27 minutes	27	<b>2</b>	<b>2</b>	<b>3</b>	<b>3</b>		
50	99213 36 minutes	36	<b>1</b>	<b>1</b>				
51	99214 53 minutes	53						
52	99215 63 minutes	63						
53	Other							
54								
55	Total Office Visit Time		<b>106</b>	<b>106</b>	<b>81</b>	<b>81</b>	<b>0</b>	<b>0</b>
56	Other Activity (please specify)							
57	<b>End: with last office visit before end of global period</b>							
58	<b>MEDICAL SUPPLIES</b>							
59	pack, minimum multi-specialty visit	SA048	<b>5</b>	<b>4</b>	<b>4</b>	<b>3</b>		
60	pack, post-op incision care (suture)	SA054	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>		
61	mask, surgical	SB033	<b>2</b>		<b>2</b>			
62	gown, staff, impervious	SB027						

	A	B	C	D	E	F	G	H
1		<b>Crosswalk Code: - 15400</b>						
2			<b>15400</b>		<b>15400 - FF36</b>		<b>15401 - FF37</b>	
3	<b>Xenografts</b>	<b>CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE</b>	<b>Application of xenograft, skin; 100 sq cm or less</b>		<b>Xenograft, skin (dermal) for temporary wound closure; trunk, arms,</b>		<b>Xenograft, skin (dermal) for temporary wound closure; trunk, arms, legs; each additional 100 sq cm, or</b>	
4	<b>LOCATION</b>		<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>		<b>90</b>	<b>90</b>	<b>90</b>	<b>90</b>	<b>ZZZ</b>	<b>ZZZ</b>
63	cap, surgical	SB001						
64	gloves, sterile	SB024						
65	shoe covers, surgical	SB039						
66	scalpel with blade, surgical (#10-20)	SF033	1		1			
67	drape, sterile barrier 16in X 29in	SB007	1		1			
68	needle, 18-27g	SC029	3		3			
69	bandage, Kling, sterile 4in2 x 131"	SG041	2		4		2	
70	tray, suturing	SA069	1		1			
71	suture, nylon, 3-0 to 6-0, c	SF036	2		2		1	
72	pack, cleaning, surgical instruments	SA043	1		1			
73	lidocaine 1% w-epi inj (Xylocaine w/ epi)	SH046	20		20		10	
74	syringe, 3cc	SC055	3		3			
75	Bacitracin oint, 0.9gm uou	SJ007	1		1			
76	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	1		1			
77	dressing, 5in X 9in 9 (Xeroform)	SG041	5	4	5	4		
78	cotton balls, sterile	SG082	5		5			
79	acellular xenograft implant	Understand that Reported with J code						
80	<b>Equipment</b>							
81	Basic Surgical Instrument Package \$500	EQ137	55		1			
82	Power Table	EF031	55		1	1		
83	Exam table	EF023	106	106				
84	Surgical lamp	EF014	55		1			
85	Exam lamp	E6Q168	106	106	1	1		
86	Mayo stand	EF015	55		1	1		
87	Digital Camera (6 megapixel)	ED004	55					

	A	I	J	K	L	M	N
1							
2							
3	<b>Xenografts</b>	<b>15420 - FF38</b> Xenograft, skin (dermal) for temporary wound closure; face, scalp,		<b>15421 - FF39</b> Xenograft, skin (dermal) for temporary wound closure; face, scalp,		<b>15430 - FF40</b> Acellular xenograft implant; first 100 sq cm or less, or one	
4	<b>LOCATION</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>	90	90	ZZZ	ZZZ	90	90
6	<b>TOTAL CLINICAL LABOR TIME</b>	171	153	36	0	318	309
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	35	60	0	0	35	60
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	55	12	36	0	40	6
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	81	81	0	0	243	243
10	<b>PRE-SERVICE</b>						
11	<b>Start: Following visit when decision for surgery or procedure made</b>						
12	Complete pre-service diagnostic & referral forms	5	5			5	5
13	Coordinate pre-surgery services	10	20			10	20
14	Schedule space and equipment in facility	0	8			0	8
15	Provide pre-service education/obtain consent	10	20			10	20
16	Follow-up phone calls & prescriptions	10	7			10	7
17	Other Clinical Activity (please specify)	0	0			0	0
18	<b>End:When patient enters office/facility for surgery/procedure</b>						
19	<b>SERVICE PERIOD</b>						
20	<b>Start: When patient enters office/facility for surgery/procedure</b>						
21	<b>Pre-service services</b>						
22	Review charts	2				2	
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	<b>Intra-service</b>						
31	Assist physician in performing procedure	20		13		10	
32	<b>Post-Service</b>						
33	Monitor pt. following service/check tubes, monitors, drains	5		5		3	
34	Clean room/equipment by physician staff	3		3		3	
35	Clean Scope						
36	Clean Surgical Instrument Package	10		10		10	

A		I	J	K	L	M	N
1							
2							
3	Xenografts	15420 - FF38 Xenograft, skin (dermal) for temporary wound closure; face, scalp,		15421 - FF39 Xenograft, skin (dermal) for temporary wound closure; face, scalp,		15430 - FF40 Acellular xenograft implant; first 100 sq cm or less, or one	
4	LOCATION	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD	90	90	ZZZ	ZZZ	90	90
37	Complete diagnostic forms, lab & X-ray requisitions	2		2		2	
38	Review/read X-ray, lab, and pathology reports						
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	3		3			
40	Discharge day management 99238 --12 minutes --15 minutes 99239		12				6
41	Other Clinical Activity (please specify)						
42	End: Patient leaves office						
43	<b>POST SERVICE PERIOD</b>						
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						
49	99212 27 minutes	3	3			9	9
50	99213 36 minutes						
51	99214 53 minutes						
52	99215 63 minutes						
53	Other						
54							
55	Total Office Visit Time	81	81	0	0	243	243
56	Other Activity (please specify)						
57	End: with last office visit before end of global period						
58	<b>NEEDLE SUPPLIES</b>						
59	pack, minimum multi-specialty visit	4	3			10	9
60	pack, post-op incision care (suture)	1	1				
61	mask, surgical	2					
62	gown, staff, impervious						

	A	I	J	K	L	M	N
1							
2							
3	<b>Xenografts</b>	<b>15420 - FF38 Xenograft, skin (dermal) for temporary wound closure; face, scalp,</b>		<b>15421 - FF39 Xenograft, skin (dermal) for temporary wound closure; face, scalp,</b>		<b>15430 - FF40 Acellular xenograft implant; first 100 sq cm or less, or one</b>	
4	<b>LOCATION</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>	<b>90</b>	<b>90</b>	<b>ZZZ</b>	<b>ZZZ</b>	<b>90</b>	<b>90</b>
63	cap, surgical						
64	gloves, sterile						
65	shoe covers, surgical						
66	scalpel with blade, surgical (#10-20)	1				1	
67	drape, sterile barrier 16in X 29in	1				1	
68	needle, 18-27g	3					
69	bandage, Kling, sterile 4in2 x 131"	2		2		2	
70	tray, suturing	1					
71	suture, nylon, 3-0 to 6-0, c	2		1			
72	pack, cleaning, surgical instruments	1				1	
73	lidocaine 1% w-epi inj (Xylocaine w/ epi)	20		10			
74	syringe, 3cc	3					
75	Bactracin oint, 0.9gm uou	1				1	
76	sodium chloride 0.9% irrigation (500-1000ml uou)	1				1	
77	dressing, 5in X 9in 9 (Xeroform)	5	4			9	8
78	cotton balls, sterile	5					
79	acellular xenograft implant					9	8
80							
81	Basic Surgical Instrument Package \$500	1				1	
82	Power Table	1	1			1	1
83	Exam table						
84	Surgical lamp	1				1	
85	Exam lamp	1	1			1	1
86	Mayo stand	1	1			1	1
87	Digital Camera (6 megapixel)						



	A	B	C	D	E	F	G	H	I	J	K
1		Apr-05		Crosswalk Code -							
2	Dressings and Debridement	CPT:		16020		16020 - FF42		16025 - FF43		16030 - FF44	
3		DESCRIPTOR:		Dressings and/or		Dressings and/or debridement		Dressings and/or		Dressings and/or	
4		GLOBAL:		0		0		0		0	
5		Code	Desc	NF	FAC	NF	FAC	NF	FAC	NF	FAC
5		Code	Desc								
48	<b>MEDICAL SUPPLIES</b>										
49	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1	
50	mask, surgical	SB033	item								
51	gown, staff, impervious	SB027	item								
52	cap, surgical	SB001	item								
53	gloves, sterile	SB024	pair	2		2		2		2	
54	shoe covers, surgical	SB039	pair								
55	kit, sharp debridement	SA029	kit	1		1		1		1	
56	bandage, Kling, non-sterile 2in	SG017	item	1		1		2		4	
57	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	1		1		1		2	
58	needle, 18-27g	SC029	item	1		1		1		2	
59	silver sulfadiazene cream (Silvadene)	SH064	gm	1		1		1		1	
60	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	20		20		20		40	
61	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	8		2		4		8	
62	tape, surgical paper 1in (Micropore)	SG079	inch	18		18		24		48	
63	dressing, 3inx4in (Telfa, Release)	SG035	item	2		2		4		8	
64	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	ml					1		2	
65	hydrogen peroxide	SJ028	ml	10		10		10		20	
66	<b>Equipment</b>										
67	light, exam	EQ168		34							
68	table, power	EF031		34		1		1		1	
69	Surgical lamp	EF014				1		1		1	
70	Mayo stand	EF015				1		1		1	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Apical Lung Tumor Resection/Lung and Chest Wall Resection**

CPT deleted three codes pertaining to lung resections because it was determined that the descriptors were ambiguous. CPT then created two new lung resection codes that more accurately describe the variation in the amount of lung resected and the work involved in these procedures. The RUC agreed with the presenters rationale for not applying work neutrality. According to the presenters, the deleted codes are not specific regarding the variation in the amount of lung resected (eg, wedge resection versus pneumonectomy), which can represent substantial differences in work for the surgeon. Additionally, the RVUS of these codes are based on the original Harvard study valuations with no documentation regarding what type of resections were included in the initial MFS valuation.

The presenters also made a case that this family of codes represented a significant rank order anomaly with the individual resection and reconstruction code families (eg, 32520 *Resection of lung and chest wall* has an RVW of 21.65 and 32500 *Wedge resection* has an RVW of 21.97). The presenters contend that the lung resection with chest wall resection codes represent a rank order anomaly within the lung procedures as the current work values do not even account for the basic work of a wedge resection, which would be the minimal amount of lung resection that may be involved in this procedure. The RUC agreed with this compelling evidence to not apply work neutrality to these codes.

32503 and 32504

The RUC reviewed code 32503 *Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction(s)* and code 32504 *Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction(s)* together to determine proper rank order. For code 32503 the RUC agreed that the median survey value of 30.00 RVUs placed the code in proper rank order and accurately reflected the physician work of this code. Once this value was determined the RUC evaluated the incremental work involved in chest wall reconstruction. The RUC agreed with the presenters that the survey respondents underestimated the incremental work involved in reconstruction by in effect only adding one RVU for an additional hour of work.

The RUC agreed with the following methodology to value 32504. The surveyed difference in total work between the 32503 and 352X2 is 60 minutes additional intraoperative time for chest wall reconstruction. Using the IWPUT of 0.080 for 32503, an RVW of 34.80 is calculated for code 32504. This RVW provides an additional 4.80 RVUs for the one hour of additional work for chest wall reconstruction. The IWPUT of 0.080 is the same as the IWPUT for 352X1, appropriately similar to the IWPUT for 32480, *Removal of lung, other than total pneumonectomy; single lobe (lobectomy)* (work RVU=23.71, IWPUT =0.084) and less than the IWPUT for MPC reference codes 33405 *Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve* (work RVU =34.95, IWPUT = 0.099) and 35646 *Bypass graft, with other than vein; aortobifemoral* (work RVU =30.95, IWPUT = 0.092).

**The RUC recommends a work RVU of 30.00 for code 32503**

**The RUC recommends a work RVU of 34.80 for code 32504**

Practice Expense

The RUC recommends the standard inputs for 90 day global porcedures performed in the facility setting with the exception of using the RN staff type rather than the standard staff blend.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
19260	EEE1	<i>Excision of chest wall tumor including ribs</i>	090	15.42  (No Change)
19271	EEE2	<i>Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy</i>	090	18.87  (No Change)
19272	EEE3	<i>with mediastinal lymphadenectomy</i>  (Do not report 19260, 19271, 19272 in conjunction with 32002, 32020, 32100, 32503, 32504)	090	21.52  (No Change)

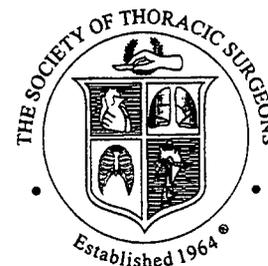
CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
32002		<i>Thoracentesis with insertion of tube with or without water seal (eg, for pneumothorax) (separate procedure)</i>  <i>(If imaging guidance is performed, see 76003, 76360, 76942)</i> <i>(Do not report 32002, in conjunction with 19260, 19271, 19272, 32503, 32504)</i>	000	2.19  (No Change)
32020		<i>Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)</i>  <i>(If imaging guidance is performed, use 75989)</i>  <i>(Do not report 32020, in conjunction with 19260, 19271, 19272, 32503, 32504)</i>	000	3.97  (No Change)
32100		<i>Thoracotomy, major; with exploration and biopsy</i>  <i>(Do not report 32100, in conjunction with 19260, 19271, 19272, 32503, 32504)</i>	090	15.22  (No Change)
32440	EEE4	<i>Removal of lung, total pneumonectomy;</i>	090	24.96  (No Change)
32442	EEE5	<i>with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)</i>	090	26.20  (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
32445	EEE6	<i>extrapleural</i>  <i>(For extrapleural pneumonectomy, with empyemectomy, use 32445 and 32540)</i>  <i>(If lung resection is performed with chest wall tumor resection, report the appropriate chest wall tumor resection code, 19260-19272, in addition to lung resection code 32440-32445)</i>	090	25.05  (No Change)
32480	EEE7	<i>Removal of lung, other than total pneumonectomy; single lobe (lobectomy)</i>	090	23.71  (No Change)
32482	EEE8	<i>two lobes (bilobectomy)</i>	090	24.96  (No Change)
32484	EEE9	<i>single segment (segmentectomy)</i> <i>(For removal of lung with bronchoplasty, use 32501)</i>	090	20.66  (No Change)
32486	EEE10	<i>with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)</i>	090	23.88  (No Change)
32488	EEE11	<i>all remaining lung following previous removal of a portion of lung (completion pneumonectomy)</i>  <i>(For total or segmental lobectomy, with concomitant decortication, use 32320 and the appropriate removal of lung code)</i>	090	25.67  (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
32491	EEE12	<i>excision-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure</i>	090	21.22  (No Change)
32500	EEE13	<i>wedge resection, single or multiple</i>  (If lung resection is performed with chest wall tumor resection, report the appropriate chest wall tumor resection code, 19260-19272, in addition to lung resection code 32480-32500)	090	21.97  (No Change)
•32503	EEE14	Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction(s)	090	30.00
•32504	EEE15	with chest wall reconstruction  (Do not report 32503, 32504 in conjunction with 19260, 19271, 19272, 32002, 32020, 32100)	090	34.80
D 32520		<del>Resection of lung; with resection of chest wall</del>	090	N/A
D 32522		<del>with reconstruction of chest wall, without prosthesis</del>	090	N/A
D 32525		<del>with major reconstruction of chest wall, with prosthesis</del> (32520, 32522, and 32525 have been deleted)  (For performance of lung resection in conjunction with chest wall resection, see 19260, 19271, 19272 and 32480-32500, and 32503, 32504)	090	N/A

# THE SOCIETY OF THORACIC SURGEONS

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April 5, 2005

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

Re: Review of Codes 19260-19272 and 32440-32500 due to the deletion of codes  
23520-32525

Dear Dr. Rich:

At the February, 2005 CPT Editorial Panel meeting, the Society of Thoracic Surgeons received approval for deletion of three ambiguous CPT codes:

- 32520 – Resection of lung; with resection of chest wall
- 32522 – Resection of lung; with reconstruction of chest wall, without prosthesis
- 32525 – Resection of lung; with major reconstruction of chest wall, with prosthesis.

The STS believes that the deletion of these very low volume ambiguous codes should not require review and revaluation of all related codes based on the arguments presented within this letter.

These codes are not specific regarding the variation in the amount of lung resected (eg, wedge resection versus pneumonectomy), which can represent substantial differences in work for the surgeon. Additionally, these codes are Harvard based with no documentation regarding what type of resections were included in the initial MFS valuation. Further, because there are separate codes for the variations of chest wall reconstruction and for the variations of lung resection procedures, the STS believes that a more appropriate method of accounting for the work would be to specify the precise and unambiguous codes and apply the '-51' modifier, as appropriate.

We also note that this family of codes represented a significant rank order anomaly with the individual resection and reconstruction code families (eg, 32520 Resection of lung and chest wall has an RVW of 21.65 and 32500 Wedge resection has an RVW of 21.97). However, we chose not to review these codes during the second five year review, and instead submitted a CPT application for deletion and referencing to report the procedures in combinations, as appropriate. The STS requested that these codes be deleted and that

when a lung resection is performed in conjunction with chest wall resection and/or reconstruction, that the procedure be reported using the appropriate lung resection code, (32440-32500) along with the appropriate chest wall resection code (19260-19272). This application was recently approved by CPT.

It is apparent that the lung resection with chest wall resection codes represent a rank order anomaly within the lung procedures as the current work values do not even account for the basic work of a wedge resection, which would be the minimal amount of lung resection that may be involved in this procedure.

Additionally, we note that most of the lung resection codes are on the current LOI for the third five year review of physician work or were reviewed during the second five year review. Thank you for your time and consideration regarding these issues.

Sincerely,

A handwritten signature in black ink that reads "Keith S. Naunheim". The signature is written in a cursive style with a long horizontal flourish at the end.

Keith Naunheim,  
STS RUC Advisor

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

CPT Code:32503 Tracking Number: EE14 Global Period: 090

**Recommended Work Relative Value**

Specialty Society RVU: **30.00**

RUC RVU: **30.00**

CPT Descriptor: Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 66 year-old female, overweight, heavy smoker with a 4 month history of right shoulder and/or arm pain. Apical lung biopsy confirms non-small cell lung cancer.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Write pre-operative orders for peri-operative medications
- Review pre-operative evaluation, including history and physical examination
- Review outside films, reports, and correspondence, chest x-ray; laboratory results (CBC, electrolytes, renal function); CT scans Chest, Abdomen, Other staging studies as appropriate, MRI Brain, MRI thoracic inlet including brachial plexus, PET scan, bone scan, plain films as appropriate, pathology / cytology biopsy reports, Pulmonary function tests which may include Spirometry with and without bronchodilators, DLCO, Ventilation perfusion (V scans, Oxygen consumption (MVO<sub>2</sub>), Arterial blood gas
- Review consultation reports if obtained
- Review planned incisions and procedure
- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family including potential arm / hand dysfunction from resection; resultant Horner's syndrome from resection of sympathetic ganglion, cosmetic changes (usually minor) resulting from resection of ribs 1, 2, and 3; and potential for blood transfusions
- Update history and physical examination if greater than 7 days but less than 30 days from last history and physical examination;
- Answer patient and family questions
- Obtain informed consent
- Surgeon to initial site / side of planned operation with patient
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Verify that antibiotics and prophylaxis for deep venous thrombosis / pulmonary embolus are provided (e.g. subcutaneous heparin administration, or placement of support stockings, or sequential compression devices on lower extremities).
- Monitor positioning of patient in lateral decubitus position, with axillary "roll" beneath dependent side to insure adequate intraoperative aeration of dependent lung, padding and support to prevent neuropraxia
- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of intersp of side be operated upon
- Conduct "TIME-OUT" with operating room team to confirm CORRECT patient, CORRECT operation to be performed, CORRECT site, and CORRECT side with verbal checks from all members of operating room team: Surgical team, circulating nurse, anesthesiologist

- Scrub and gown

Description of Intra-Service Work: A high thoracotomy is performed with a planned entry into the 4th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting a 1 cm segment of the rib posteriorly to facilitate exposure and spreading of the ribs (Care is taken to avoid injury to the intercostal neurovascular bundles). The chest is explored, assessing for the presence of adhesions between the lung and the chest wall which are carefully divided before inserting the rib spreader to prevent a tear of the lung. The superior sulcus lung tumor is carefully palpated and its specific relationship to the chest wall, vertebral column, thoracic inlet, great vessels, and brachial plexus as well as its specific pulmonary vasculature and bronchial tree anatomy, and its relationship to the right middle and right lower lobe, defined to determine that a resection of this superior sulcus tumor with right upper lobectomy and chest wall of ribs 1, 2, and 3, is required and is feasible. Single lung ventilation of the contralateral lung is instituted to facilitate exposure of the operative lung side, the chest wall, vasculature and bronchus. The extent of the tumor is identified from within the thorax and its anterior-ventral and posterior-caudal extent is defined. The trapezius and rhomboid muscles are divided between the posterior medial border of the scapula and the spinous processes such that the scapula can be elevated. A retractor is placed to elevate the scapula superiorly and laterally, and the 4th rib inferiorly. Exposure to the ribs of the thoracic inlet / superior sulcus is thus obtained. The 3rd rib is divided anteriorly 5 cm beyond the closest tumor margin. An additional 1 cm piece of rib is resected to facilitate exposure of the 2nd rib. The 3rd rib is divided posteriorly at the level of the transverse process. If the tumor involves this area, the rib is resected from the transverse process by dividing the costo-transversus ligament, and then the costo-vertebral ligament; thus freeing the rib from the vertebral body. The intercostal bundle is identified, ligated, and divided. The 2nd rib is divided anteriorly 5 cm beyond the closest tumor margin. An additional 1 cm piece of rib is resected to facilitate exposure of the 2nd rib. The 2nd rib is divided posteriorly at the level of the transverse process. If the tumor involves this area, the rib is resected from the transverse process by dividing the costo-transversus ligament, and then the costo-vertebral ligament; thus freeing the rib from the vertebral body. The intercostal bundle is identified, ligated, and divided. The sympathetic ganglion is resected with the specimen. The 1st rib is divided anteriorly at the junction of the 1st rib with the sternum and the clavicle. Care is in dissecting tumor off the great vessels especially the Subclavian artery, the vena cava, innominate vein; as well as the phrenic nerve and the brachial plexus. The 1st rib is divided posteriorly at the level of the transverse process. If the tumor involves this area, the rib is resected from the transverse process by dividing the costo-transversus ligament, and then the costo-vertebral ligament; thus freeing the rib from the vertebral body. The T1 nerve root (just inferior to the posterior aspect of the 1st rib) is divided where it is involved with tumor. The C8 nerve root is inspected and if involved is resected en bloc. The tumor is freed from its fibrous adhesions to the brachial plexus. The en bloc resection is thus allowed to drop into the chest. The lung is retracted posteriorly and inferiorly, and as appropriate for the mediastinal pleura to be incised, carefully avoiding injury to the phrenic nerve. The lobar arterial blood supply is carefully dissected, mobilized, and encircled with ties. The upper and lower lobes are carefully separated by dissecting within the major fissure until the appropriate lobar arteries are identified. The isolated lobar arteries to the right upper lobe are ligated, suture-ligated, and then divided, carefully inspecting for bleeding from the proximal end. Specifically the major fissure is dissected to facilitate exposure and precise identification of the lobar branch to the posterior segment of the right upper lobe (posterior ascending branch of the pulmonary artery), care being taken to identify and protect the superior segmental artery to the right lower lobe, and the middle lobe artery. The lung is retracted appropriately to permit exposure of the pulmonary venous drainage returning to the heart. Two pulmonary veins are confirmed. The pulmonary vein to just the right upper lobe is carefully dissected, mobilized and encircled with ties. Specifically the venous drainage to the right middle lobe is identified, care being taken to identify and protect the venous drainage from the right middle and lower lobe. The veins (from the right upper lobe) are ligated proximally with heavy suture, its distal branches ligated, the proximal end suture-ligated, and the vein divided, carefully assessing for bleeding from the proximal end. The lobar bronchus to the right upper lobe is carefully dissected, mobilized, and encircled with a tape. Specifically, the bronchus to the right middle lobe is identified, care being taken to identify and protect this bronchus, as well as the superior segmental bronchus and the basilar bronchi to the right lower lobe. The right upper lobe bronchus is individually crossed with a surgical stapler as close as possible to its origin with the bronchus intermedius. After ascertaining that ventilation of the remaining lobe have not been compromised by clamping of the bronchus, the lobar bronchus is divided sharply and the stapler is removed. The lobe is removed from the field and submitted for frozen section confirmation of a "clear" bronchial margin of resection. The divided bronchial stump is oversewn distal to the staples suture line with interrupted sutures. The pleural cavity is filled with warm saline. The anesthetist is asked to inflate the airway with 20 cm to 40 cm of water pressure, and the bronchial stump is carefully inspected for an air leak. The saline is aspirated from the chest. Chest tubes are inserted through separate interspace incisions to provide optimal drainage of air from the apex of the chest and of fluid from the base. The chest tubes are secured to the skin with sutures. The ribs are

reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles. The extrathoracic chest wall musculature is closed in layers with running suture. Subcutaneous tissue and skin are approximated

#### Description of Post-Service Work:

##### Post-op same day work through discharge from recovery

- Sterile dressings are applied to the incisions
- The chest tubes are inspected to ensure that adequate suction and adequate water seal are in place and working
- The patient is positioned supine on the operating table
- A postoperative chest x-ray is obtained and reviewed to document chest tube placement, satisfactory expansion of the ipsilateral and contralateral lung, and position of the mediastinum
- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Review ICU care and medications with ICU staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function, neurological function of the patient and of the RIGHT upper extremity and hand, and assess status of dressings

##### Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient / family questions
- Answer nursing/other staff questions
- Examine chest x-ray obtained within 6-12 hours of operation to assess changes in the pleural space and expansion of remaining lung
- Monitor and evaluate critical care elements of pulmonary, cardiology, neurology, and hematology (including but not limited to ventilator settings, arterial blood gases, heart rate and rhythm, blood pressure, etc.)
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

##### Post-op other hospital work [beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Extubate patient as appropriate or required
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress
- Review chest radiograph
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- As appropriate, write discharge order to telemetry unit or general care ward

## Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

## Post-op office work – After discharge from hospital through 90 day global period

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Keith Naunheim, M.D.				
<b>Specialty(s):</b>	Society of Thoracic Surgeons				
<b>CPT Code:</b>	32503				
<b>Sample Size:</b>	60	<b>Resp n:</b>	30	<b>Response:</b>	50.00 %
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	24.30	26.63	30.00	34.99	44.20
<b>Pre-Service Evaluation Time:</b>			60.0		
<b>Pre-Service Positioning Time:</b>			15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			25.0		
<b>Intra-Service Time:</b>	130.00	203.00	240.00	270.00	360.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>45.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>144.0</u>	99231x 6.0	99232x 1.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>61.0</u>	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>
33405	090	34.95

CPT Descriptor Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35646	090	30.95

CPT Descriptor 1 Bypass graft, with other than vein; aortobifemoral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
32480	090	23.71

CPT Descriptor 2 Removal of lung, other than total pneumonectomy; single lobe (lobectomy)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 5      % of respondents: 16.6 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 32503	Key Reference CPT Code: 33405
Median Pre-Service Time	100.00	40.00
Median Intra-Service Time	240.00	240.00
Median Immediate Post-service Time	45.00	60.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	144.0	144.00
Median Discharge Day Management Time	36.0	45.00
Median Office Visit Time	61.0	83.00
Median Total Time	626.00	612.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.60	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	3.75
Urgency of medical decision making	3.80	4.00

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

Technical skill required	4.60	4.00
Physical effort required	5.00	3.75
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.40	4.50
Outcome depends on the skill and judgment of physician	5.00	4.50
Estimated risk of malpractice suit with poor outcome	4.20	4.00

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

Pre-Service intensity/complexity	4.60	3.75
Intra-Service intensity/complexity	5.00	4.00
Post-Service intensity/complexity	4.00	4.00

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used 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 30.00 is recommended for 325X1. This value results in an IWPUT of 0.080 which is appropriately similar to the IWPUT for 32480 and less than the IWPUT for MPC reference codes 33405 and 356. (See Attachment for table with comparison data and calculations for survey codes and reference codes cited.)

**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) 32480, 32520, 32522,32525

How often do physicians 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? 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 cardiothoracic surgery                      Frequency 900                      Percentage                      %

Specialty general surgery                                      Frequency 100                      Percentage                      %

Specialty    Frequency                                      Percentage                                      %

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

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

Specialty cardiothoracic surgery                      Frequency 750                      Percentage                      %

Specialty general surgery                                      Frequency 50                                      Percentage                                      %

Specialty    Frequency                                      Percentage                                      %

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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 31766 should be used because it has a similar work RVU at 30.38 RVUs.

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

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

CPT Code:32504 Tracking Number: EE15 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **34.80**  
RUC RVU: **34.80**

CPT Descriptor: Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 66 year-old female, overweight, heavy smoker with a 4 month history of right shoulder and/or arm pain. Apical lung biopsy confirms non-small cell lung cancer.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Write pre-operative orders for peri-operative medications
- Review pre-operative evaluation, including history and physical examination
- Review outside films, reports, and correspondence, chest x-ray; laboratory results (CBC, electrolytes, renal function); CT scans Chest, Abdomen, Other staging studies as appropriate, MRI Brain, MRI thoracic inlet including brachial plexus, PET scan, bone scan, plain films as appropriate, pathology / cytology biopsy reports, Pulmonary function tests which may include Spirometry with and without bronchodilators, DLCO, Ventilation perfusion (V/Q) scans, Oxygen consumption (MVO<sub>2</sub>), Arterial blood gas
- Review consultation reports if obtained
- Review planned incisions and procedure
- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family including potential arm / hand dysfunction from resection; resultant Horner's syndrome from resection of sympathetic ganglion, cosmetic changes (usually minor) resulting from resection of ribs 1, 2, and 3; and potential for blood transfusions
- Update history and physical examination if greater than 7 days but less than 30 days from last history and physical examination;
- Answer patient and family questions
- Obtain informed consent
- Surgeon to initial site / side of planned operation with patient
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Verify that antibiotics and prophylaxis for deep venous thrombosis / pulmonary embolus are provided (e.g. subcutaneous heparin administration, or placement of support stockings, or sequential compression devices on lower extremities).
- Monitor positioning of patient in lateral decubitus position, with axillary "roll" beneath dependent side to insure adequate intraoperative aeration of dependent lung, padding and support to prevent neuropraxia
- Verify correct placement of patient on OR table so that flexion of table results in optimal widening of interspaces of side to be operated upon
- Conduct "TIME-OUT" with operating room team to confirm CORRECT patient, CORRECT operation to be performed, CORRECT site, and CORRECT side with verbal checks from all members of operating room team: Surgical team, circulating nurse, anesthesiologist

- Scrub and gown

Description of Intra-Service Work: 325X2 Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction(s)

A high thoracotomy is performed with a planned entry into the 5th intercostal space, dividing extrathoracic muscles with electrocautery for hemostasis and resecting a 1 cm segment of the rib posteriorly to facilitate exposure and spreading of the ribs (Care is taken to avoid injury to the intercostal neurovascular bundles). The chest is explored, assessing for the presence of adhesions between the lung and the chest wall which are carefully divided before inserting the rib spreader to prevent a tear of the lung. The superior sulcus lung tumor is carefully palpated and its specific relationship to the chest wall, vertebral column, thoracic inlet, great vessels, and brachial plexus as well as its specific pulmonary vasculature and bronchial tree anatomy, and its relationship to the right middle and right lower lobe, defined to determine that a resection of this superior sulcus tumor with right upper lobectomy and chest wall of ribs 1, 2, 3 and 4, is required and is feasible. Single lung ventilation of the contralateral lung is instituted to facilitate exposure of the operative lung side, the chest wall, vasculature and bronchus. The extent of the tumor is identified from within the thorax and its anterior-ventral and posterior-caudal extent is defined. The trapezius and rhomboid muscles are divided between the posterior medial border of the scapula and the spinous processes such that the scapula can be elevated. A retractor is placed to elevate the scapula superiorly and laterally, and the 5th rib inferiorly. Exposure to the ribs of the thoracic inlet / superior sulcus is thus obtained. The 4th rib is divided anteriorly 5 cm beyond the closest tumor margin. An additional 1 cm piece of rib is resected to facilitate exposure of the 3rd rib. The 4th rib is divided posteriorly at the level of the transverse process. If the tumor involves this area, the rib is resected from the transverse process by dividing the costo-transversus ligament, and then the costo-vertebral ligament; thus freeing the rib from the vertebral body. The intercostal bundle is identified, ligated, and divided. The 3rd rib is divided anteriorly 5 cm beyond the closest tumor margin. An additional 1 cm piece of rib is resected to facilitate exposure of the 2nd rib. The 3rd rib is divided posteriorly at the level of the transverse process. If the tumor involves this area, the rib is resected from the transverse process by dividing the costo-transversus ligament, and then the costo-vertebral ligament; thus freeing the rib from the vertebral body. The intercostal bundle is identified, ligated, and divided. The 2nd rib is divided anteriorly 5 cm beyond the closest tumor margin. An additional 1 cm piece of rib is resected to facilitate exposure of the 2nd rib. The 2nd rib is divided posteriorly at the level of transverse process. If the tumor involves this area, the rib is resected from the transverse process by dividing the costo-transversus ligament, and then the costo-vertebral ligament; thus freeing the rib from the vertebral body. The intercostal bundle is identified, ligated, and divided. The sympathetic ganglion is resected with the specimen. The 1st rib is divided anteriorly at the junction of the 1st rib with the sternum and the clavicle. Care is in dissecting tumor off the great vessels especially the Subclavian artery, the vena cava, innominate vein; as well as the phrenic nerve and the brachial plexus. The 1st rib is divided posteriorly at the level of the transverse process. If the tumor involves this area, the rib is resected from the transverse process by dividing the costo-transversus ligament, and then the costo-vertebral ligament; thus freeing the rib from the vertebral body. The T1 nerve root (just inferior to the posterior aspect of the 1st rib) is divided where it is involved with tumor. The C8 nerve root is inspected and if involved is resected en bloc. The tumor is freed from its fibrous adhesions to the brachial plexus. The en bloc resection is thus allowed to drop into the chest. The lung is retracted posteriorly and inferiorly, and as appropriate for the mediastinal pleura to be incised, carefully avoiding injury to the phrenic nerve. The lobar arterial blood supply is carefully dissected, mobilized, and encircled with ties. The upper and lower lobes are carefully separated by dissecting within the major fissure until the appropriate lobar arteries are identified. The isolated lobar arteries to the right upper lobe are ligated, suture-ligated, and then divided, carefully inspecting for bleeding from the proximal end. Specifically the major fissure is dissected to facilitate exposure and precise identification of the lobar branch to the posterior segment of the right upper lobe (posterior ascending branch of the pulmonary artery), care being taken to identify and protect the superior segmental artery to the right lower lobe, and the middle lobe artery. The lung is retracted appropriately to permit exposure of the pulmonary venous drainage returning to the heart. Two pulmonary veins are confirmed. The pulmonary vein to just the right upper lobe is carefully dissected, mobilized and encircled with ties. Specifically the venous drainage to the right middle lobe is identified, care being taken to identify and protect the venous drainage from the right middle and lower lobe. The veins (from the right upper lobe) are ligated proximally with heavy suture, its distal branches ligated, the proximal end suture-ligated, and vein divided, carefully assessing for bleeding from the proximal end. The lobar bronchus to the right upper lobe is carefully dissected, mobilized, and encircled with a tape. Specifically, the bronchus to the right middle lobe is identified, care being taken to identify and protect this bronchus, as well as the superior segmental bronchus and the basilar bronchi to the right lower lobe. The right upper lobe bronchus is individually crossed with a surgical stapler as close as possible to its origin with the bronchus intermedius. After ascertaining that ventilation of the remaining lobe have not been

compromised by clamping of the bronchus, the lobar bronchus is divided sharply and the stapler is removed. The lobe is removed from the field and submitted for frozen section confirmation of a "clear" bronchial margin of resection. The divided bronchial stump is oversewn distal to the staples suture line with interrupted sutures. The pleural cavity is filled with warm saline. The anesthetist is asked to inflate the airway with 20 cm to 40 cm of water pressure, and the bronchial stump is carefully inspected for an air leak. The saline is aspirated from the chest. The musculoskeletal defect is then measured and a prolene mesh patch cut to the appropriate size. Holes are drilled in the ribs anteriorly and the 5th rib posteriorly to facilitate anchoring the patch. The patch is then sewn into the ribs anteriorly and inferiorly with interrupted 2-0 prolene sutures. The posterior aspect of the patch is fixed either to the transverse processes or the paraspinal musculature with 2-0 Prolene sutures. The apex of the patch is bordered by the subclavian vessels and brachial plexus so no fixation sutures are placed in that site. Chest tubes are inserted through separate interspace incisions to provide optimal drainage of air from the apex of the chest and of fluid from the base. The chest tubes are secured to the skin with sutures. The ribs are reapproximated with heavy pericostal sutures, carefully avoiding injury to the intercostal neurovascular bundles. The extrathoracic chest wall musculature is closed in layers with running suture. Subcutaneous tissue and skin are approximated

#### Description of Post-Service Work:

##### Post-op same day work through discharge from recovery

- Sterile dressings are applied to the incisions
- The chest tubes are inspected to ensure that adequate suction and adequate water seal are in place and working
- The patient is positioned supine on the operating table
- A postoperative chest x-ray is obtained and reviewed to document chest tube placement, satisfactory expansion of the ipsilateral and contralateral lung, and position of the mediastinum
- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Review ICU care and medications with ICU staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function, neurological function of the patient and of the RIGHT upper extremity and hand, and assess status of dressings

##### Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient / family questions
- Answer nursing/other staff questions
- Examine chest x-ray obtained within 6-12 hours of operation to assess changes in the pleural space and expansion of remaining lung
- Monitor and evaluate critical care elements of pulmonary, cardiology, neurology, and hematology (including but not limited to ventilator settings, arterial blood gases, heart rate and rhythm, blood pressure, etc.)
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

##### Post-op other hospital work [beginning on post-op day 1 until discharge day:

- Examine and talk with patient
- Extubate patient as appropriate or required
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress

- Review chest radiograph
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- As appropriate, write discharge order to telemetry unit or general care ward

## Discharge day work:

- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

## Post-op office work – After discharge from hospital through 90 day global period

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Keith Naunheim, M.D.				
<b>Specialty(s):</b>	Society of Thoracic Surgeons				
<b>CPT Code:</b>	32504				
<b>Sample Size:</b>	60	<b>Resp n:</b>	30	<b>Response:</b> 50.00 %	
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	24.80	27.89	31.00	36.00	46.00
<b>Pre-Service Evaluation Time:</b>			60.0		
<b>Pre-Service Positioning Time:</b>			15.0		

Pre-Service Scrub, Dress, Wait Time:				25.0		
Intra-Service Time:		180.00	233.00	300.00	330.00	405.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>45.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>144.0</u>	99231x 6.0	99232x 1.0	99233x 0.0		
Discharge Day Mgmt:	<u>36.0</u>	99238x 1.00	99239x 0.00			
Office time/visit(s):	<u>61.0</u>	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>
33405	090	34.95

CPT Descriptor Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35646	090	30.95

CPT Descriptor 1 Bypass graft, with other than vein; aortobifemoral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
32480	090	23.71

CPT Descriptor 2 Removal of lung, other than total pneumonectomy; single lobe (lobectomy)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 7      % of respondents: 23.3 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 32504</u>	<u>Key Reference CPT Code: 33405</u>
Median Pre-Service Time	100.00	40.00
Median Intra-Service Time	300.00	240.00
Median Immediate Post-service Time	45.00	60.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	144.0	144.00
Median Discharge Day Management Time	36.0	45.00
Median Office Visit Time	61.0	83.00
Median Total Time	686.00	612.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.43	3.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.43	3.71
Urgency of medical decision making	3.86	3.71

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

Technical skill required	4.57	4.00
Physical effort required	4.71	3.29
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.50	4.67
Outcome depends on the skill and judgment of physician	4.83	4.67
Estimated risk of malpractice suit with poor outcome	4.20	4.00

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

Pre-Service intensity/complexity	4.14	3.29
Intra-Service intensity/complexity	4.57	3.43
Post-Service intensity/complexity	3.57	4.14

**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 consensus committee reviewing the survey data for 325X2 believe that the survey respondents underestimated the value for the incremental work of reconstruction because the median RVW of 31.00 is only 1.00 RVU greater than 325X1. The surveyed difference in total work between the 352X1 and 352X2 is 60 minutes additional intraoperative time for chest wall reconstruction, and we do not believe that 1.00 RVU correctly accounts for this difference.

Using the IWPUT of 0.080 for 325X1, we calculated an RVW of 34.80 for 325X2. This RVW provides an additional 4.80 RVUs for the one hour of additional work for chest wall reconstruction. The IWPUT of 0.080 is the same as the IWPUT for 352X1, appropriately similar to the IWPUT for 32480, and less than the IWPUT for MPC reference codes 33405 and 35646. (See Attachment for table with comparison data and calculations for survey codes and reference codes cited.) Additionally, we believe this is a conservative estimate of the reconstructive work. If reconstruction were to be reported separately using 15734 (muscle flap), 50% of 17.76 or 8.88 RVUs would represent the additional 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) 32480, 32520, 32522,32525

How often do physicians 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? 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 cardiothoracic surgery	Frequency 900	Percentage	%
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Specialty general surgery	Frequency 100	Percentage	%
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Specialty	Frequency	Percentage	%
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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 cardiothoracic surgery	Frequency 750	Percentage	%
Specialty general surgery	Frequency 50	Percentage	%
Specialty	Frequency	Percentage	%

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

### Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. Code 31766 Carinal reconstruction (work RVU=30.38) should be used as the crsswolk rather than the reference service as it has a similar work RVU

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

**Attachment to Summary Recommendation for 32503 and 32504**

	CPT	Descriptor	IWP/UT	RVW	Total Time	Minutes			Hospital Visits (992-)						Office Visits (99-)				
						Pre	Intra	Imm-post	91	33	32	31	38	39	15	14	13	12	11
EEE14	32503	Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction	0.080	30.00	626	100	240	45			1	6	1				2	1	
Ref (MPC)	33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	0.099	34.95	612	40	240	60			1	6		1		1	1	1	1
Ref (MPC)	32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	0.084	23.71	552	90	155	30	1	1	1	3	1				1	2	
Ref (MPC)	35646	Bypass graft, with other than vein; aortobifemoral	0.092	30.95	602	100	210	30		1	2	3	1			1		2	

EEE15	32504	Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction	0.067	31.00	686	100	300	45			1	6	1				2	1	
		<i>IF IWP/UT same as 325x1</i>	0.080	34.80	686	100	300	45			1	6	1				2	1	
Ref (MPC)	33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	0.099	34.95	567	40	240	60			1	6		1		1	1	1	1
Ref (MPC)	32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	0.084	23.71	552	90	155	30	1	1	1	3	1				1	2	
Ref (MPC)	35646	Bypass graft, with other than vein; aortobifemoral	0.092	30.95	602	100	210	30		1	2	3	1			1		2	

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

CPT	DESCRIPTION	GLOBAL
32503 EEE14	Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction	090
32504 E EEE15	Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction	090

**CLINICAL STAFF TIME: RN staff**

**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 12 minutes (as supported by the PEAC) relative to coding of 99238 for discharge management for inpatient services has been applied.

**Post-service period clinical staff time:** Standard EM postop OFFICE visit times for clinical staff have been applied as appropriate.

**SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:**

Standard PEAC minimum multispecialty office visit supplies and incision care have been applied.

	A	B	C	D	E	F	G
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		32503		32504	
2				EE1		EE2	
3				Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction		Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction	
4				090		090	
5				Code	StaffType	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L051A	RN	N/A	171	N/A	171
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN		60		60
8	TOTAL INTRA CLINICAL LABOR TIME	L051A	RN		12		12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN		99		99
10	<b>PRE-SERVICE</b>						
11	<i>Start: After visit for procedure/service</i>						
12	Complete pre-service diagnostic & referral forms	L051A	RN		5		5
13	Coordinate pre-surgery services	L051A	RN		20		20
14	Schedule space and equipment in facility	L051A	RN		8		8
15	Provide pre-service education/obtain consent	L051A	RN		20		20
16	Follow-up phone calls & prescriptions	L051A	RN		7		7
18	<i>End: Pt. enters site for procedure/service</i>						
19	<b>SERVICE PERIOD</b>						
40	Discharge day management 99238 –12 minutes	L051A	RN		12		12
41	Other Clinical Activity (please specify)						
42	<i>End: Patient leaves site of procedure/service</i>						
43	<b>POST-SERVICE Period</b>						
44	<i>End: Patient leaves site of procedure/service</i>						
45	Conduct phone calls/call in prescriptions						
46	<i>List Number and Level of Office Visits</i>						
47	99211 16 minutes						
48	99212 27 minutes	L051A	RN		1		1
49	99213 36 minutes	L051A	RN		2		2
50	99214 53 minutes	L051A					
51	99215 63 minutes	L051A					
52	<b>Total Office Visit Time</b>	L051A	RN		99		99
53	Other:						
54	<i>End: Last office visit in global period</i>						
55	<b>MEDICAL SUPPLIES</b>	Code	Unit				
56	pack, minimum multi-specialty visit	SA048	pack		3		3
57	pack, post-op incision care (suture & staple)	SA053	pack		1		1
58							
59	<b>Equipment</b>	Code					
60	table, power	EF031			99		99
61	light, exam	EQ168			99		99

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Incision and Drainage Spinal Deep Abscess**

The CPT Editorial Panel created two new codes to describe incision and drainage of deep spinal abscesses, which were inadvertently deleted when spine codes were revised.

The RUC reviewed the survey data for 22010 *Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic* and 22015 *Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral* and determined that codes 22010 and 22015 involved more pre-, intra- and post- service time, as well as a higher intensity of mental effort, technical skill and psychological stress than the reference code 26990 *Incision and drainage, pelvis or hip joint area; deep abscess or hematoma* (work RVU=7.47). However, the RUC observed that the median survey data on the pre-service evaluation time appeared high. The RUC reduced the pre-service evaluation time for 22010 and 22015 from 45 minutes to 30 minutes. **The RUC recommends a work RVU of 11.05 for 22010 and 10.94 for 22015.**

Code	Pre-Service Eval	Pre-Service Positioning	Pre-Service Scrub, Dress, Wait	Intra-Service	Post-Service	Work RVU
22010	30	20	15	60	30	11.05
22015	30	15	15	60	30	10.94

Practice Expense

The RUC assessed and approved the standard 090-day global facility only practice expense inputs for 22010 and 22015.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
21501		<i>Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax;</i>  (For posterior spine subfascial incision and drainage, see 22010-22015)	090	3.80  (No Change)
• 22010	HH1	Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic	090	11.05
• 22015	HH2	lumbar, sacral, or lumbosacral  (Do not report 22015 in conjunction with 22010)  (Do not report in conjunction with instrumentation removal, 10180, 22850, 22852)  (For incision and drainage of abscess or hematoma, superficial, see 10060, 10140)	090	10.94

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

**Recommended Work Relative Value**Specialty Society RVU: **11.05**RUC RVU: **11.05**

CPT Code:22010 Tracking Number: HH1 Global Period: 090

CPT Descriptor: Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 47-year-old man underwent C3-C7 posterior spinal fusion. Two months post operatively, he presents febrile with erythema and drainage of the neck wound and neck pain. He undergoes incision and drainage of deep abscess of the cervical spine.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

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 new history and physical exam is performed with specific attention to signs and symptoms of sepsis. New laboratory and imaging studies of the spine are obtained and reviewed. The medical record is updated to ensure that the patient is stable for the planned surgical procedure. Consultation is sought from medical and infections disease specialists. Radiographic findings are correlated with the clinical exam and the surgical plan is confirmed. The surgeon confers with the patient and family; explaining the current condition and the need for surgical intervention. Questions are answered, consent obtained, the surgical site is marked, and a note written in the record. He confers with the anesthesiologist and the operating room staff to review positioning, the intraoperative plan and equipment needs. After the patient is anesthetized and monitoring lines are placed, a Mayfield head rest, if used, is attached and the patient is positioned. Positioning is inspected to verify the absence of pressure on vital structures and the surgical site is prepped and draped into a sterile field.

Description of Intra-Service Work: A posterior approach to the spine is performed using the prior midline incision which may require extension. The deep fascia is incised. Cultures are obtained. The midline wound is widely opened, irrigated, and débrided. Hematoma, necrotic tissue and/or purulent collections are carefully débrided and the entire field irrigated using copious amounts of fluid. Hemostasis is obtained and the wound is closed over drains, packed open or closed over a wound vacuum device. A sterile dressing is applied.

Description of Post-Service Work: The patient is rolled onto a recovery bed, awakened and a neurologic exam performed and documented. The surgeon calls the family and describes the findings at operation and answers their questions. Orders are written and a note is dictated. During the postoperative hospitalization, the patient is examined for neurologic function. The dressing is inspected and changed as needed. Postoperative X-rays are obtained to check alignment of the spine. Daily visits are made while on the hospital floor and notes are written documenting the in-hospital progress. Drains are removed. Intra operative cultures are checked and antibiotics if used are adjusted in consultation with infections disease specialists. Activity parameters are modified to advance the patient's ambulation and mobility. The patients diet is advanced as tolerated. Questions from the physiotherapy staff are answered. Discharge instructions are reviewed and follow-up care coordinated with rehabilitation center or visiting nurse services.

After discharge, the patient returns to the office for suture removal close monitoring of the wound. Questions regarding physiotherapy and activity levels are answered. Phone calls are answered concerning pain levels and activity restrictions. Subsequent follow-up office visits are scheduled to review activity levels and physiotherapy. X-rays of the spine are ordered and reviewed showing the alignment of the spine. Prescription medication refills are reviewed and

written. Laboratory studies monitoring response to antibiotics and signs of drug related toxicity are obtained and reviewed. An exercise program is recommended and printed material regarding therapy is provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>		Dale Blasier, MD, American Academy of Orthopaedic Surgeons Charles Mick, MD, North American Spine Society			
<b>Specialty(s):</b>		American Academy of Orthopaedic Surgeons American Association of Neurological Surgeons North American Spine Society			
<b>CPT Code:</b>		22010			
<b>Sample Size:</b>	500	<b>Resp n:</b>	99	<b>Response:</b> 19.80 %	
<b>Sample Type:</b>		Random			
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		4.00	7.47	10.00	12.00
<b>Pre-Service Evaluation Time:</b>				30.0	
<b>Pre-Service Positioning Time:</b>				20.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15.0	
<b>Intra-Service Time:</b>		30.00	45.00	60.00	90.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>		
<b>Immed. Post-time:</b>		<u>30.00</u>			
<b>Critical Care time/visit(s):</b>		<u>0.0</u>	99291x 0.0	99292x 0.0	
<b>Other Hospital time/visit(s):</b>		<u>87.0</u>	99231x 3.0	99232x 1.0	99233x 0.0
<b>Discharge Day Mgmt:</b>		<u>36.0</u>	99238x 1.00	99239x 0.00	
<b>Office time/visit(s):</b>		<u>84.0</u>	99211x 0.0	12x 1.0	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>
6990	090	7.47

CPT Descriptor Incision and drainage, pelvis or hip joint area; deep abscess or hematoma

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
63030	090	11.98

CPT Descriptor 1 Laminotomy (hemilaminectomy), with decompression of nerve root(s),-including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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PT Descriptor

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

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

**Number of respondents who choose Key Reference Code: 39      % of respondents: 39.3 %**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 22010</u>	<u>Key Reference CPT Code: 26990</u>
Median Pre-Service Time	65.00	46.00
Median Intra-Service Time	60.00	55.00
Median Immediate Post-service Time	30.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	87.0	36.00
Median Discharge Day Management Time	36.0	0.00
Median Office Visit Time	84.0	43.00
<b>Median Total Time</b>	<b>362.00</b>	<b>200.00</b>
<u>her time if appropriate</u>		

**INTENSITY/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	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.39	3.30
Urgency of medical decision making	4.29	4.16

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

Technical skill required	3.33	3.21
Physical effort required	3.15	3.12
<b>Psychological Stress (Mean)</b>		
The risk of significant complications, morbidity and/or mortality	4.06	3.85
Outcome depends on the skill and judgment of physician	3.88	3.88
Estimated risk of malpractice suit with poor outcome	4.48	4.24

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

Pre-Service intensity/complexity	3.73	3.61
Intra-Service intensity/complexity	3.33	3.30
Post-Service intensity/complexity	3.21	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 RATIONALE FOR 22010



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? 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 Recommendations**

**Additional Rationale for 22010**

A multispecialty expert panel reviewed the RUC survey data for 22010. The expert panel believed the pre, intra-, and post-operative times were appropriate. The expert panel also believed the hospital and office visit patterns were reasonable for 22010. However, the expert panel believed survey respondents failed to adequately capture all of the intra-service work for this procedure. Using median RVW and time values, 22010 has an IWPUT of 0.019 and an intra-service RVW of 1.11. The expert panel believed both of these values were too low for 22010.

	Svy Data	Svy RUC Std.	Svy RVW: <span style="border: 1px solid black; padding: 2px;">10.00</span>
<hr/>			
	<b>Time</b>	<b>Intensity</b>	<b>RVW (=time x intensity)</b>
<b><u>Pre-service:</u></b>			
Pre-service eval & positioning	65	0.0224	1.46
Pre-service scrub, dress, wait	15	0.0081	0.12
<b>Pre-service total</b>			<b>1.58</b>
<hr/>			
	<b>Time</b>	<b>Intensity</b>	<b>(=time x intensity)</b>
<b><u>Post-service:</u></b>			
Immediate post	30	0.0224	0.67
Subsequent visits:	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
ICU 99291		4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233		1.51	0.00
99232	1	1.06	1.06
99231	3	0.64	1.92
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214		1.08	0.00
99213	3	0.65	1.95
99212	1	0.43	0.43
99211		0.17	0.00
<b>Post-service total</b>			<b>7.31</b>
<hr/>			
	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
<b><u>Intra-service:</u></b>	60	<span style="border: 1px solid black; padding: 2px;">0.019</span>	1.11

The expert panel believed the two reference codes most commonly selected by survey respondents, 26990 (Incision and drainage, pelvis or hip joint area; deep abscess or hematoma, IWPUT = 0.036) and 63030 (Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach, IWPUT = 0.057), represented a range of intra-operative intensity that is more appropriate for 22010.

The expert panel used the lower intensity value of 26990 (IWPUT = 0.036) to calculate a RVW for 22010. This calculation is shown below.

		Calculated	RVW
		RVW:	11.05
	Svy Data	RUC Std.	RVW
			(=time x intensity)
<b><u>Pre-service:</u></b>	<b>Time</b>	<b>Intensity</b>	
Pre-service eval & positioning	65	0.0224	1.46
Pre-service scrub, dress, wait	15	0.0081	0.12
<b>Pre-service total</b>			<b>1.58</b>
			(=time x intensity)
<b><u>Post-service:</u></b>	<b>Time</b>	<b>Intensity</b>	
Immediate post	30	0.0224	0.67
Subsequent visits:	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
ICU 99291		4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233		1.51	0.00
99232	1	1.06	1.06
99231	3	0.64	1.92
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214		1.08	0.00
99213	3	0.65	1.95
99212	1	0.43	0.43
99211		0.17	0.00
<b>Post-service total</b>			<b>7.31</b>
		<b>Time</b>	<b>IWPUT</b>
<b><u>Intra-service:</u></b>	60	<b>0.036</b>	2.16

The expert panel recommends 11.05 RVW for 22010. This recommendation is based on median time and visit data from the RUC survey results and an intensity value from a comparable incision and drainage code, 26990.

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

CPT Code:22015 Tracking Number: HH2 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **10.94**  
RUC RVU: **10.94**

CPT Descriptor: Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 51-year-old woman underwent L4-S1 posterior spinal fusion. Seven weeks post operatively, she presents febrile with erythema and drainage of the back wound and back pain. She undergoes incision and drainage of deep abscess of the lumbar spine.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: A new history and physical exam is performed with specific attention to signs and symptoms of sepsis. New laboratory and imaging studies of the spine are obtained and reviewed. The medical record is updated to ensure that the patient is stable for the planned surgical procedure. Consultation is sought from medical and infections disease specialists. Radiographic findings are correlated with the clinical exam and the surgical plan is confirmed. The surgeon confers with the patient and family; explaining the current condition and the need for surgical intervention. Questions are answered, consent obtained, the surgical site is marked, and a note written in the record. He confers with the anesthesiologist and the operating room staff to review positioning, the intraoperative plan and equipment needs. After the patient is anesthetized and monitoring lines are placed, the patient is positioned. Positioning is inspected to verify the absence of pressure on vital structures and the surgical site is prepped and draped into a sterile field.

Description of Intra-Service Work: A posterior approach to the spine is performed using the prior midline incision which may require extension. The deep fascia is incised. Cultures are obtained. The midline wound is widely opened, irrigated, and débrided. Hematoma, necrotic tissue and/or purulent collections are carefully débrided and the entire field irrigated using copious amounts of fluid. Hemostasis is obtained and the wound is closed over drains, packed open or closed over a wound vacuum device. A sterile dressing is applied.

Description of Post-Service Work: The patient is rolled onto a recovery bed, awakened and a neurologic exam performed and documented. The surgeon calls the family and describes the findings at operation and answers their questions. Orders are written and a note is dictated. During the postoperative hospitalization, the patient is examined for neurologic function. The dressing is inspected and changed as needed. Postoperative X-rays are obtained to check alignment of the spine. Daily visits are made while on the hospital floor and notes are written documenting the in-hospital progress. Drains are removed. Intra operative cultures are checked and antibiotics if used are adjusted in consultation with infections disease specialists. Activity parameters are modified to advance the patient's ambulation and mobility. The patients diet is advanced as tolerated. Questions from the physiotherapy staff are answered. Discharge instructions are reviewed and follow-up care coordinated with rehabilitation center or visiting nurse services.

After discharge, the patient returns to the office for suture removal close monitoring of the wound. Questions regarding physiotherapy and activity levels are answered. Phone calls are answered concerning pain levels and activity restrictions. Subsequent follow-up office visits are scheduled to review activity levels and physiotherapy. X-rays of the spine are ordered and reviewed showing the alignment of the spine. Prescription medication refills are reviewed and written. Laboratory studies monitoring response to antibiotics and signs of drug related toxicity are obtained and reviewed. An exercise program is recommended and printed material regarding therapy is provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Dale Blasier, MD, American Academy of Orthopaedic Surgeons Charles Mick, MD, North American Spine Society					
<b>Specialty(s):</b>	American Academy of Orthopaedic Surgeons American Association of Neurological Surgeons North American Spine Society					
<b>CPT Code:</b>	22015					
<b>Sample Size:</b>	500	<b>Resp n:</b>	99	<b>Response:</b> 19.80 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>		3.80	7.47	9.00	12.00	25.00
<b>Pre-Service Evaluation Time:</b>				30.0		
<b>Pre-Service Positioning Time:</b>				15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15.0		
<b>Intra-Service Time:</b>		30.00	45.00	60.00	90.00	220.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b>30.00</b>					
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b>87.0</b>	99231x 3.0	99232x 1.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b>36.0</b>	99238x 1.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b>84.0</b>	99211x 0.0	12x 1.0	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>
5990	090	7.47

CPT Descriptor Incision and drainage, pelvis or hip joint area; deep abscess or hematoma

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
63030	090	11.98

CPT Descriptor 1 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<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: 40      % of respondents: 40.4 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 22015	Key Reference CPT Code: 26990
Median Pre-Service Time	60.00	46.00
Median Intra-Service Time	60.00	55.00
Median Immediate Post-service Time	30.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	87.0	36.00
Median Discharge Day Management Time	36.0	0.00
Median Office Visit Time	84.0	43.00
Median Total Time	357.00	200.00
ther time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.26	3.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.41	3.32
Urgency of medical decision making	4.27	4.15

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

Technical skill required	3.21	3.15
Physical effort required	3.24	3.24
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.00	3.79
Outcome depends on the skill and judgment of physician	3.82	3.82
Estimated risk of malpractice suit with poor outcome	4.47	4.26

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

Pre-Service intensity/complexity	3.73	3.64
Intra-Service intensity/complexity	3.27	3.21
Post-Service intensity/complexity	3.18	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.*

SEE ATTACHED RATIONALE FOR 22015.



Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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- Do many physicians perform this service across the United States?

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

**AMA Specialty Society RVS Update Process  
Summary of Recommendations**

**Additional Rationale for 22015**

A multispecialty expert panel reviewed the RUC survey data for 22015. The expert panel believed the pre-, intra-, and post-operative times were appropriate. The expert panel also believed the hospital and office visit patterns were reasonable for 22015. However, the expert panel believed survey respondents failed to adequately capture all of the intra-service work for this procedure. Using median RVW and time values, 22015 has an IWPUT of 0.004 and an intra-service RVW of 0.22. The expert panel believed both of these values were too low for 22015.

	Svy Data	Survey RUC Std.	RVW
		Survey RVW:	<b>9.00</b>
		RUC Std.	RVW
<b><u>Pre-service:</u></b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x intensity)</b>
Pre-service eval & positioning	60	0.0224	1.34
Pre-service scrub, dress, wait	15	0.0081	0.12
<b>Pre-service total</b>			<b>1.47</b>
<b><u>Post-service:</u></b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x intensity)</b>
Immediate post	30	0.0224	0.67
Subsequent visits:	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
ICU 99291		4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233		1.51	0.00
99232	1	1.06	1.06
99231	3	0.64	1.92
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214		1.08	0.00
99213	3	0.65	1.95
99212	1	0.43	0.43
99211		0.17	0.00
<b>Post-service total</b>			<b>7.31</b>
<b><u>Intra-service:</u></b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
	60	<b>0.004</b>	0.22

The expert panel believed the two reference codes most commonly selected by survey respondents, 26990 (Incision and drainage, pelvis or hip joint area; deep abscess or hematoma, IWPUT = 0.036) and 63030 (Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach, IWPUT = 0.057), represented a range of intra-operative intensity that is more appropriate for 22015.

The expert panel used the lower intensity value of 26990 (IWPUT = 0.036) to calculate a RVW for 22015. This calculation is shown below.

		Calculated	RVW
		RVW:	10.94
Svy Data	RUC Std.	RVW	
			(=time x intensity)
<b><u>Pre-service:</u></b>	<b>Time</b>	<b>Intensity</b>	
Pre-service eval & positioning	60	0.0224	1.34
Pre-service scrub, dress, wait	15	0.0081	0.12
<b>Pre-service total</b>			<b>1.47</b>
			(=time x intensity)
<b><u>Post-service:</u></b>	<b>Time</b>	<b>Intensity</b>	
Immediate post	30	0.0224	0.67
Subsequent visits:	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
ICU 99291		4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233		1.51	0.00
99232	1	1.06	1.06
99231	3	0.64	1.92
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214		1.08	0.00
99213	3	0.65	1.95
99212	1	0.43	0.43
99211		0.17	0.00
<b>Post-service total</b>			<b>7.31</b>
<b><u>Intra-service:</u></b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
	60	0.036	2.16

The expert panel recommends 10.94 RVW for 22015. This recommendation is based on median time and visit data from the RUC survey and an intensity value from a comparable incision and drainage code, 26990.

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

CPT	DESCRIPTION	GLOBAL
22010	Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic	090
22015	Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral	090

**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 12 minutes (as supported by the PEAC) relative to coding of 99238 for discharge management for inpatient services has been applied.

**Post-service period clinical staff time:** Standard EM postop OFFICE visit times for clinical staff have been applied as appropriate.

**SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:**

Standard PEAC minimum multispecialty office visit supplies and incision care have been applied.

	A	B	C	D	E	F	G		
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		22010		22015			
2				HH1		HH2			
3				Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic		Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral			
4						090		090	
5				Code	StaffType	NF	FAC	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	207	N/A	207		
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60		60		
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12		12		
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		135		135		
10	PRE-SERVICE								
11	<i>Start: After visit for procedure/service</i>								
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		
18	<i>End: Pt. enters site for procedure/service</i>								
19	SERVICE PERIOD								
40	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		12		12		
42	<i>End: Patient leaves site of procedure/service</i>								
43	POST-SERVICE Period								
44	<i>End: Patient leaves site of procedure/service</i>								
46	List Number and Level of Office Visits								
47	99211 16 minutes	L037D	RN/LPN/MTA						
48	99212 27 minutes	L037D	RN/LPN/MTA		1		1		
49	99213 36 minutes	L037D	RN/LPN/MTA		3		3		
50	99214 53 minutes	L037D	RN/LPN/MTA						
51	99215 63 minutes	L037D	RN/LPN/MTA						
52	Total Office Visit Time			0	135	0	135		
53	Other:								
54	<i>End: Last office visit in global period</i>								
55	MEDICAL SUPPLIES	Code	Unit						
56	pack, minimum multi-specialty visit	SA048	pack		4		4		
57	pack, post-op incision care (suture & staple)	SA053	pack		1		1		
58									
59	Equipment	Code							
60	table, power	EF031			135		135		
61	light, exam	EQ168			135		135		

**From:** "Sung, Daniel" <sung@aaos.org>  
**To:** <roseanne\_eagle@ama-assn.org>  
**Date:** 5/26/2005 12:28:53 PM  
**Subject:** Kyphoplasty Utilization Estimates

Hi Roseanne. Using the RUC data for percutaneous vertebroplasty and the estimates from the CPT coding proposal, below are annual frequency estimates for kyphoplasty:

2252X1 -- National: 14,000, Medicare: 5600  
2252X2 -- National: 14,000, Medicare: 5600  
2252X3 -- National: 7000, Medicare 1400

This means that the total annual frequency estimate for kyphoplasty is approximately 35,000 times a year nationally, and 12,600 times a year for Medicare.

Daniel H. Sung, JD  
American Academy of Orthopaedic Surgeons  
Department of Socioeconomic & State Society Affairs  
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AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Vertebral Augmentation – Kyphoplasty**

The CPT Editorial Panel created three new codes to accurately report distinct, multi-step, open or percutaneous, fluoroscopic guided, fracture reduction, cavity creation, vertebral augmentation/stabilization surgical procedures which treat progressive osteopathic and osteolytic vertebral compression fractures.

**22523**

The RUC discussed 22523 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic*. After reviewing the survey data, the RUC felt that a reduction in the specialty societies' recommended pre-service time: 53 minutes evaluation time, 18 minutes positioning time, and 15 minutes scrub, dress and wait time was necessary to accurately reflect the physician pre-service time. The specialty societies responded by proposing reduced pre-service times: 30 minutes evaluation time, 15 minutes positioning time, and 15 minutes scrub, dress and wait time. They also stated that although they were comfortable modifying the pre-service times, they would like to maintain their original specialty societies' recommendation of 8.94 RVUs. The specialty societies reiterated that the value of 8.94 RVUs reflected their consensus panel's recommendation to remove the work associated with the 99232 hospital visit from the 25<sup>th</sup> percentile of their survey results. The specialty societies felt this value is appropriate as compared to the reference service code, 22520 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic* (Work RVU=8.89) as the surveyed code and the reference code had similar total service times (197 minutes and 199 minutes, respectively) and the surveyed code was deemed slightly more intense and required greater technical skill and effort than the reference code. **The RUC agreed with the specialty societies' amended pre-service times and work RVU and recommends 8.94 RVUs for 22523.**

**22524**

The RUC discussed 22524 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar*. The RUC reviewed the specialty societies' survey data. The survey data demonstrates that the reference code 22520 *Percutaneous*

*vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar (Work RVU=8.33) has lower intensity/complexity measures when compared to the surveyed code. In addition, the specialty society recommended that the approved pre-service times of 22524 be revised to mirror the recommended pre-service times of 22523 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic (30 minutes evaluation time, 15 minutes positioning time, and 15 minutes scrub, dress and wait time). However, because the specialty society felt that the median and 25<sup>th</sup> percentile RVW survey results were not accurate, the specialty societies recommended using an IWPUT analysis to derive the work associated with this procedure. The specialty societies recommended a value of 8.54 RVUs for 22524 as this RVU recommendation is based on an IWPUT intensity value that is slightly lower than 22523 (0.094 and 0.092, respectively) and therefore preserves the rank-order structure between 22523 and 22524. The RUC agreed with the specialty societies' recommendation. **The RUC recommends the specialty societies' amended pre-service times and work value of 8.54 work RVUs for 22524.***

#### **22525**

The RUC discussed 22525 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body*. The specialty societies explained their recommendation by stating that the 10 minutes of pre-service time and the 5 minutes of immediate post-service time has been deleted (as well as the associated work RVUs from the 25<sup>th</sup> percentile of their survey results) as this is an add-on code and it was felt by the specialty societies' consensus panel that the inclusion of this time was survey respondent error. Also, the specialty societies recommended value of 4.47 work RVUs for the surveyed code when compared with the reference service code 22522 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (Work RVU=4.30)* is appropriately placed as the surveyed and reference code have similar times (40 and 50 minutes respectively) and that the surveyed code was deemed more intense and required greater technical skill and effort than the reference code. **The RUC agreed with the specialty societies' amended pre-/post-service times and work RVU and recommends 4.47 work RVUs.**

The RUC noted that the reference codes, selected as a comparison to value these new procedures, have been identified to be reviewed in the Five Year Review process. Therefore, the RUC may need to re-evaluate the work associated with these new procedures if the work associated with the percutaneous vertebroplasty codes changes.

**Practice Expense:**

The RUC approved the practice expense inputs as recommended by the specialty societies with one modification. When 22523 and 22524 are performed in the facility setting, the discharge day management service 99238 should be reduced from 12 minutes to 6 minutes to reflect that 99238 is performed on the same day. **The RUC approved this reduction in the practice expense inputs.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 22523	M1	Percutaneous vertebral augmentation, including cavity creation (fracture reduction included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic	010	8.94
● 22524	M2	lumbar	010	8.54
+ ● 22525	M3	each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)  (Do not report with 20225 when performed at the same level as 22523-22525)  (Use 22525 in conjunction with codes 22523, 22524, as appropriate)  (For radiological supervision and interpretation, see 76012, 76013)	ZZZ	4.47

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
22520		<i>Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic</i>	010	8.90 (No Change)
22521		<i>lumbar</i>	010	8.33 (No Change)
+22522		<i>each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)</i>  <i>(Use 22522 in conjunction with 22520, 22521 as appropriate)</i>  <u>(For vertebral augmentation including cavity creation using mechanical device, see 22523-22525)</u>  <i>(For radiological supervision and interpretation, see 76012, 76013)</i>	ZZZ	4.30 (No Change)
▲76012		Radiological supervision and interpretation, percutaneous vertebroplasty <u>or vertebral augmentation including cavity creation</u> , per vertebral body; under fluoroscopic guidance	XXX	1.31 for PC (No Change)
▲76013		under CT guidance  (For procedure, see 22520-22522, 22523-22525)	XXX	1.38 for PC (No Change)

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

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CPT Code:22523 Tracking Number: M1 Global Period: 010

**Recommended Work Relative Value**

Specialty Society RVU: **8.94**

RUC RVU: **8.94**

CPT Descriptor: Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 75-year-old woman presents with severe, persistent back pain and progressive spinal deformity, secondary to osteoporotic vertebral collapse. Radiographic imaging including MRI confirms the recent compression fracture at T10. A bone biopsy and percutaneous vertebral augmentation with fracture reduction using a mechanical device to create a cavity is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

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: The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The radiographic studies are reviewed. Radiographic findings are correlated with the clinical exam and the surgical plan is confirmed. The surgeon confers with the patient and family; explaining the current condition and the need for surgical intervention. Questions are answered, consent obtained and a note written in the record. The physician confers with the anesthesiologist to review patient positioning and the intraoperative plan and the operating room staff to confirm the patient, equipment needs, the surgical site and procedure. After administration of anesthesia, monitoring lines are placed as necessary (separately reported). The patient is positioned on a radiolucent table in the prone position and the surgical site is prepped and draped into a sterile field.

Description of Intra-Service Work: A small skin incision is made at the appropriate position based on fluoroscopic visualization of the pertinent anatomy. Using AP and lateral plane fluoroscopy (separately reported), the following (in contrast to just using a small bone biopsy needle to inject bone cement into a vertebral body) are sequentially placed: a needle, guidewire, 4.2 mm cannula (working channel), drill and then mechanical cavity creation device is placed via either a transpedicular or extrapedicular approach into the compressed vertebral body. The entire process is repeated on the contralateral side – hence this is a bilateral procedure. The mechanical cavity creation fracture reduction device is gradually deployed to create a cavity. The device is then removed leaving behind the formed cavity. Bone cement is mixed and allowed 18-25 minutes for the mixed cement to have a consistency appropriate for injection. The cavities are filled with the bone substitute. Final intraoperative imaging is obtained to confirm alignment and fill. The working cannulae are removed and the incisions are closed with a single stitch. Sterile dressings are applied.

Description of Post-Service Work: Anesthesia is completed and the patient is taken to the recovery room. The surgeon checks the neurological status of the patient in the PACU. Postoperative orders are written and a note is dictated in the medical record. The family is visited in the waiting and the procedure and patient's condition are discussed. The patient stays overnight in the hospital. The following morning, the patient is evaluated and the wounds checked. The vital signs are reviewed. Discharge planning, prescriptions, activity parameters and instructions are provided.

After discharge, the patient returns to the office for suture removal, neurological examination and wound check. Questions regarding physiotherapy and activity levels are answered. Phone calls are answered. Subsequent follow-up office visits are scheduled to review activity levels and physiotherapy. X-rays of the spine are ordered and reviewed. Prescription medication refills are reviewed and written. An exercise program is recommended and printed material regarding therapy is provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>		Dale Blasier, MD, American Academy of Orthopaedic Surgeons John Wilson, MD, American Association of Neurological Surgeons				
<b>Specialty(s):</b>		American Academy of Orthopaedic Surgeons American Academy of Pain Medicine American Association of Neurological Surgeons American College of Radiology American Society of Anesthesiologists American Society of Neuroradiology Congress of Neurological Surgeons North American Spine Society Society of Interventional Radiology				
<b>CPT Code:</b>		22523				
<b>Sample Size:</b>	350	<b>Resp n:</b>	112	<b>Response:</b> 32.00 %		
<b>Sample Type:</b>		Random				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>		4.50	10.00	13.00	16.00	25.00
<b>Pre-Service Evaluation Time:</b>				30.0		
<b>Pre-Service Positioning Time:</b>				15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15.0		
<b>Intra-Service Time:</b>		20.00	40.00	58.00	60.00	180.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>		<b>20.00</b>				
<b>Critical Care time/visit(s):</b>		<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>		<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>		<b>36.0</b>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>		<b>23.0</b>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
520	010	8.89

CPT Descriptor Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

**Number of respondents who choose Key Reference Code: 66      % of respondents: 58.9 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 22523</b>	<b>Key Reference CPT Code: 22520</b>
Median Pre-Service Time	60.00	30.00
Median Intra-Service Time	58.00	80.00
Median Immediate Post-service Time	20.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	23.0	23.00
<b>Median Total Time</b>	<b>197.00</b>	<b>199.00</b>
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.04	2.91
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.15	3.00
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Urgency of medical decision making	2.51	2.43
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.87	3.23
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Physical effort required	3.02	2.64
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.45	3.21
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Outcome depends on the skill and judgment of physician	3.77	3.47
--	------	------

Estimated risk of malpractice suit with poor outcome	3.64	3.57
--	------	------

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

Pre-Service intensity/complexity	3.04	2.83
----------------------------------	------	------

Intra-Service intensity/complexity	3.72	3.02
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Post-Service intensity/complexity	2.08	2.00
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**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 RATIONALE FOR 2252X1



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

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### **Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. The RUC when discussing the professional liability insurance crosswalk, the committee recognized that the CPT code identified as the crosswalk for all of the three new codes was performed by a non-surgical specialty on a patient under conscious sedation or regional anesthesia. These procedures are more typically performed by surgical specialties under general anesthesia. Therefore, a new professional liability insurance crosswalk is needed for all three codes. The specialty societies recommended, 64610 Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch (Work RVU=7.15, PLI RVU=1.48) for 2252X1 and 2252X2 and 63035 Laminectomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; each additional interspace, cervical or lumbar (Work RVU=3.15, PLI RVU=0.77) for 2252X3. The RUC agreed with the specialty societies' recommendations and recommend that the PLI Crosswalk for 2252X1 and 2252X2 be 64610 and for 2252X3 be 63035

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 Recommendations**

**Additional Rationale for 22523**

A multispecialty expert panel (AAOS, AANS, AAPM, ACR, ASA, ASN, CNS, NASS, SIR) reviewed the RVW survey data for 22523. 22520 (Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic) was the most common reference code selected by survey respondents. The expert panel believes 22520 is a good comparison code for 22523 because similar work is involved in both procedures. The expert panel believes 22523 includes slightly more work when compared to 22520, which has a RVW of 8.89. Mean intensity/complexity measures confirm that survey respondents view 22523 as slightly more difficult than 22520. Based on a comparison of the RVW for 22520, the expert panel believes the median RVW survey data of 13.00 is too high for 22523. The panel believes the 25<sup>th</sup> percentile RVW of 10.00 is a more appropriate starting point for analyzing the work value for 22523.

The expert panel then reviewed the time and visit survey data for 22523. The panel believes the pre-, intra-, and post-service times are appropriate. The expert panel also believes one office visit (99213) is reasonable for 22523. However, the expert panel believes survey respondents overestimated the number of hospital visits, and believes only a discharge day (99238) is necessary for 22523. A closer examination of the survey data reveals that 40% of respondents (38 surveys) reported only a discharge day (99238) for 22523. As such, the expert panel recommends removing a hospital visit (99232) and 1.06 RVW to account for this reduction.

**The expert panel believes an appropriate RVW for 225X1 is 8.94.** The recommendation is based on removing one hospital visit (99232) and a corresponding 1.06 RVW from the 25<sup>th</sup> percentile RVW survey data. The recommended RVW is slightly higher than 22520, which preserves the rank-order appropriateness of 22523 when compared to other existing spine procedures.

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

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**Recommended Work Relative Value**Specialty Society RVU: **8.54**RUC RVU: **8.54**

CPT Code:22524 Tracking Number: M2 Global Period: 010

CPT Descriptor: Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 75-year-old woman presents with severe, persistent back pain and progressive spinal deformity, secondary to osteoporotic vertebral collapse. Radiographic imaging including MRI confirms the recent compression fracture at L3. A bone biopsy and percutaneous vertebral augmentation with fracture reduction using a mechanical device to create a cavity is performed.

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: The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The radiographic studies are reviewed. Radiographic findings are correlated with the clinical exam and the surgical plan is confirmed. The surgeon confers with the patient and family; explaining the current condition and the need for surgical intervention. Questions are answered, consent obtained and a note written in the record. The physician confers with the anesthesiologist to review patient positioning and the intraoperative plan and the operating room staff to confirm the patient, equipment needs, the surgical site and procedure. After administration of anesthesia, monitoring lines are placed as necessary (separately reported). The patient is positioned on a radiolucent table in the prone position and the surgical site is prepped and draped into a sterile field.

Description of Intra-Service Work: A small skin incision is made at the appropriate position based on fluoroscopic visualization of the pertinent anatomy. Using AP and lateral plane fluoroscopy (separately reported), the following (in contrast to just using a small bone biopsy needle to inject bone cement into a vertebral body) are sequentially placed: a needle, guidewire, 4.2 mm cannula (working channel), drill and then mechanical cavity creation device is placed via either a transpedicular or extrapedicular approach into the compressed vertebral body. The entire process is repeated on the contralateral side – hence this is a bilateral procedure. The mechanical cavity creation fracture reduction device is gradually deployed to create a cavity. The device is then removed leaving behind the formed cavity. Bone cement is mixed and allowed 18-25 minutes for the mixed cement to have a consistency appropriate for injection. The cavities are filled with the bone substitute. Final intraoperative imaging is obtained to confirm alignment and fill. The working cannulae are removed and the incisions are closed with a single stitch. Sterile dressings are applied.

Description of Post-Service Work: Anesthesia is completed and the patient is taken to the recovery room. The surgeon checks the neurological status of the patient in the PACU. Postoperative orders are written and a note is dictated in the medical record. The family is visited in the waiting and the procedure and patient's condition are discussed. The patient stays overnight in the hospital. The following morning, the patient is evaluated and the wounds checked. The vital signs are reviewed. Discharge planning, prescriptions, activity parameters and instructions are provided.

After discharge, the patient returns to the office for suture removal, neurological examination and wound check. Questions regarding physiotherapy and activity levels are answered. Phone calls are answered. Subsequent follow-up office visits are scheduled to review activity levels and physiotherapy. X-rays of the spine are ordered and reviewed. Prescription medication refills are reviewed and written. An exercise program is recommended and printed material regarding therapy is provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>		Dale Blasier, MD, American Academy of Orthopaedic Surgeons John Wilson, MD, American Association of Neurological Surgeons				
<b>Specialty(s):</b>		American Academy of Orthopaedic Surgeons American Academy of Pain Medicine American Association of Neurological Surgeons American College of Radiology American Society of Anesthesiologists American Society of Neuroradiology Congress of Neurological Surgeons North American Spine Society Society of Interventional Radiology				
<b>CPT Code:</b>		22524				
<b>Sample Size:</b>	350	<b>Resp n:</b>	112	<b>Response:</b> 32.00 %		
<b>Sample Type:</b>		Random				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>		4.40	9.50	12.00	15.00	23.00
<b>Pre-Service Evaluation Time:</b>				30.0		
<b>Pre-Service Positioning Time:</b>				15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15.0		
<b>Intra-Service Time:</b>		20.00	40.00	55.00	60.00	120.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>		<u>20.00</u>				
<b>Critical Care time/visit(s):</b>		<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>		<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>		<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>		<u>23.0</u>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
22521	010	8.33

CPT Descriptor Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 58      % of respondents: 51.7 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 22524	Key Reference CPT Code: 22521
Median Pre-Service Time	60.00	30.00
Median Intra-Service Time	55.00	75.00
Median Immediate Post-service Time	20.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	36.0	18.00
Median Office Visit Time	23.0	23.00
Median Total Time	194.00	176.00
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	3.06	2.98
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.26	3.16
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Urgency of medical decision making	2.60	2.56
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.76	3.26
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Physical effort required	3.00	2.72
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.32	3.18
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Outcome depends on the skill and judgment of physician	3.88	3.58
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Estimated risk of malpractice suit with poor outcome	3.64	3.58
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.08	2.92
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Intra-Service intensity/complexity	3.50	2.98
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Post-Service intensity/complexity	2.06	2.00
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**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 RATIONALE FOR 2252X2

**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) 22899 (Unlisted procedure, spine ), 76499 (Unlisted diagnostic radiographic procedure)

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

Specialty Orthopaedics	How often? Sometimes
Specialty Neurosurgery	How often? Sometimes
Specialty Interventional Radiology	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 8000  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Orthopaedics	Frequency 5200	Percentage	%
Specialty Neurosurgery	Frequency 1600	Percentage	%
Specialty Interventional Radiology	Frequency 1200	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 Orthopaedics	Frequency 2600	Percentage	%
Specialty Neurosurgery	Frequency 800	Percentage	%
Specialty Interventional Radiology	Frequency 600	Percentage	%

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

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### **Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. The RUC when discussing the professional liability insurance crosswalk, the committee recognized that the CPT code identified as the crosswalk for all of the three new codes was performed by a non-surgical specialty on a patient under conscious sedation or regional anesthesia. These procedures are more typically performed by surgical specialties under general anesthesia. Therefore, a new professional liability insurance crosswalk is needed for all three codes. The specialty societies recommended, 64610 Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch (Work RVU=7.15, PLI RVU=1.48) for 2252X1 and 2252X2 and 63035 Laminectomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; each additional interspace, cervical or lumbar (Work RVU=3.15, PLI RVU=0.77) for 2252X3. The RUC agreed with the specialty societies' recommendations and recommend that the PLI Crosswalk for 2252X1 and 2252X2 be 64610 and for 2252X3 be 63035

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 Recommendations**

### **Additional Rationale for 22524**

A multispecialty expert panel (AAOS, AANS, AAPM, ACR, ASA, ASN, CNS, NASS, SIR) reviewed the RVW survey data for 22524. 22521 (Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar) was the most common reference code selected by survey respondents. The expert panel believes 22521 is a good comparison code for 22524 because similar work is involved for both procedures. The expert panel believes 22524 includes slightly more work than 22520, which has a RVW of 8.33. Mean intensity/complexity measures confirm that survey respondents view 22524 as slightly more difficult than 22521. Based on a comparison of the RVW for 22521, the expert panel believes both the median RVW survey data of 12.00 and the 25<sup>th</sup> percentile RVW of 9.50 are too high for 22524.

The expert panel then reviewed the time and visit survey data for 22524. The panel believes the pre-, intra-, and post-service times are appropriate. Survey results show one discharge day (99238) and one office visit (99213) are most typical for 22524, and the expert panel agrees that this hospital and office visit pattern is reasonable.

Because median and 25<sup>th</sup> percentile RVW survey results were too high, the panel believes a more appropriate starting point for analyzing the work value for 22524 is by examining the work intensity (IWPUT). 2252X1 has an IWPUT of 0.084, and is slightly more intense when compared to 22524 because 2252X1 involves the thoracic region of the spine while 22524 involves the lumbar region of the spine. The expert panel believes an IWPUT of 0.081 represents an appropriate lesser intensity for 22524.

Using an IWPUT of 0.081, and survey data as indicated above, the calculated RVW for 22524 is shown below.

		Calculated RVW:	RVW
			8.54
	Svy Data	RUC Std.	RVW
			(=time x intensity)
<b><u>Pre-service:</u></b>			
Pre-service eval & positioning	71	0.0224	1.59
Pre-service scrub, dress, wait	15	0.0081	0.12
<b>Pre-service total</b>			<b>1.71</b>
			(=time x intensity)
<b><u>Post-service:</u></b>			
Immediate post	20	0.0224	0.45
			(=n x RVW)
Subsequent visits:	n	E/M RVW	
99233		1.51	0.00
99232		1.06	0.00
99231		0.64	0.00
Discharge 99238	1	1.28	1.28
99215		1.73	0.00
99214		1.08	0.00
99213	1	0.65	0.65
99212		0.43	0.00
99211		0.17	0.00
<b>Post-service total</b>			<b>2.38</b>
	Time	IWPUT	INTRA-RVW
<b><u>Intra-service:</u></b>	55	0.081	4.46

The expert panel believes an appropriate RVW for 22524 is 8.54. This RVW recommendation is based on an IWPUT intensity value slightly lower than 22523 and uses survey time and visit data. The recommended RVW is slightly higher than 22521, but lower than 22520 and 22523, which preserves the rank-order appropriateness of 22524 when compared to existing spine procedures.

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

**Recommended Work Relative Value**

CPT Code:22525 Tracking Number: M3 Global Period: ZZZ

Specialty Society RVU: **4.67**RUC RVU: **4.47**

CPT Descriptor: Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 75-year-old woman presents with severe, persistent back pain and progressive spinal deformity, secondary to osteoporotic vertebral collapse. Radiographic imaging including MRI confirms the recent compression fracture at T9 and T10. After undergoing vertebral augmentation of T10 (coded separately), the additional level at T9 is treated. [Note: when completing this survey, only consider your "add-on" work for the additional vertebral body. The primary procedure would be billed separately.]

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 37%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: After completion of the first vertebral level treated, the physician proceeds to the next level repositioning the patient and drapes as necessary assuring a sterile field.

A small skin incision is made at the appropriate position based on fluoroscopic visualization of the pertinent anatomy. Using AP and lateral plane fluoroscopy (separately reported), the following (in contrast to just using a small bone biopsy needle to inject bone cement into a vertebral body) are sequentially placed: a needle, guidewire, 4.2 mm cannula (working channel), drill and then mechanical cavity creation device is placed via either a transpedicular or extrapedicular approach into the compressed vertebral body. The entire process is repeated on the contralateral side – hence this is a bilateral procedure. The mechanical cavity creation fracture reduction device is gradually deployed to create a cavity. The device is then removed leaving behind the formed cavity. Bone cement is mixed and allowed 18-25 minutes for the mixed cement to have a consistency appropriate for injection. The cavities are filled with the bone substitute. Final intraoperative imaging is obtained to confirm alignment and fill. The working cannulae are removed and the incisions are closed with a single stitch. Sterile dressings are applied.

Description of Post-Service Work: N/A

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Dale Blasier, MD, American Academy of Orthopaedic Surgeons John Wilson, MD, American Association of Neurological Surgeons

<b>Specialty(s):</b>	American Academy of Orthopaedic Surgeons American Academy of Pain Medicine American Association of Neurological Surgeons American College of Radiology American Society of Anesthesiologists American Society of Neuroradiology Congress of Neurological Surgeons North American Spine Society Society of Interventional Radiology					
<b>CPT Code:</b>	22525					
<b>Sample Size:</b>	350	<b>Resp n:</b>	112	<b>Response:</b> 32.00 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>		2.00	5.00	6.00	8.00	22.00
<b>Pre-Service Evaluation Time:</b>				0.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		15.00	30.00	40.00	54.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>0.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
22522	ZZZ	4.30

CPT Descriptor Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 71      % of respondents: 63.3 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 22525	Key Reference CPT Code: 22522
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	40.00	50.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>40.00</b>	<b>50.00</b>
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	2.95	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.87	2.84
Urgency of medical decision making	2.45	2.45

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

Technical skill required	3.78	3.24
Physical effort required	2.89	2.60

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.47	3.33
Outcome depends on the skill and judgment of physician	3.72	3.46
Estimated risk of malpractice suit with poor outcome	3.46	3.37

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

Pre-Service intensity/complexity	2.83	2.69
Intra-Service intensity/complexity	3.56	3.04
Post-Service intensity/complexity	2.13	2.17

**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 RATIONALE FOR 2252X3

**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) 22899 (Unlisted procedure, spine ), 76499 (Unlisted diagnostic radiographic procedure)

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

Specialty Orthopaedics                      How often? Sometimes

Specialty Neurosurgery                      How often? Sometimes

Specialty Interventional Radiology                      How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 4000

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

Specialty Orthopaedics                      Frequency 2600                      Percentage 65.00 %

Specialty Neurosurgery                      Frequency 800                      Percentage 20.00 %

Specialty Interventional Radiology                      Frequency 600                      Percentage 15.00 %

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 Orthopaedics                      Frequency 1800                      Percentage 90.00 %

Specialty Neurosurgery                      Frequency 400                      Percentage 20.00 %

Specialty Interventional Radiology                      Frequency 300                      Percentage 15.00 %

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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? 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 Recommendations**

**Additional Rationale for 22525**

A multispecialty expert panel (AAOS, AANS, AAPM, ACR, ASA, ASN, CNS, NASS, SIR) reviewed the RVW survey data for 22525. 22522 (Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)) was the most common reference code selected by survey respondents. The expert panel believes 22522 is a good comparison code for 22525 because both procedures are add-on procedures, and there is similar work involved for both procedures. The expert panel believes 22525 includes slightly more work when compared to 22522, which has a RVW of 4.30. Mean intensity/complexity measures confirm that survey respondents view 22525 as slightly more difficult than 22522. Based on a comparison of the RVW for 22522, the expert panel believes the median RVW survey data of 6.00 is too high for 22525. The panel believes the 25<sup>th</sup> percentile RVW of 5.00 is a more appropriate starting point for analyzing the work value for 22525.

The expert panel then reviewed the time data for 22525. The panel believes the intra-service time is appropriate. Since 22525 is an add-on code, there are no hospital or office visits associated with this procedure. However, the expert panel believes survey respondents incorrectly included pre- and post-service time for this procedure. As such, the expert panel recommends removing 10 minutes of pre-service time and 5 minutes of post-service time from this add-on procedure. The expert panel also recommends removing 0.33 RVW to account for the reduction in pre- and post-service time.

**The expert panel believes an appropriate RVW for 22525 is 4.67.** The recommended RVW is based on a reduction of the pre- and post-service time and a corresponding reduction in the RVW from the 25<sup>th</sup> percentile RVW survey data. The recommended RVW is slightly higher than 22522, which preserves the rank-order appropriateness of 22525 when compared to other existing spine procedures. The rank-order of 22525 is further justified because the recommended RVW value is close to the mid-point of the **intra-service RVW** for 22523 (4.87) and 22524 (4.46).

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation**

**Facility-ONLY Direct Inputs**

22523	M1	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic	10
22524	M2	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar	10
22525	M3	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body	ZZZ

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time:**

Pre-service time for the 10-day global codes 22523-25 have been crosswalked from 22520 and 22521.

Add-on code 22525 would have no pre-service clinical staff time.

**Service period clinical staff time:**

The assignment of 6 minutes (as supported by the PEAC) relative to coding of 99238 for discharge management for inpatient services has been applied to 22523 AND 22524.

**Post-service period clinical staff time:**

Standard EM postop OFFICE visit times for clinical staff have been applied to 22523-25

**SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:**

Standard PEAC minimum multispecialty office visit supplies and incision care have been applied to 22523-25

The ZZZ global code would have no related office supplies and equipment.

	A	B	C	D	E	F	G
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		22523 X-WALKED FROM 22520		22524 X-WALKED FROM 22521	
2				M1 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic		M2 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty), lumbar	
3				010		010	
4		Code	StaffType	NF	FAC	NF	FAC
5							
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	72	N/A	72
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		30		30
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		6		6
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		36		36
10	PRE-SERVICE						
11	<i>Start: After visit for procedure/service</i>						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		10		10
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5		5
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		7		7
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3
18	<i>End: Pt. enters site for procedure/service</i>						
19	SERVICE PERIOD						
40	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		6		6
41	Other Clinical Activity (please specify)						
42	<i>End: Patient leaves site of procedure/service</i>						
43	POST-SERVICE Period						
44	<i>End: Patient leaves site of procedure/service</i>						
45	Conduct phone calls/call in prescriptions						
46	List Number and Level of Office Visits						
47	99211 16 minutes	L037D	RN/LPN/MTA				
48	99212 27 minutes	L037D	RN/LPN/MTA				
49	99213 36 minutes	L037D	RN/LPN/MTA		1		1
50	99214 53 minutes	L037D	RN/LPN/MTA				
51	99215 63 minutes	L037D	RN/LPN/MTA				
52	<b>Total Office Visit Time</b>			<b>0</b>	<b>36</b>	<b>0</b>	<b>36</b>
53	Other						
54	<i>End: Last office visit in global period</i>						
55	MEDICAL SUPPLIES	Code	Unit				
56	pack, minimum multi-specialty visit	SA048	pack		1		1
57	pack, post-op incision care (suture & staple)	SA053	pack		1		1
58							
59	Equipment	Code					
60	table, power	EF031			36		36
61	light, exam	EQ168			36		36

	A	B	C	H	I
1				22525	
2	Meeting Date: April 2005			M3	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body	
4				ZZZ	
5		Code	StaffType	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0
10	<b>PRE-SERVICE</b>				
11	<i>Start: After visit for procedure/service</i>				
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		0
18	<i>End: Pt. enters site for procedure/service</i>				
19	<b>SERVICE PERIOD</b>				
40	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		
41	Other Clinical Activity (please specify)				
42	<i>End: Patient leaves site of procedure/service</i>				
43	<b>POST-SERVICE Period</b>				
44	<i>End: Patient leaves site of procedure/service</i>				
45	Conduct phone calls/call in prescriptions				
46	<i>List Number and Level of Office Visits</i>				
47	99211 16 minutes	L037D	RN/LPN/MTA		
48	99212 27 minutes	L037D	RN/LPN/MTA		
49	99213 36 minutes	L037D	RN/LPN/MTA		
50	99214 53 minutes	L037D	RN/LPN/MTA		
51	99215 63 minutes	L037D	RN/LPN/MTA		
52	<b>Total Office Visit Time</b>				
53	Other				
54	<i>End: Last office visit in global period</i>				
55	<b>MEDICAL SUPPLIES</b>	Code	Unit		
56	pack, minimum multi-specialty visit	SA048	pack		
57	pack, post-op incision care (suture & staple)	SA053	pack		
58					
59	<b>Equipment</b>	Code			
60	table, power	EF031			
61	light, exam	EQ168			

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**High Energy Extracorporeal Shock Wave Therapy**

The CPT Editorial Panel created a new code to differentiate between high energy and low energy Extra Corporeal Shock Wave Therapy in the treatment of plantar fasciitis. CPT also revised a category III code that describes other extracorporeal shock wave procedures. The RUC evaluated the procedure performed in the facility setting since the CPT RUC representative confirmed that during the CPT presentation, the Panel approved the code based on the presenters' statements that it is only performed in the facility setting because the procedure requires general anesthesia due to the high level of pain involved. However, during the RUC presentation, a presenter stated that the procedure is also performed in the non-facility setting. The RUC did not take formal action on the non-facility practice expense for CPT code 28890, but will forward the specialty recommendation for CMS' independent evaluation.

During the RUC review, the presenters agreed to reduce the pre-service time and eliminate one post-service office visit from the survey results as the presenters felt that the results overstated the total time. By reducing these inputs a revised recommended value of 3.85 was presented for RUC consideration. The RUC agreed that code 25001 *Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)* (work RVU, 3.37, 090 day global) should be used as an additional reference service because the physician time for 25001 (pre time = 30, intra = 30, immediate post=30, ½ day discharge, 2 x 99212, and 1x99213) is very similar to the new code. The RUC concluded that the new code should be valued slightly below this reference procedure. Also, the RUC made a number of changes to the physician time:

- **Pre-Evaluation time = 15 minutes**
- **Pre-Positioning time= 5 minutes**
- **Pre-Wait (related to ultrasound)= 10 minutes**
- **Intra-Service Time = 25 minutes**
- **Immediate Post time = 18 minutes**
- **Half Day Discharge = 18 minutes**
- **Three post operative visits at a level of 99212 (most typically at 1 week, 4 weeks, and 8 weeks following the procedure)**

Based on these changes and in comparison to code 25001, the RUC concluded that a work RVU of 3.30, which is slightly below the value of the reference service 25001 would place the code in proper rank order. **The RUC recommends a work RVU of 3.30 for code 28890.**

**Practice Expense**

Facility Setting

The RUC altered the post-operative visit clinical labor time, medical supplies, and equipment to reflect the reduction in physician post operative visits. The RUC agreed with the specialty proposed 24 minutes of pre-service time. Attached are the revised practice expense recommendations for this site of service.

Non-Facility Setting

The RUC did not take formal action on the non-facility practice expense for CPT code 28890, but will forward the specialty recommendation for CMS' independent evaluation.

**Professional Liability**

The RUC recommends that the Professional Liability Insurance (PLI) RVU be cross-walked to code 28430 *Closed treatment of talus fracture, without manipulation* since it is a non invasive procedure.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 28890	N1	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, involving the plantar fascia  (For extracorporeal shock wave therapy involving musculoskeletal system not otherwise specified, see Category III codes 0143T, 0144T)	090	3.30

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

CPT Code:28890 Tracking Number: N1 Global Period: 090

**Recommended Work Relative Value**Specialty Society RVU: **4.50**RUC RVU: **3.30**

CPT Descriptor: Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, involving plantar fascia

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 43-year-old female with chronic plantar fasciitis, who has undergone more than six months of conservative therapy without resolution of her symptoms, presents to the DPM, MD, or DO and the decision is made to proceed with high energy extracorporeal shock wave (ESW) of the plantar fascia requiring anesthesia other than local (separately reportable).

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? 18%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review previous treatment, including consulting with referring physician, if necessary. Meet and communicate with the patient and/or the patient's family to explain the procedure and obtain informed consent. Other pre-operative services include: dressing, and waiting to begin the procedure; supervising the positioning of the patient; and ensuring that the necessary equipment and supplies are present and available in the operative suite.

Description of Intra-Service Work: The point of maximal tenderness is identified and marked on the patient's heel. The foot is prepped and a local heel block is placed. Coupling gel is applied to the heel, and the shock wave generating device is positioned over the heel. Shock waves are then administered according to the manufacturers' protocol until the appropriate energy level is achieved. During shock wave administration, the position of the shock wave generating device is adjusted, and the power level and shock frequency is increased according to a standard protocol.

Description of Post-Service Work: The patient's stability in the recovery room is monitored. Postoperative orders, discharge instructions and prescriptions are written. The provider communicates with the family and other health care professionals, explaining home care instructions to the patient and/or family. The operative report is dictated.

The patient is typically seen in the office four times during the 90-day global period for post operative evaluations. The patient's clinical progress is monitored and the patient is given instructions on the resumption of further personal and recreational activities.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005			
<b>Presenter(s):</b>	Tye Ouzounian, MD; Lloyd Smith, DPM; Frank Spinosa, DPM				
<b>Specialty(s):</b>	American Academy of Orthopaedic Surgeons, American Orthopaedic Foot and Ankle Society, American Podiatric Medical Association				
<b>CPT Code:</b>	28890				
<b>Sample Size:</b>	90	<b>Resp n:</b>	32	<b>Response:</b>	%
<b>Sample Type:</b>	Panel				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		3.30	4.50	5.00	5.22
					<b>High</b>
					9.00

Pre-Service Evaluation Time:				15.0		
Pre-Service Positioning Time:				5.0		
Pre-Service Scrub, Dress, Wait Time:				10.0		
Intra-Service Time:		15.00	24.50	25.00	30.00	40.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>18.00</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>45.0</u>	99211x 0.0	12x 3.0	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>
28893	090	5.21

CPT Descriptor Endoscopic plantar fasciotomy

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
28060	090	5.22

CPT Descriptor Fasciectomy, plantar fascia; partial (separate procedure)

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

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

Number of respondents who choose Key Reference Code: 11      % of respondents: 34.3 %

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 28890</b>	<b>Key Reference CPT Code: 29893</b>
Median Pre-Service Time	30.00	60.00
Median Intra-Service Time	25.00	30.00
Median Immediate Post-service Time	18.00	40.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	0.00
Median Office Visit Time	45.0	114.00
Median Total Time	136.00	244.00
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	3.30	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.36
Urgency of medical decision making	2.23	2.45

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

Technical skill required	2.60	3.36
Physical effort required	2.70	3.09

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.13	3.00
Outcome depends on the skill and judgment of physician	2.87	3.27
Estimated risk of malpractice suit with poor outcome	2.40	3.64

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

Pre-Service intensity/complexity	3.10	3.18
Intra-Service intensity/complexity	2.87	3.64
Post-Service intensity/complexity	2.60	3.18

**ADDITIONAL RATIONALE**

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

The survey 25<sup>th</sup> percentile wRVU of 4.50 is recommended for 2825X (IWPUT = 0.043). The wRVU recommendation is lower than the wRVU for 29893 (primary reference code). The recommended wRVU for 2825X takes into account 1) the lower total time as compared to 29893, 2) the lower time segment complexity measures as compared to 29893, and 3) the lower intensity/complexity measures as compared to 29893.

The recommended wRVU for 2825X was also compared to another reference code 28060, which has a wRVU of 5.22, total time of 142 minutes, and IWPUP of 0.062 (Harvard).

## SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0020T

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

Specialty Orthopaedics How often? Rarely

Specialty Podiatry How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 20000

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

Specialty Orthopaedics Frequency 4000 Percentage 20.00 %

Specialty Podiatry Frequency 16000 Percentage 80.00 %

Specialty Frequency 0 Percentage 0.00 %

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

5,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Orthopaedics Frequency 1000 Percentage 20.00 %

Specialty Podiatry                      Frequency 4000                      Percentage 80.00 %

Specialty                                      Frequency 0                                      Percentage 0.00 %

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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 2825X is a non-invasive procedure; as such, the reference code 29893 is not an appropriate PLI crosswalk because it is an invasive procedure with a 2005 PLI RVU of 0.65. Code 28430 Closed treatment of talus fracture, without manipulation since it is a non invasive procedure. .

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

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
090-DAY GLOBAL PERIOD - FACILITY DIRECT INPUTS**

CPT	DESCRIPTION	GLOB
28890	Extracorporeal shock wave,high energy, performed by a physician, requiring anesthesia other than local, involving plantar fascia	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 the American Academy of Orthopaedic Surgeons (AAOS), American Orthopaedic Foot and Ankle Society (AOFAS), and the American Podiatric Medical Association (APMA) reviewed and approved the facility setting practice expense details outlined below.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** We are recommending less than the typical 90-day global pre-service clinical staff time package. The complexity of this procedure is less than a typical 90-day global open surgical procedure. Staff must coordinate appropriate pre-operative laboratory studies, schedule operative time and space, and arrange equipment. The consent process is less complex than for an open procedure, and less time is necessary to make additional phone calls and verify prescriptions.

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

**Post-service period clinical staff time (post discharge):** PEAC standard times for each office visit are indicated.

**SUPPLIES AND EQUIPMENT:**

Supplies and equipment necessary at one or more POV are indicated.

	A	B	C	D
1				
2	<b>RUC Recommendation</b>			<b>28890</b>
3		<b>CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE</b>		<b>Code Descriptor</b>
4	<b>LOCATION</b>			<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			
6	<b>TOTAL CLINICAL LABOR TIME</b>	<b>RN/LPN/MA</b>		<b>138.0</b>
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			<b>24.0</b>
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			<b>6.0</b>
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			<b>108.0</b>
10				
11	<b>Start: Following visit when decision for surgery or procedure made</b>			
12	Complete pre-service diagnostic & referral forms			5
13	Coordinate pre-surgery services			7
14	Schedule space and equipment in facility			8
15	Provide pre-service education/obtain consent			4
16	Follow-up phone calls & prescriptions			
17	Other Clinical Activity (please specify)			
18	<b>End: When patient enters office/facility for surgery/procedure</b>			
19				
20	<b>Start: When patient enters office/facility for surgery/procedure</b>			
21	<b>Pre-service services</b>			
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	<b>Intra-service</b>			
31	Assist physician in performing procedure			
32	<b>Post-Service</b>			
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			6
41	Other Clinical Activity (please specify)			
42	<b>End: Patient leaves office</b>			
43				
44	<b>Start: Patient leaves office/facility</b>			
45	Conduct phone calls/call in prescriptions			
46	<b>Office visits</b>			
47	<b>List Number and Level of Office Visits</b>			
48	99211 16 minutes	16		
49	99212 27 minutes	27		3
50	99213 36 minutes	36		
51	99214 53 minutes	53		
52	99215 63 minutes	63		
53	Other			
54				
55	<b>Total Office Visit Time</b>			<b>108</b>
56	Other Activity (please specify)			
57	<b>End: with last office visit before end of global period</b>			
58				
59	PEAC multispecialty supply package			3
60				
61				
62	Power Table			3
63	Exam Lamp			3

	A	B	C	D
1				
2			28890	
3		cms codes	Code Descriptor	
4	LOCATION		Non Facility	
5	GLOBAL PERIOD			
6	TOTAL CLINICAL LABOR TIME	RN/LPN/MA	170.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME		16.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		46.0	
9	TOTAL POST-SERV CLINICAL LABOR TIME		108.0	
10	<b>Start: Following visit when decision for surgery or procedure made</b>			
11	Start: Following visit when decision for surgery or procedure made			
12	Complete pre-service diagnostic & referral forms		5	
13	Coordinate pre-surgery services		7	
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	<b>Start: When patient enters office/facility for surgery/procedure</b>			
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		3	
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		16	
32	Post-Service			
33	Monitor pt. following service/check tubes, monitors, drains			
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		3	
40	Discharge day management 99238 --12 minutes 99239 --15 minutes			
41	Other Clinical Activity (please specify)			
42	End: Patient leaves office			
43	<b>Start: Patient leaves office/facility</b>			
44	Start: Patient leaves office/facility			
45	Conduct phone calls/call in prescptions			
46	Office visits:			
47	List Number and Level of Office Visits			
48	99211 16 minutes	16		
49	99212 27 minutes	27	3	
50	99213 36 minutes	36		
51	99214 53 minutes	53		
52	99215 63 minutes	63		
53	Other			
54				
55	Total Office Visit Time		108	
56	Other Activity (please specify)			
57	End: with last office visit before end of global period			
58	<b>PEAC multispecialty supply package</b>			
59	PEAC multispecialty supply package		3	
60	Fenestrated drape		1	
61				
62	Needles, 18 to 24 gauge		3	
63	Syringe, 10cc		1	
64	Xylocaine 1%		5 cc	
65	Marcaine 0.5%		5 cc	
66	Alcohol swab		2	
67				
68	<b>Power table</b>			
69	Power table		5	
70	Exam lamp		5	
71	ESW machine		1	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Inferior Turbinate Procedures**

The CPT Editorial Panel revised codes 30130 *Excision inferior turbinate, partial or complete, any method* (Work RVU=3.37), 30140 *Submucous resection inferior turbinate, partial or complete, any method* (Work RVU=3.42), 30801 *Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method, (separate procedure); superficial* (Work RVU=1.09), and 30930 *Fracture nasal inferior turbinate(s), therapeutic* (Work RVU=1.26) to clarify the appropriate use as private payors were not processing claims appropriately for inferior turbinates. The specialty society presented that these changes are editorial, which identifies that these procedures only include the inferior turbinate (not the superior or middle turbinate). The RUC did not feel that these codes need to be surveyed again. **The RUC recommends that the revisions are editorial. The RUC recommends to maintain the current values of 30131, 30140, 30801, 30802 and 30930.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 30130	O1	Excision <u>inferior</u> turbinate, partial or complete, any method  (For excision of superior or middle turbinate, use 30999)	090	3.37  (No Change)
▲ 30140	O2	Submucous resection <u>inferior</u> turbinate, partial or complete, any method  (Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140)  (For submucous resection of superior or middle turbinate, use 30999)	090	3.42  (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(For endoscopic resection of concha bullosa of middle turbinate, use 31240)		
▲30801	O3	Cautery and/or ablation, mucosa of <u>inferior</u> turbinates, unilateral or bilateral, any method, (separate procedure); superficial  (For cautery and ablation of superior or middle turbinates, use 30999)	010	1.09  (No Change)
▲30802	O4	intramural  (Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140)	010	2.03  (No Change)
▲30930	O5	Fracture nasal <u>inferior</u> turbinate(s), therapeutic  (Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140)  (For fracture of superior or middle turbinate(s), use 30999)	010	1.26  (No Change)

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Cavopulmonary Shunting**

CPT created a new add-on code to report the additional work of performing an additional cavopulmonary anastomosis for bilateral superior venae cavae since the current codes do not capture this work that occurs in about 10% of cases.

The presenters stated that the survey respondents significantly underestimated the time of this code and therefore resulting in an overstated IWP/UT. The presenters explained that the significant amount of work involved can not be done in only 30 minutes, which was the median survey intra-service time. The RUC agreed that this time was not accurate and concluded that the RUC recommendation should state that the median time value is an underestimate, therefore the resulting IWP/UT should not be used. The RUC agreed that given the intensity of this procedure it was valued correctly, especially in comparison with the other congenital add-on code 33294 *Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure* (Work RVU = 5.94, intra-service time = 30 minutes). Although the RUC did not agree on an appropriate intra-service time, the RUC felt that it is greater than 30 minutes and the value should be higher than 33294. The RUC agreed that the median recommended RVU of 8.00 was appropriate and would place the code in proper rank order especially in relation to 33294.

**The RUC recommends a work RVU of 8.00 for code 33768.**

Practice Expense

The RUC recommends zero practice expense inputs for code 3376X as it is an add-on code performed only in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
33478		<p>Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection</p> <p>(Use 33478 in conjunction with + ● 33768 when cavopulmonary anastomosis using a second superior vena cava is performed)</p>	090	<p>26.70</p> <p>(No Change)</p>
33617		<p>Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure</p> <p>(Use 33617 in conjunction with + ● 33768 when a cavopulmonary anastomosis to a second superior vena cava is performed)</p>	090	<p>36.94</p> <p>(No Change)</p>
33750		Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)	090	<p>21.38</p> <p>(No Change)</p>
33755		ascending aorta to pulmonary artery (Waterston type operation)	090	<p>21.76</p> <p>(No Change)</p>
33762		<p>descending aorta to pulmonary artery (Potts-Smith type operation)</p> <p>(Do not report modifier 63 in conjunction with 33750, 33755, 33762)</p>	090	<p>21.76</p> <p>(No Change)</p>

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
33764		central, with prosthetic graft	090	21.76 (No Change)
33766		superior vena cava to pulmonary artery for flow to one lung (classical Glenn procedure)	090	22.73 (No Change)
33767		superior vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure)	090	24.46 (No Change)
+●33768	F1	Anastomosis, cavopulmonary, second superior vena cava (List separately in addition to primary procedure)  (Use +●33768 in conjunction with 33478, 33617 or 33767)  (Do not report +●33768 in conjunction with 32020, 33210, 33211)	ZZZ	8.00

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

CPT Code:33768 Tracking Number: F1 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: 8.00

RUC RVU: 8.00

CPT Descriptor: Anastomosis, cavopulmonary, second superior vena cava (List separately into addition to primary procedure)

(Use +33768 in conjunction with 33478, 33617 or 33767)

(Do not report +33768 in conjunction with 32020, 33210, 33211)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Child with single ventricle physiology who has bilateral superior venae cavae with low pulmonary vascular resistance.

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? 100%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

Description of Intra-Service Work: The additional superior vena cava is dissected out along with the adjacent branch pulmonary artery. Prepare additional vena cava for insertion of bypass cannula and divide the azygos vein or hemi-azygos vein and insert bypass cannula in the additional superior vena cava. Divide the additional superior vena cava at the cardiac end. Make an incision in the superior aspect of the adjacent pulmonary artery and perform an end-to-side anastomosis of the additional superior vena cava to the adjacent pulmonary artery. De-cannulate the second superior vena cava and repair the cannulation site.

## Description of Post-Service Work:

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	Kirk Kanter				
Specialty(s):	Society of Thoracic Surgeons/American Association for Throacic Surgery				
CPT Code:	33768				
Sample Size:	40	Resp n:	13	Response:	%
Sample Type:	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:	7.00	8.00	8.00	12.00	20.00
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	27.50	30.00	42.50	45.00
Post-Service	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>0.00</u>				

<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0				
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0			
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00				
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0	

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
33924	ZZZ	5.49

CPT Descriptor Ligation and takedown of systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure) (List separately in addition to code for primary procedrue)  
(Use 33924 in conjunction with 33470-33475, 33600-33619, 33684-33688, 33692-33697, 33735-33767, 33770-33781, 33786, 33918-33922)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35600	ZZZ	4.94
<u>CPT Descriptor 1</u> Harvest of upper extremity artery, one segment, for coronay artery bypass procedure		

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
22842	ZZZ	12.86

CPT Descriptor 2 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>
33530	ZZZ	5.85

CPT Descriptor Reoperation, coronayr artery bypass procedrue or valve procedure, more then one month after original operation (List separately in addition to code fo rprimary procedrue) (Use 33530 in conjunctiton with codes 33400-33496, 33510-33536, 33863)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 53.8 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 33768</u>	<u>Key Reference CPT Code: 33924</u>
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
5		

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

The number of possible diagnosis and/or the number of management options that must be considered	5.00	3.00
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	4.00	3.00
--------------------------	------	------

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

**Psychological Stress (Mean)**

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

Outcome depends on the skill and judgment of physician	4.00	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	4.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.00	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 IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The IWPUT for this code is consistent with the other congenital add-on code 33294. The risks for this procedure are significant for injury to the phrenic nerve and if the anastomosis is not widely patent then there is risk for significant neurological injury. In order to carry out this procedure an additional venous cannula must be inserted into the left superior vena cava.

**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 same surgeon generally performs this procedure in conjunction with codes 33478, 33767, 33615, 33617,

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33919

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

Specialty cardiothoracic surgery                      How often? Rarely

Specialty    How often?

Specialty    How often?

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

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? No

If no, please select another crosswalk and provide a brief rationale. Instead of the reference service code 35682 Bypass graft; autogenous composite, two segments of veins from two locations (work RVU = 7.19) should be used since it has a more similar work RVU

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-ONLY Direct Inputs**

CPT	DESCRIPTION	GLOBAL
33768 F1	Anastomosis, cavopulmonary, second superior vena cava (List separately into addition to primary procedure)	ZZZ

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time: N/A**

**Service period clinical staff time: N/A**

**Post-service period clinical staff time: N/A**

**SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS: N/A**

	A	B	C	D	E
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		33768	
2				F1	
3				Anastomosis, cavopulmonary, second superior vena cava (List separately into addition to primary procedure)	
4				ZZZ	
5		Code	StaffType	NF	FAC
6	TOTAL CLINICAL LABOR TIME			N/A	N/A
7	TOTAL PRE-SERV CLINICAL LABOR TIME				
8	TOTAL INTRA CLINICAL LABOR TIME				
9	TOTAL POST-SERV CLINICAL LABOR TIME				
10	<b>PRE-SERVICE</b>				
11	<i>Start: After visit for procedure/service</i>				
18	<i>End: Pt. enters site for procedure/service</i>				
19	<b>SERVICE PERIOD</b>				
42	<i>End: Patient leaves site of procedure/service</i>				
43	<b>POST-SERVICE Period</b>				
44	<i>End: Patient leaves site of procedure/service</i>				
54	<i>End: Last office visit in global period</i>				
55	<b>MEDICAL SUPPLIES</b>	Code	Unit		
58					
59	<b>Equipment</b>	Code			

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Coronary Artery Anomaly Unroofing**

CPT created a new code for the repair of anomalous aortic origin of coronary artery due to the availability of new echocardiography imaging technology that allows the detection of a coronary artery anomaly. There was not a current CPT code that described the repair of the anomaly.

The presenters stated that this is a risky procedure because of the risk of injuring the aortic valve or the coronary artery during the procedure. Based on a comparison with the reference code, the RUC agreed that the median survey value of 30.00 RVUs was appropriate. The presenters noted that although there were only 22 respondents to the survey this represented about 10% of the surgeons that performed this procedure. The RUC noted that the times listed for the reference codes were Harvard data rather than more recent RUC data and were concerned that the lower Harvard times may have skewed the final specialty society recommendation. The presenters stated that the value of reference service 33504 *Repair of anomalous coronary artery; by graft, with cardiopulmonary bypass* (work RVU=24.62) was based on RUC data from 1993 but also stated that the reference code is significantly undervalued and that the RUC data from the early days of the RUC may not have been completely accurate. This code was presented as part of a much larger presentation of 80 cardiothoracic codes in 1993 and the data presented for this code may have been undervalued. Also, only 1/3<sup>rd</sup> of the survey respondents choose this code as the reference service and since the respondents were not provided the times, the recommended RVU survey results should be valid. Both procedures are low volume codes where it is difficult to obtain accurate data. The RUC was convinced that the 240 minutes intra-service time for reference code 33504 may be an error. The RUC also compared 33507 to MPC codes such as 35631 *Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU= 33.95, intra-service time =225) and code 35531 *Bypass graft, with vein; aortoceliac or aortomesenteric* (work =36.15, intraservice time = 240 minutes) and felt that the recommended median value of 30.00 RVUs and intra-service time of 180 minutes was appropriate especially in light of an IWP/UT of 0.101. Based on the description of the procedure and the intensity involved including the work of a post-operative ICU visit, the RUC was convinced that the recommended value of 30.00 is appropriate.

**The RUC recommends a work RVU of 30.00 for code 33507.**

Additionally, because the RUC felt that reference code 33504 may be undervalued, the RUC passed the following motion: **The RUC supports the specialty society's efforts to survey the reference service code 33504 and present the results to the RUC for consideration, provided CMS supports evaluation of the code.**

Practice Expense

The RUC recommends the standard inputs for 90 day global porcedures performed in the facility setting with the exception of using the RN staff type rather than the standard staff blend.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(e) 33502		Repair of anomalous coronary artery, from pulmonary artery origin; by ligation	090	21.01 (No Change)
(e) 33503		by graft, without cardiopulmonary bypass (Do not report modifier 63 in conjunction with 33502, 33503)	090	21.75 (No Change)
(e) 33504		by graft, with cardiopulmonary bypass	090	24.62 (No Change)
(e) 33505		with construction of intrapulmonary artery tunnel (Takeuchi procedure)	090	26.80 (No Change)
(e) 33506		by translocation from pulmonary artery to aorta (Do not report modifier 63 in conjunction with 33505, 33506)	090	35.45 (No Change)
● 33507	D1	Repair of anomalous (eg. intramural) aortic origin of coronary artery by unroofing or translocation	090	30.00

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

CPT Code: 33507 Tracking Number: D1 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: 30  
RUC RVU: 30.00

CPT Descriptor: Repair of anomalous (eg. intramural) aortic origin of coronary artery by unroofing or translocation

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A child with chest pain or syncope who is evaluated by echocardiogram or cardiac catheterization and is found to have origin of a coronary artery from an anomalous position on the aorta (typically the left coronary artery arises from the right coronary sinus and courses between the aorta and pulmonary artery).

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? 100%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write pre-operative orders for peri-operative medications

- Review pre-operative work-up
- Review Radiology
- Review Cardiac Catheterization and ECHO Cardiograms
- Review Laboratory findings
- Obtain informed consent
- Review planned incisions and procedure
- Confirm OR start time - notify patient and family
- Arrange for surgical assistant
- Change into scrub clothes
- Check with lab - check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown
- Available in operating room during insertion of monitoring lines and induction of anesthesia

Description of Intra-Service Work: Under general endotracheal anesthesia, in the supine position, the patient was prepped and draped in standard aseptic fashion. Skin incision made via standard median sternotomy. Sternum is divided in the midline. Cardiac cannulas placed Cardiopulmonary bypass initiated. The aortic cross clamp applied and cardioplegic arrest obtained. Aortotomy, repair of the defect is accomplished via unroofing an intramural anomalous coronary artery or through translocation of the origin to the anatomically correct position. Aortotomy is closed. Heart and aorta are de-aired, cross-clamp is removed, the patient is rewarmed and separated from bypass. Chest tubes and temporary pacing wires are placed. The sternum is closed with wires, the abdominal fascia, skin and subcutaneous tissue closed in layers.

Description of Post-Service Work: • Apply dressings

- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity

- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Write post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Remain with patient in ICU 1-3 hours until patient is hemodynamically stable and there is no evidence of postoperative bleeding
- Visit ICU 2-3 times (15-20 minutes each) and before leaving hospital at the end of the day
- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, management of wound, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes
- Examine and talk with patient Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

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**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Kirk Kanter

<b>Specialty(s):</b>	Society of Thoracic Surgeons/American Association for Throacic Surgery				
<b>CPT Code:</b>	33507				
<b>Sample Size:</b>	40	<b>Resp n:</b>	22	<b>Response:</b> 55.00 %	
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	25.00	28.12	30.00	35.75	40.00
<b>Pre-Service Evaluation Time:</b>			82.5		
<b>Pre-Service Positioning Time:</b>			15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			15.0		
<b>Intra-Service Time:</b>	100.00	150.00	180.00	200.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>60.00</u>				
<b>Critical Care time/visit(s):</b>	<u>63.0</u>	99291x 1.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>68.0</u>	99231x 2.0	99232x 1.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>23.0</u>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
33504	090	24.62

CPT Descriptor Repair of anomalous coronary artery; by graft, with cardiopulmonary bypass

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35631	090	33.95

CPT Descriptor 1 Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorena

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
35531	090	36.15

CPT Descriptor 2 Bypass graft, with vein; aortoceliac or aortomesenteric

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
33415	090	27.11

CPT Descriptor Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 36.3 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 33507</u>	<u>Key Reference CPT Code: 33504</u>
Median Pre-Service Time	112.50	120.00
Median Intra-Service Time	180.00	240.00
Median Immediate Post-service Time	60.00	300.00
Median Critical Care Time	63.0	0.00
Median Other Hospital Visit Time	68.0	0.00
Median Discharge Day Management Time	36.0	0.00
Median Office Visit Time	23.0	76.00
Median Total Time	542.50	736.00
Other time if appropriate		

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

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

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	3.00	3.00
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**Technical Skill/Physical Effort (Mean)**

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

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

**Psychological Stress (Mean)**

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

Outcome depends on the skill and judgment of physician	4.00	3.00
--	------	------

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	3.00
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Intra-Service intensity/complexity	4.00	3.00
------------------------------------	------	------

Post-Service intensity/complexity	3.00	3.00
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**ADDITIONAL RATIONALE**

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

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33505/33506/35211/35216

How often do physicians 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? Sometimes

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	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? 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? Yes

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 33606 Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure) was chosen because it has a more similar work RVU of 30.69.

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

IWPUT ANALYSIS		Survey CPT code: 33507		
Row / Column		A	B	C
				MEDIAN Svy RVW: 30.00
		Survey Data	RUC Standard	RVW
	Pre-service	Time	Intensity	(= Time x intensity)
	Pre-service eval & positioning	82.5	0.0224	1.848
	Pre-service scrub, dress, wait	30	0.0081	0.243
	Pre-service total			2.091
	Post-service	Time	Intensity	(=time x intensity)
	Immediate post	60	0.0224	1.344
	Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
	ICU 99291	1	4	4
	ICU 99292	0	2	0
	NICU 99296	0	16	0
	NICU 99297	0	8	0
	99233	0	1.51	0
	99232	1	1.06	1.06
	99231	2	0.64	1.28
	Discharge 99238	1	1.28	1.28
	Discharge 99239	0	1.75	0
	99215	0	1.73	0
	99214	0	1.08	0
	99213	1	0.65	0.65
	99212	0	0.43	0
	99211	0	0.17	0
	Post-service total			9.614
		Time	IWPUT	INTRA-RVW
	Intra-service:	180	0.1016389	18.295

Reference CPT code: 33504		
D	E	F
		MFS RVW for Ref: 24.62
Database Data	RUC Standard	RVW
Time	Intensity	(=time x intensity)
45	0.0224	1.008
36	0.0081	0.2916
		1.2996
Time	Intensity	(=time x intensity)
46	0.0224	1.0304
Visit n	E/M RVW	(=n x RVW)
0	4	0
0	2	0
0	16	0
0	8	0
0	1.51	0
2.5	1.06	2.65
4.5	0.64	2.88
1	1.28	1.28
0	1.75	0
0	1.73	0
1	1.08	1.08
1	0.65	0.65
0	0.43	0
0	0.17	0
		9.5704
Time	IWPUT	INTRA-RVW
179	0.0768156	13.75

Svy-T\* indicates insert survey time data.

Svy-V\* indicates insert survey visit data.

Ref-T\* indicates insert reference time data, from RUC database.

Ref-V\* indicates insert reference visit data, from RUC database

\*\*Note: Office visit RVW's shown reflect RUC/CMS "discounted" values.

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

CPT	DESCRIPTION	GLOBAL
33507 D1	Repair of anomalous (eg. intramural) aortic origin of coronary artery by unroofing or translocation	090

**CLINICAL STAFF TIME: RN Staff**

**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 12 minutes (as supported by the PEAC) relative to coding of 99238 for discharge management for inpatient services has been applied.

**Post-service period clinical staff time:** Standard EM postop OFFICE visit times for clinical staff have been applied as appropriate.

**SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:**

Standard PEAC minimum multispecialty office visit supplies and incision care have been applied.

	A	B	C	D	E
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		33507	
2				D1	
3				Repair of anomalous (eg. intramural) aortic origin of coronary artery by unroofing or translocation	
4				090	
5				Code	StaffType
6	<b>TOTAL CLINICAL LABOR TIME</b>	L051A	RN	N/A	108
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN		60
8	TOTAL INTRA CLINICAL LABOR TIME	L051A	RN		12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN		36
10	<b>PRE-SERVICE</b>				
11	<i>Start: After visit for procedure/service</i>				
12	Complete pre-service diagnostic & referral forms	L051A	RN		5
13	Coordinate pre-surgery services	L051A	RN		20
14	Schedule space and equipment in facility	L051A	RN		8
15	Provide pre-service education/obtain consent	L051A	RN		20
16	Follow-up phone calls & prescriptions	L051A	RN		7
18	<i>End: Pt. enters site for procedure/service</i>				
19	<b>SERVICE PERIOD</b>				
40	Discharge day management 99238 --12 minutes	L051A	RN		12
41	Other Clinical Activity (please specify)				
42	<i>End: Patient leaves site of procedure/service</i>				
43	<b>POST-SERVICE Period</b>				
44	<i>End: Patient leaves site of procedure/service</i>				
45	Conduct phone calls/call in prescriptions				
46	<i>List Number and Level of Office Visits</i>				
47	99211 16 minutes	L051A	RN		
48	99212 27 minutes	L051A	RN		
49	99213 36 minutes	L051A	RN		1
50	99214 53 minutes	L051A	RN		
51	99215 63 minutes	L051A	RN		
52	<b>Total Office Visit Time</b>				36
53	Other:				
54	<i>End: Last office visit in global period</i>				
55	<b>MEDICAL SUPPLIES</b>	Code	Unit		
56	pack, minimum multi-specialty visit	SA048	pack		1
57	pack, post-op incision care (suture & staple)	SA053	pack		1
58					
59	<b>Equipment</b>	Code			
60	table, power	EF031			36
61	light, exam	EQ168			36

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Ventricular Restoration**

Due to advancements in technology that has allowed for standardization of the restoration of the ventricle, CPT created a new code to account for this type of procedure that is technically more complicated and involves different work than is described by current codes.

The presenters stated that the existing code 33542 *Myocardial resection (eg, ventricular aneurysmectomy)* (work RVU = 28.21) involves different work and does not accurately describe this procedure. The presenters stated that patients undergoing ventricular restoration are among the sickest patients with advanced heart failure with the average patient staying in the ICU post-operatively 4-5 days. The RUC agreed that the median survey value of 37.97 work RVUs was appropriate especially given an intra-service time of four hours. The presenters clarified that in about 80 to 90 percent of these patients, bypass surgery is also performed at the same time and it was explained that the recommended value does not include any of the bypass surgery work. However, there was considerable discussion regarding the specialty request to include this new code in the upcoming five-year review. The presenters felt that because the reference services used to value this code are included in the five-year review and may have underestimated intra-service time, the those responding to the survey may have undervalued the new code by using an undervalued reference service. The presenters cited as evidence an IWPOT of 0.082 for this new code as being too low. The RUC agreed that an interim value could be assigned and the presenters would present new data based on the STS five-year review alternative methodology for RUC consideration in September, 2005.

**The RUC recommends an interim work RVU of 37.97 for code 33548.**

Practice Expense

The RUC recommends the standard inputs for 90 day global procedures performed in the facility setting with the exception of using the RN staff type rather than the standard blend.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 33548	E1	<p>Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, DOR procedures)</p> <p>(Do not report ● 33548 in conjunction with 32020, 33210, 33211, 33310, 33315)</p> <p>(For Batista procedure or pachopexy, use 33999)</p>	090	<p>37.97</p> <p>(Interim)</p>

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

CPT Code:33548 Tracking Number: E1 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **37.97**  
RUC RVU: **37.97**

CPT Descriptor: Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, DOR procedure)

(For Bastista procedure or pachopexy, use 33999)

(Do not report 3354X in conjunction with 32020, 33211, 33310-33315)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 56 year old man presents with Class IV congestive heart failure symptoms that are refractory to medical management and have required 4 hospitalizations in the past 6 months. He has no angina pectoris, but has a history of multiple myocardial infarctions and several percutaneous revascularizations. Cardiac catheterization reveals a totally occluded proximal LAD and a poor distal LAD supplied by right-to-left collaterals and a diminutive circulflex coronary system. The right coronary is dominant and without significant in-stent restenosis. Left ventriculography shows anterior and anteroapical akinesis, trace mitral regurgitation, global left ventricular dilatation, and an overall ejection fraction of 15%. Left ventricular regional and global function is carefully assessed through echocardiography and viability studies. He is evaluated for cardiac transplantation, and is found to have prohibitive pre-formed antibodies. He is considered unsuitable for transplantation due to this, his weight of 250 pounds, and an O blood type. A surgical ventricular restoration procedure is recommended and accepted by the patient.

Percentage of Survey Respondents who found Vignette to be Typical: 65%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: - Write pre-operative orders for peri-operative medications

- Review pre-operative work-up
- Review Radiology
- Review Cardiac Catheterization and ECHO Cardiograms
- Review Laboratory findings
- Obtain informed consent
- Review planned incisions and procedure
- Arrange for surgical assistant
- Change into scrub clothes
- Check with lab - check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown
- Available in operating room during insertion of monitoring lines and induction of anesthesia

Description of Intra-Service Work: - Skin incision made via standard median sternotomy

- Sternum is divided in the midline
- Cannulation using ascending aorta and two-stage RA venous return
- Cardiopulmonary bypass initiated

- A left ventricular vent is inserted via the Right Superior Pulmonary Vein
- The heart is carefully inspected to assess anteroapical akinetic area for resectability, LAD confirmed to be inoperable and supplied tissue non-viable.
- The ascending aorta is clamped and cardioplegic arrest instituted
- An anterior ventriculotomy is performed to the left of the LAD, and extended to the apex of the heart
- The junction between scarred abnormal myocardium and normal myocardium is determined by visual inspection and palpation.
- An encircling 0-prolene suture is placed at the junction and tied to reduce the orifice and restore the normal elliptical shape of the Left Ventricle (Fontan Stich). Available sizers and intraventricular balloons may be utilized to determine the final corrected LV volume.
- A circular patch of autologous or artificial material is sutured at the level of the Fontan stich to close the defect without reducing ventricular volume further.
- The left ventriculotomy is closed in layers
- The patient is rewarmed and weaned from cardiopulmonary bypass using moderate doses of inotropic agents.
- Hemostasis is obtained, and the surgical wound repaired after placing appropriate drainage tubes.

**Description of Post-Service Work:**

- Apply dressings
- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review intensive care plan and medications with staff
- Discuss procedure outcome with family, patient after emergence from aneshtesia and with referring physician
- Write post-op report
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Remain with patient in ICU 1-3 hours until patient is hemodynamically stable and there is no evidence of postoperative bleeding. Manage inotropic agents and afterload reducing agents to maintain adequate cardiac output and minimize str on the left ventriculotomy
- Visit ICU 2-3 times (15-20 minutes each) and before leaving hospital at the end of the day.
- Call ICU nurse in the evening to ensure patient progress, modify orders as necessary

On a daily basis as necessary, the postoperative care will include the following:

- Examine and talk with patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions, review nursing/other staff patient chart notes
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review post-discharge wound care and activity limitations with patient
- Review post-discharge labs/films
- Remove sutures/drains
- Dictate patient progress notes for medical chart

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**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	John Conte
<b>Specialty(s):</b>	Society of Thoracic Surgeons/ American Association for Thoracic Surgery
<b>CPT Code:</b>	33548

<b>Sample Size:</b> 200	<b>Resp n:</b> 20	<b>Response:</b> 10.00 %			
<b>Sample Type:</b> Random					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	30.00	3475.00	37.97	42.00	49.74
<b>Pre-Service Evaluation Time:</b>			57.5		
<b>Pre-Service Positioning Time:</b>			17.5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			20.0		
<b>Intra-Service Time:</b>	180.00	207.50	240.00	242.50	360.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>60.00</u>				
<b>Critical Care time/visit(s):</b>	<u>63.0</u>	99291x 1.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>185.0</u>	99231x 6.0	99232x 1.0	99233x 1.0	
<b>Discharge Day Mgmt:</b>	<u>45.0</u>	99238x 0.00	99239x 1.00		
<b>Office time/visit(s):</b>	<u>84.0</u>	99211x 0.0	12x 0.0	13x 2.0	14x 1.0 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>
33542	090	28.21

CPT Descriptor Myocardial resection (eg. ventricular aneurysmetcomy)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35531	090	36.15

CPT Descriptor 1 Bypass graft, with vein; aortoceliac or aortomesenteric

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
61585	090	37.26

CPT Descriptor 2 Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); with orbital exenteration

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
33860	090	37.94

CPT Descriptor Ascending aorta graft, with cardiopulmonary bypass, with our without valve suspension;

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 70.0 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 33548</u>	<u>Key Reference CPT Code: 33542</u>
Median Pre-Service Time	95.00	84.00
Median Intra-Service Time	240.00	192.00
Median Immediate Post-service Time	60.00	59.00
Median Critical Care Time	63.0	35.00
Median Other Hospital Visit Time	185.0	69.00
Median Discharge Day Management Time	45.0	0.00
Median Office Visit Time	84.0	24.00
Median Total Time	772.00	463.00
Other time if appropriate		

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

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

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

Technical skill required	5.00	5.00
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Physical effort required	5.00	4.00
--------------------------	------	------

**Psychological Stress (Mean)**

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

Outcome depends on the skill and judgment of physician	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	5.00	5.00
----------------------------------	------	------

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

Post-Service intensity/complexity	5.00	4.00
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**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 36.47 RVUs, which is the survey median. However, because the key reference service is one of the codes that is being reviewed in the 2005 5-year review process, the STS would like to request that the median value in this survey be considered interim by the RUC for purposes of reporting to CMS for MFS 2006 and that this new code be added to the 5-year review list with the other adult cardiac codes for review during the 5 year review to avoid creating a rank order anomaly within these codes from the outset.



Specialty	Frequency	Percentage	%
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How many physicians perform this service across the United States? No

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 33860 should be used because it has a work RVU that is more similar.

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-ONLY Direct Inputs**

CPT	DESCRIPTION	GLOBAL
33548 E1	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, DOR procedure)	090

**CLINICAL STAFF TIME: RN staff type for all activites**

**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 12 minutes (as supported by the PEAC) relative to coding of 99238 for discharge management for inpatient services has been applied.

**Post-service period clinical staff time:** Standard EM postop OFFICE visit times for clinical staff have been applied as appropriate.

**SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:**

Standard PEAC minimum multispecialty office visit supplies and incision care have been applied.

	A	B	C	D	E
1				33548	
2	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		E1	
3				Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, DOR procedure)	
4				090	
5		Code	StaffType	NF	FAC
6	<b>TOTAL CLINICAL LABOR TIME</b>	L051A	RN	N/A	197
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN		60
8	TOTAL INTRA CLINICAL LABOR TIME	L051A	RN		12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN		125
10	<b>PRE-SERVICE</b>				
11	<i>Start: After visit for procedure/service</i>				
12	Complete pre-service diagnostic & referral forms	L051A	RN		5
13	Coordinate pre-surgery services	L051A	RN		20
14	Schedule space and equipment in facility	L051A	RN		8
15	Provide pre-service education/obtain consent	L051A	RN		20
16	Follow-up phone calls & prescriptions	L051A	RN		7
18	<i>End: Pt. enters site for procedure/service</i>				
19	<b>SERVICE PERIOD</b>				
40	Discharge day management 99238 --12 minutes	L051A	RN		12
41	Other Clinical Activity (please specify)				
42	<i>End: Patient leaves site of procedure/service</i>				
43	<b>POST-SERVICE Period</b>				
44	<i>End: Patient leaves site of procedure/service</i>				
45	Conduct phone calls/call in prescriptions				
46	<i>List Number and Level of Office Visits</i>				
47	99211 16 minutes	L051A	RN		
48	99212 27 minutes	L051A	RN		
49	99213 36 minutes	L051A	RN		2
50	99214 53 minutes	L051A	RN		1
51	99215 63 minutes	L051A	RN		
52	<b>Total Office Visit Time</b>				125
53	Other:				
54	<i>End: Last office visit in global period</i>				
55	<b>MEDICAL SUPPLIES</b>	Code	Unit		
56	pack, minimum multi-specialty visit	SA048	pack		3
57	pack, post-op incision care (suture & staple)	SA053	pack		1
58					
59	<b>Equipment</b>	Code			
60	table, power	EF031			125
61	light, exam	EQ168			125

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

**Descending Thoracic Aorta Endovascular Repair**

The CPT Editorial Panel created a family of seven new codes to define new techniques for repairing aneurysm involving descending thoracic aorta endovascular repair, and four other codes associated with the placement of proximal extension prosthesis and coverage of the left subclavian artery origin. In addition, the Panel revised two open artery exposure abdominal aortic aneurysm codes, a bypass graft code, and an arterial transposition code. These changes to CPT were made to provide more specificity with the existing codes while introducing new category I codes reflecting existing practice patterns of codes that were previously category III codes. The Panel also believed that there was an urgency to move these new technology codes to category I, as minimally invasive repair of the thoracic aorta provides an alternative to the complexity and sometimes mortality of the similar open surgical procedures.

The RUC carefully reviewed the survey results of all eleven new codes associated with descending thoracic aorta endovascular repair, and agreed that the specialty society's recommended physician work values were correctly rank ordered and well justified. The RUC first addressed the surgical aspects of endovascular repair and then the diagnostic radiology aspects.

**33880**

The RUC reviewed the specialty society recommended median survey results for code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin*, and understood the significant work involved for this service. The RUC reviewed this code against its RUC reviewed reference code 34803 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs)* (090 day global, Work RVU = 24.00), and determined this new code involved more time and intensity. The RUC agreed with the intensity and physician time in the pre-intra and immediate post periods, for this new code, however did not agree with the level four office visit shown in the specialty's survey results. The RUC recommended, and the specialty agreed, that the level four office visit should be changed to a level three. **The RUC recommends the modification to the specialty's surveyed results to indicate two level three post operative visits rather than one level three and one level four. The RUC also recommends a relative work value of 33.00 for code 33880.**

**33881**

The RUC reviewed the specialty society recommended median survey results for code 33881 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to*

*level of celiac artery origin*, and understood its rank order in relation to 33880. The RUC reviewed this code against its RUC reviewed reference code 34803 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs)* (090 day global, Work RVU = 24.00), and determined this new code involved more time and intensity. The RUC agreed with the intensity and physician time in the pre-intra and immediate post periods, for this new code, however did not agree with the level four office visit shown in the specialty's survey results. The RUC recommended, and the specialty agreed, that the level four office visit should be changed to a level three. **The RUC recommends the modification to the specialty's surveyed results to indicate two level three post operative visits rather than one level three and one level four. The RUC also recommends a relative work value of 28.00 for code 33881.**

### **33883**

The RUC reviewed the specialty society recommended median survey results for code 33883 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); initial extension*, and understood that it is a complex and challenging endovascular procedure. The RUC examined the specialty's RUC surveyed key reference code 34825 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel*, (090 global, Work RVU = 11.98), and believed the survey results that indicated higher levels of physician time and complexity. The also RUC agreed with the intensity and physician time in the pre-intra and immediate post periods, for this new code, however did not agree with the level four office visit shown in the specialty's survey results. The RUC recommended, and the specialty agreed, that the level four office visit should be changed to a level three. **The RUC recommends the modification to the specialty's surveyed results to indicate two level three post operative visits rather than one level three and one level four. The RUC also recommends a relative work value of 20.00 for code 33883.**

### **33884**

The RUC reviewed the specialty society recommended 75<sup>th</sup> percentile survey results for code 33884 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); each additional proximal extension* and believed that intensity is comparable to its key reference code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)* (ZZZ day global, Work RVU = 4.12). The specialty's survey results indicated a median survey work value of 7.00, however the RUC agreed with the specialty that placing an additional proximal thoracic endovascular extension is justifiably 20% more intense than a proximal or distal additional extension in the infrarenal aorta. Therefore, considering the additional physician time and increased intensity of the service than its key reference service, the RUC agreed with the specialty's 75<sup>th</sup> percentile survey results for physician work. **The RUC recommends a relative work value of 8.20 for code 33884.**

### 33886

The RUC reviewed the specialty society recommended median survey results for code 33886 *Placement of distal extension prosthesis(es) delayed after endovascular repair of descending thoracic aorta* and agreed that the time and complexity was greater than its key reference 34825 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel*, (090 global, Work RVU = 11.98). The RUC agreed with the survey results, however disagreed with the level four office visit and recommended a reduction to a level three. The specialty agreed with the physician time change and considered it more typical. **The RUC recommends a relative work value of 17.00 for code 33886.**

### 33889

The RUC reviewed the specialty society survey results for code 33889 *Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral* and agreed with the specialty that the code was overvalued by the respondents which indicated a median survey value of 18.00 work RVUs for this new 000 day global service. The RUC agreed with the specialty society recommendation involving the direct comparison of code 35694 *Transposition and/or reimplantation; subclavian to carotid artery* (090 day global, Work RVU = 19.13) to this new code. The RUC agreed with the intensity comparison of the two codes and developed a building block approach, backing out the post-operative visits and applying the specialty surveyed time. **The RUC recommends a work relative value of 15.92 for code 33889.** The RUC and specialty society also agreed that since the new code is a 000 day global code, that the post-operative time period would only encompass the immediate post service time. Therefore, the RUC recommended the specialty's surveyed discharge day management time be moved to the immediate post service time. **The RUC recommends the discharge day management time from the specialty surveyed results be moved to the immediate post service time.**

### 33891

The RUC reviewed the specialty society survey results for code 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* and realized that this procedure has a high level of intensity. The RUC evaluated this service and believed the median survey value of 20.00 was justified, based on the time and intensity of the new procedure. **The RUC recommends a work relative value of 20.00 for code 33891.** The RUC and specialty society also agreed that since the new code is a XXX global code, that the post-operative time period would only encompass the immediate post service time. Therefore, the RUC recommended the specialty's surveyed discharge day management time be moved to the immediate post service time. **The RUC recommends the discharge day management time from the specialty surveyed results be moved to the immediate post service time.**

The RUC was aware that all of the new imaging codes include supervision and interpretation (S&I). It was explained that the codes will be reported together with the primary codes and they are not subject to multiple procedure reduction. However, typically there would be one S&I billed, and occasionally there would be more than one.

### **New Diagnostic Radiology Codes involved in Endovascular Repair**

The RUC reviewed and agreed the recommended median survey results of all the diagnostic radiology codes. The RUC was aware that all of these new imaging codes included supervision and interpretation (S&I), and that the codes would be reported together with the primary codes and would not be subject to the multiple procedure reduction. However, the specialty understood that typically there would be one S&I billed and occasionally there would be more than one.

#### **75956**

The RUC reviewed the median survey results for code 75956 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* and agreed with the specialty survey results. The RUC compared the new code to the specialty's key reference code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* (Work RVU = 4.49). The RUC understood that the new procedure involved much more time than 75952 at a similar complexity level. The time and intensity difference was understandable considering the time for the new code is based on the anatomic complexity of the aortic arch in a three-dimensional space. The RUC agreed with the specialty society survey results and recommendation. **The RUC recommends a work relative value of 7.00 for code 75956.**

#### **75957**

The RUC reviewed the median survey results for code 75957 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation* and agreed with the specialty survey results. The RUC compared the new code to the specialty's key reference code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* (Work RVU = 4.49). The RUC understood that the new procedure involved much more time than 75952 at a similar complexity level. The time and intensity difference was understandable considering the time for the new code is based on the anatomic complexity of the aortic arch in a three-dimensional space. The RUC agreed with the specialty society survey results and recommendation. **The RUC recommends a work relative value of 6.00 for code 75957.**

#### **75958**

The RUC reviewed the median survey results for code 75958 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic*

disruption); *radiological supervision and interpretation* and agreed with the specialty survey results. The RUC compared the new code to the specialty's key reference code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* (Work RVU = 4.49). The RUC understood that in the intra-service period, the new procedure involved similar time as 75952 at a higher intensity. The intensity was understood whereas the proximal extension is deployed adjacent to, or crosses, the left subclavian origin. The RUC agreed with the specialty society survey results and recommendation. **The RUC recommends a work relative value of 4.00 for code 75958.**

**75959**

The RUC reviewed the median survey results for code 75959 *Placement of distal extension prosthesis(es) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin; radiological supervision and interpretation* and agreed with the specialty survey results. The RUC compared the new code to the specialty's key reference code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* (Work RVU = 4.49). The RUC understood that the new procedure involved less time than 75952 with a higher intensity level during the intra-service period. The RUC agreed with the specialty society survey results and its comparison to the reference code to substantiate their recommendation. **The RUC recommends a work relative value of 3.50 for code 75959.**

**Practice Expense**

The RUC agreed with the standard inputs for this set of codes, however the RUC made two changes in order to reflect the RUC's changes to the surveyed time and the elimination of all inputs for codes 33889-7. The post-operative visit time, supplies, and equipment were changed to reflect the reduction in one post operative visit for codes 33880-3, and 33886. In addition, the practice expense of codes 33889-7 were eliminated as they are billed with the other major procedures within the family at the same time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Codes 33880-33891 represent a family of procedures to report placement of an endovascular graft for repair of the descending thoracic aorta. These codes include all device introduction, manipulation, positioning and deployment. All balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment, are not separately reportable. Open arterial exposure and associated closure of the arteriotomy sites (eg, 34812, 34820, 34833, 34834), introduction of guidewires and catheters (eg, 36200, 36215-36218, 36140), and extensive repair or replacement of an artery (eg, 35226, 35286) should be additionally reported. Transposition of subclavian artery to carotid, and carotid-carotid bypass performed in conjunction with endovascular repair of the descending thoracic aorta (eg, 33889, 33891) should be separately reported. The primary codes 33880 and 33881 include placement of all distal extensions, if required, in the distal thoracic aorta, while proximal extensions, if needed, are reported separately.</p> <p>For fluoroscopic guidance in conjunction with endovascular repair of the thoracic aorta, see codes 75956-75959 as appropriate. Codes 75956 and 75957</p>				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>include all angiography of the thoracic aorta and its branches for diagnostic imaging prior to deployment of the primary endovascular devices (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff). Code 75958 includes the analogous services for placement each proximal thoracic endovascular extension. Code 75959 includes the analogous services for placement of a distal thoracic endovascular extension(s) placed during a procedure after the primary repair.</p> <p>Other interventional procedures performed at the time of endovascular repair of the descending thoracic aorta should be additionally reported (eg, innominate, carotid, subclavian, visceral, or iliac artery transluminal angioplasty or stenting, arterial embolization, intravascular ultrasound) when performed before or after deployment of the aortic prostheses.</p>				
●33880	II1	<p>Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin</p> <p>(For radiological supervision and interpretation, use 75956 in conjunction with 33880)</p>	090	33.00
●33881	II2	<p>not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin</p> <p>(For radiological supervision and interpretation, use 75957 in conjunction with 33881)</p>	090	28.00
●33883	II3	<p>Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); initial extension</p> <p>(For radiological supervision and interpretation, use 75958 in conjunction with 33883)</p>	090	20.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Do not report 33881, 33883 when extension placement converts repair to cover left subclavian origin. Use only 33880)		
+●33884	II4	<p>each additional proximal extension (List separately in addition to code for primary procedure)</p> <p>(Use 33884 in conjunction with 33883)</p> <p>(For radiological supervision and interpretation, use 75958 in conjunction with 33884)</p>	ZZZ	8.20
●33886	II5	<p>Placement of distal extension prosthesis(es) delayed after endovascular repair of descending thoracic aorta</p> <p>(Do not report 33886 in conjunction with 33880, 33881)</p> <p>(Report 33886 once, regardless of number of modules deployed)</p> <p>(For radiological supervision and interpretation, use 75959 in conjunction with 33886)</p>	090	17.00
●33889	II6	<p>Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral</p> <p>(Do not report 33889 in conjunction with 35694)</p>	000	15.92
●33891	II7	<p>Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision</p>	000	20.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Do not report 33891 in conjunction with 35509, 35601)		
<b>Endovascular Repair of Abdominal Aortic Aneurysm</b>				
▲ 34833		Open iliac artery exposure with creation of conduit for delivery of <del>infrarenal</del> aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral  (For bilateral procedure, use modifier 50)  (Do not report 34833 in addition to 34820)	000	11.98  (No Change)
▲ 34834		Open brachial artery exposure to assist in the deployment of <del>infrarenal</del> aortic or iliac endovascular prosthesis by arm incision, unilateral  (For bilateral procedure, use modifier 50)	000	5.34  (No Change)
<b>Bypass Graft Other Than Vein</b>				
35601		Bypass graft, with other than vein; carotid  (For open transcervical common carotid-common carotid bypass performed in conjunction with endovascular repair of descending thoracic aorta, use 33891)	090	17.47  (No Change)
<b>Arterial Transposition</b>				
35691		Transposition and/or reimplantation; vertebral to carotid artery	090	18.02  (No Change)
35694		subclavian to carotid artery  (For open subclavian to carotid artery transposition performed in conjunction with endovascular <del>thoracic aneurysm repair, use</del>	090	19.13  (No Change)



CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>Category III code 0037F repair of descending thoracic aorta, use 33889)</u>		
<i>Diagnostic Radiology (Diagnostic Imaging)</i> <i>Vascular Procedures</i> <i>Transcatheter Procedures</i>				
●75956	II8	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation  (For implantation of endovascular graft, use 33880)	XXX	7.00
●75957	II9	not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation  (For implantation of endovascular graft, use 33881)	XXX	6.00
●75958	II10	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption), radiological supervision and interpretation  (Report 75958 for each proximal extension)  (For implantation of proximal endovascular extension, see 33883, 33884)	XXX	4.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●75959	III 1	Placement of distal extension prosthesis(es) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation  (Do not report 75959 in conjunction with 75956, 75957)  (Report 75959 once, regardless of number of modules deployed)  (For implantation of distal endovascular extension, use 33886)	XXX	3.50
<b>Category III Codes</b>				
D 0033T		<del>Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection; involving coverage of left subclavian artery origin, initial endoprosthesis</del>  (For radiological supervision and interpretation, use 0038T)  <u>(0033T has been deleted. For endovascular repair of descending thoracic aorta, involving coverage of left subclavian artery origin, use 33880)</u>	YYY	N/A
D 0034T		<del>not involving coverage of left subclavian artery origin, initial endoprosthesis</del>  (For radiological supervision and interpretation, use 0039T)  <u>(0034T has been deleted. For endovascular repair of descending thoracic aorta, not involving coverage of left subclavian artery origin, use 33881)</u>	YYY	N/A
D 0035T		<del>Placement of proximal or distal extension prosthesis for endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection; initial extension</del>  (For radiological supervision and interpretation, use 0040T)	YYY	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p><del>(Do not report 0034T and 0035T when placement of extension converts repair to cover left subclavian origin, use only 0033T)</del></p> <p><u>(0035T has been deleted. For proximal extension during endovascular repair of descending thoracic aorta, use 33883. Distal extensions are included in 33880, 33881. Distal extensions performed after endovascular repair of descending thoracic aorta are reported with 33886)</u></p>		
D +0036T		<p>each additional extension (List separately in addition to code for primary procedure)</p> <p><del>(Use 0036T in conjunction with 0035T)</del></p> <p><del>(For radiological supervision and interpretation, use 0040T)</del></p> <p><u>(0036T has been deleted. For additional proximal extensions use 33884. Additional distal extensions during endovascular repair of descending thoracic aorta are included in 33880, 33881. Additional distal after endovascular repair of thoracic aorta included in 33886)</u></p>	YYY	N/A
D 0037T		<p><del>Open subclavian to carotid artery transposition performed in conjunction with endovascular thoracic aneurysm repair, by neck incision, unilateral</del></p> <p><del>(For bilateral procedure, use modifier 50)</del></p> <p><del>(Do not report 0037T in addition to 35694)</del></p> <p><u>(0037T has been deleted. For open subclavian to carotid artery transposition performed in conjunction with endovascular thoracic aortic repair by neck incision, use 33889)</u></p>	YYY	N/A
D 0038T		<p><del>Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection involving coverage of left subclavian artery origin, initial endoprosthesis, radiological supervision and interpretation</del></p> <p><del>(For implantation of endovascular graft, use 0033T)</del></p>	YYY	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>(0038T has been deleted. For endovascular repair of descending thoracic aorta, involving coverage of left subclavian artery origin, radiological supervision and interpretation, use 75956)</u>		
D 0039T		<p>Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection not involving coverage of left subclavian artery origin, initial endoprosthesis, radiological supervision and interpretation</p> <p>(For implantation of endovascular graft, use 0034T)</p> <p><u>(0039T has been deleted. For endovascular repair of descending thoracic aorta, not involving coverage of left subclavian artery origin, radiological supervision and interpretation, use 75957)</u></p>	YYY	N/A
D 0040T		<p>Placement of proximal or distal extension prosthesis for endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection, each extension, radiological supervision and interpretation</p> <p>(For implantation of endovascular graft extensions, see 0035T, 0036T)</p> <p><u>(0040T has been deleted. For placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta, radiological supervision and interpretation, use 75958. For placement of distal extension prosthesis after thoracic endovascular repair of descending thoracic aorta, radiological supervision and interpretation, use 75959)</u></p>	YYY	N/A

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

**Recommended Work Relative Value**  
Specialty Society RVU: **33.00**  
RUC RVU: **33.00**

CPT Code:33880 Tracking Number: II1 Global Period: 090

CPT Descriptor: Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old male with hypertension, 50 pack-years smoking, and previous myocardial infarction is found to have a 7.0 cm diameter descending thoracic aortic aneurysm that begins immediately beyond the origin of left subclavian artery. Risks and benefits of open surgical repair, endovascular repair, and watchful waiting have been discussed, and patient has chosen endovascular repair. Perioperative risk evaluation including cardiac workup indicated suitability for the endovascular approach. Imaging studies (typically a combination of CT scan, MRI, and/or angiography) demonstrate that the aneurysm is within acceptable parameters for endovascular repair if the left subclavian artery origin is covered by the endoprosthesis. Endovascular repair of the descending thoracic aortic aneurysm is performed. The proximal extent of the endoprosthesis covers the left subclavian artery origin.

NOTE: The proposed new code includes all distal extensions required to complete the typical repair. Left subclavian to carotid transposition is separately reportable. This code follows endovascular repair guidelines such that open arterial exposure, arterial catheterization, and radiological supervision and interpretation are separately reported.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 9%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Review history, physical, and all pre-operative risk assessment studies
- Perform mandated update, with special attention to cardiovascular symptoms
- Perform extensive review and measurement of imaging studies (some combination of CT , CT angiogram, CT with 3-D reconstructions, MRI, angiograms) to determine the exact measurements of aorta
- Based on measurements, determine all potential components required for repair, plus contingencies and backups
- Ensure presence of all required components
- Review operative plan, risks and benefits with patient and family
- Review informed consent and obtain patient signature
- Conduct final operative coordination and planning with anesthesia and nursing teams
- Don surgical scrubs & lead
- Position patient
- Prep, scrub, drape and wait.

**Description of Intra-Service Work:**

Reporting 3388X1 will follow the detailed coding guidelines in the CPT introductory notes for Endovascular Repairs. It is important to note that 3388X1 includes placement of as many distal extension components as required to complete the repair. The intra-service work begins after achieving arterial exposure and after initial catheter and guidewire placement have been completed. The intraservice work includes:

- Perform road-mapping arteriogram with specific attention to great vessel artery origins, celiac origin
- Image aortic arch in multiple projections to determine exact orthogonal coordinates to deploy prosthesis

Wait for anesthesia to insert and adjust TEE, if employed  
 Final out-of-body examination of endovascular components for correct models, diameters, lengths, etc  
 Exchange soft J-wires for superstiff wires  
 Unpackage the initial component, inspect for damage, and prepare the device for insertion  
 Anticoagulate patient with IV heparin  
 Load initial component and carrier onto superstiff wire and advance to the femoral artery  
 Introduce tip of carrier into arteriotomy  
 Open proximal vascular clamp and advance leading edge of device into artery  
 Use rubber constrictor loops to limit blood loss  
 Under fluoroscopic guidance direct first component and carrier through external iliac  
 Advance first component & carrier into common iliac, abdominal aorta, thoracic aorta up to arch  
 Advance with extreme care at arch so nosecone lies in ascending aorta and leading edge across left subclavian origin  
 Repeat arteriography as needed to absolutely confirm great vessel origins wrt leading edge of device  
 Ask anesthesiologist to lower blood pressure and wait for desired effect  
 Begin deployment  
 Perform contrast injections in multiple planes to allow final exact positioning  
 Make final precise adjustments to align leading edge of component in arch, across left subclavian origin  
 Deploy initial component with constant attention to exact positioning  
 Advance carrier to recapture nosecone  
 Retract carrier and nosecone with care not to disturb 1st component  
 Back carrier & nosecone through descending aorta & through iliac arteries with care not to disrupt iliacs  
 Remove 1st component carrier from femoral artery, reclamp artery  
 Introduce compliant balloon under fluoro guidance, advance through iliac, abd aorta, thoracic aorta, to arch  
 Warn anesthesiologist that aortic arch is about to be occluded  
 Inflate compliant balloon under constant fluoroscopic observation to expand & seat first component  
 Deflate compliant balloon and back carefully out of 1<sup>st</sup> component  
 Advance multisidehole catheter into aortic arch  
 Inject contrast and image graft to confirm accurate placement  
 Prepare and load second component onto superstiff wire in groin  
 Advance 2nd component into femoral artery, thru iliacs, thru abdominal aorta, into thoracic aorta  
 Observe fluoroscopically while carefully invaginating 2nd component into first  
 Adjust overlap  
 Advance multisidehole catheter and inject contrast to ensure distal edge hasn't covered celiac  
 Make final leading and following edge adjustments with imaging  
 Deploy 2nd component  
 Carefully retract carrier without disrupting deployed components or iliac artery  
 Remove carrier from groin, minimize blood loss  
 Advance multisidehole catheter and inject contrast to assess positioning of 2<sup>nd</sup> component, endoleak, etc  
 Determine need for additional distal components  
 Repeat all above steps in sequence with sufficient components to complete a hemostatic distal anastomosis above celiac  
 Introduce compliant balloon for final expansion and seating of all additional component  
 Final arteriogram to determine appropriate coverage, patency of major arteries, absence of endoleaks  
 Remove introducers, using fluoroscopic guidance to prevent disruption of graft position  
 Perform completion pressure measurements  
 Remove catheters/wires/sheaths using fluoroscopic guidance

Description of Post-Service Work: Post-service work begins after skin closure. Tasks include apply dressings, transfer patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he/she fully awake. When stable, the patient is transferred to the floor. The physician makes daily visits, takes history, performs physical exam, makes assessment and plan, writes orders & notes, and communicates with patient, family, nurses, and all other caregivers. Discharge day management includes communicating with all support services such as

visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow up for wound checks, suture/staple removal, etc.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Gary Seabrook, MD Bibb Allen, MD Zachary Rattner, MD Robert Vogelzang, MD				
<b>Specialty(s):</b>	Society for Vascular Surgery American College of Radiology Society of Interventional Radiology				
<b>CPT Code:</b>	33880				
<b>Sample Size:</b>	200	<b>Resp n:</b>	41	<b>Response:</b> 20.50 %	
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	21.00	30.00	33.00	37.00	60.00
<b>Pre-Service Evaluation Time:</b>			90.0		
<b>Pre-Service Positioning Time:</b>			20.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			20.0		
<b>Intra-Service Time:</b>	90.00	180.00	225.00	240.00	360.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>45.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>90.0</u>	99231x 1.0	99232x 1.0	99233x 1.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<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:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
34803	090	24.00

CPT Descriptor Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35646	090	30.95

CPT Descriptor 1 Bypass graft with other than vein, aortobifemoral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
37182	000	16.97

CPT Descriptor Transvenous Intrahepatic Portocaval Shunt (TIPS)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 43.9 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 33880</u>	<u>Key Reference CPT Code: 34803</u>
Median Pre-Service Time	130.00	110.00
Median Intra-Service Time	225.00	165.00
Median Immediate Post-service Time	45.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	90.0	49.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	46.0	38.00
Median Total Time	572.00	428.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.78	3.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.89	4.11
Urgency of medical decision making	4.11	3.72

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

Technical skill required	4.94	4.33
Physical effort required	4.50	4.06

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	5.00	4.28
Outcome depends on the skill and judgment of physician	5.00	4.56
Estimated risk of malpractice suit with poor outcome	4.83	4.17

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

Pre-Service intensity/complexity	4.89	4.06
Intra-Service intensity/complexity	4.94	4.22
Post-Service intensity/complexity	4.28	3.56

**ADDITIONAL RATIONALE**

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

**SUMMARY OF ADDITIONAL RATIONALE**

Repairing a descending thoracic aortic aneurysm or dissection that requires precise deployment of the proximal component right across the origin of the left subclavian artery is the most complex and challenging endovascular procedure yet devised. The hemodynamic forces across the aortic arch are extreme. In addition, the arch itself lies on a

completely oblique three-dimensional plane between AP and true lateral, and in order to accomplish accurate device deployment the imaging guidance must identify the exact orthogonal coordinates. Nevertheless, the reduction in patient morbidity and mortality accomplished by noninvasive repair of the descending thoracic aorta makes this procedure a standout in minimally invasive surgery. This brief introduction should help one understand why the recommendation RVWs is more than those previously recommended for endovascular infrarenal aortic repairs.

The multispecialty Consensus Panel that reviewed the survey results determined that the median survey RVW of 33.00 is appropriate. We recommend the median based on comparison with three similarly complex and intense procedures, all of which have been RUC surveyed. The three comparisons include the most commonly chosen key reference, which is an infrarenal aortic endovascular repair, an open aortic repair, and a complex interventional radiology procedure. The median survey RVW of the new service withstands intensive comparisons to benchmark procedures performed by both participating specialties.

#### BUILDING AN RVW FOR 388X1 FROM KEY REFERENCE SERVICE 34803

Commonly chosen clinical reference service 34803 (Endovascular repair of infrarenal aorta using modular bifurcated prosthesis with two docking limbs) has the following characteristics compared to the new service. It can be seen that pre-time elements are similar, intra-time is longer for the new service, post-op inpt stay is one-day longer, and office visits are the same number although one level more complex for the new service.

	34803	3388X1
Global Period	90-days	90-days
RVW	24.00	33.00 median survey
Pre-service eval:	75 min	90 min
Pre-service position:	15 min	20 min
Pre-service SDW:	20 min	20 min
Intra-service:	165 min	225 min
Immed Post:	30 min	45 min
Inpatient Visits:	3	4
Outpt Visits:	2	2
IWPUT from survey data	0.104	0.103

In order to construct an RVW for 388X1 from 34803, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** 34803 has 110-minutes of pre-service time according to the RUC database. New service 3388X1 has 15 minutes additional evaluation time and 5-minutes more positioning time, both consistent with the additional complexity of a procedure involving the aortic arch where the left subclavian artery will be intentionally occluded. The difference represents 0.45 RVUs in favor of 3388X1 ( $20 \times 0.0224$ ). Total Pre-service work for 34803 is 1.96 RVUs, and based on that, Pre-service work for 3388X1 is 2.41 RVUs.

**INTRA-SERVICE WORK:** Intra-service time for 3388X1 is 225-minutes, while 34803 intra-service time is 165-minutes. Despite the calculated IWPUTs, the intra-service intensity of 3388X1 is higher according to the intensity measures 4.94 compared to 4.22. In addition, everyone on the Consensus Panel agrees the new service, involving deployment of endovascular components in the aortic arch, crossing the great vessel origins, is clearly more intense than 34803. Thus, to build intraservice work of 3388X1 from 34803, we need to make a time adjustment ( $225/165$ ) and an intensity adjustment ( $4.94/4.22$ ). Intra-service work of 34803 is 17.09 RVUs. Intra-service work of 3388X1 may then be calculated as  $(225/165) \times (4.94/4.22) \times 17.09 = 27.19$ .

**POST-SERVICE WORK:** 34803 has 30-minutes of immediate post-service time. 3388X1 has 45 minutes of immediate post-service time consistent with involvement of aortic arch, need to perform neurologic evaluation, left arm perfusion evaluation, etc. Thus, immediate post service favors 3388X1 by  $15 \times 0.0224 = 0.34$  RVUs. In addition, 3388X1 has an additional inpatient day, assigned a 99233 visit that is not present in 34803. Finally, the office visit pattern for the new service is one each of 99214 and 99213 for new service compared to one each of 99213 and 99212 for 34803.

## SUMMARY of 3388X1 built from 34803

	34803	3388X1 built from 34803
Pre-service:	1.96	2.41
Intra-service:	17.31	27.19
Remainder InPt stay:	3.65	4.76
Office Visits:	1.08	1.73
Total Service RVW:	24.00 (=2005 MFS)	36.09 RVW for 3388X1 based on key reference service

According to this comparison with the key reference service, the respondents median survey RVW of 33.00 actually underestimated the true value of the new service by more than 3 RVUs.

## BUILDING AN RVW FOR 388X1 FROM AN OPEN AORTIC REPAIR ON THE MPC LIST

The MPC list reference is CPT 35646, Bypass with other than vein, aortobifemoral. This is an "A" service on the MPC list with the following characteristics. 35646 was evaluated by the RUC in April 2001.

	35646	3388X1
Global Period	90 days	90 days
2005 RVW:	30.95	33.00 median survey
Pre-eval:	70 min	90 min
Pre-position	15 min	20 min
Pre-SDW	15 min	20 min
Intra-service:	210 min	225 min
Immed Post:	30 min	45 min
Inpatient visits:	7	4
Office visits:	3	2
IWPUT*	0.093	0.103 (*IWPUTs calculated from survey data)

In order to construct an RVW for 388X1 from 35646, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** Compared to 35646, 3388X1 has 25-minutes additional evaluation time and 5-minutes more scrub, dress, wait time. The difference represents 0.60 RVUs in favor of 3388X1 ( $25 \times 0.022 + 5 \times 0.008$ ). Total Pre-service work for 35646 is 1.95 RVUs, and based on that, Pre-service work for 3388X1 is 2.55 RVUs.

**INTRA-SERVICE WORK:** Intra-service time for 3388X1 is 225-minutes, while 35646 intra-service time is 210-minutes. Intra-service intensity of 3388X1 is greater than that of the reference service, so adjustments for time and intensity must be made. Intra-service work of 35646 is 19.55 RVUs. Intensity adjustment can be considered as  $0.103/0.093$ . A time adjustment is  $225/210$ . Thus, the intra-service work of 388X1 may be estimated at  $19.55 \times (225/210) \times (0.103/0.093) = 23.18$ .

**POST-SERVICE WORK:** 35646 has 30-minutes of immediate post-service time, 1x99233, 2x99232, 3x99231, 1x99238, 1x99214, and 2x99212. 388X1 has 30 minutes of immediate post-service time and one MMM hospital visit. Mathematical adjustments for post-service time and visits result in  $MMM = MMM$  RVUs.

## SUMMARY of 3388X1 built from 35646

	35646	3388X1 built from 35646
Pre-service:	1.95	2.55
Intra-service:	19.56	23.18
Remainder InPt stay:	7.50	4.76
Office Visits:	1.94	1.73
Total Service RVW:	30.95 (=2005 MFS)	32.22 RVW for 3388X1 based on open aortic surgery 35646

This comparison justifies an RVW for 388X1 of 32.22 RVUs, slightly less than the median survey. Thus, of the two analyses thus far, the first justified 3.5 RVUs more than median survey while the second justified 0.8 RVUs less.

#### BUILDING AN RVW FOR 3388X1 FROM INTERVENTIONAL RADIOLOGY PROCEDURE 37182 TIPS

This comparison determines an RVW for 388X1 based on the RUC-surveyed interventional radiology reference service CPT 37182, Transvenous Intrahepatic Portocaval Shunt (TIPS). TIPS is a complex multi-step interventional stenting procedure typically performed in extremely ill patients, so in that sense it is much like 388X1. The RUC surveyed TIPS in 2002.

	37182 TIPS	3388X1
Global Period:	0-days	90-days
2005 RVW	16.97	33.00 median survey
Pre-eval:	15 min	90 min
Pre-position:	10 min	20 min
Pre-SDW	5 min	20 min
Intra-service:	150-min	225 min
Post-service:	30-min	45 min
Inpatient visits	0	4
Office visits	0	2
IWPUT*	0.106	0.103 (*IWPUTs calculated from survey data)

In order to construct an RVW for 388X1 from TIPS, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** TIPS has 30-minutes of pre-service time in the RUC database. Assuming that represents 25-minutes of evaluation and 5-minutes of scrub/drape/wait, then 3388X1 has 85-minutes additional evaluation time and 17 minutes more SDW time than TIPS. The difference represents 1.94 RVUs in favor of 3388X1 ( $85 \times 0.0224 = 1.90$ ). Total Pre-service work for TIPS is 0.46 RVUs, and based on that, Pre-service work for 3388X1 should be 2.40 RVUs.

**INTRA-SERVICE WORK:** Intra-service time for 3388X1 is 225-minutes, while TIPS intra-service time is 150-minutes. Intra-service intensity of TIPS is similar to that of 388X1 based on IWPUT, so an adjustment for time is the major factor. Intra-service work of TIPS is 15.84. Based on a time adjustment (without intra-service intensity adjustment) the intra-service work of 388X1 may be estimated at  $225/150 \times 15.84 = 23.76$ .

**IMMEDIATE POST-SERVICE WORK:** TIPS has 30-minutes of immediate post-service time to complete the 0-day global. 388X1 has 45 minutes of immediate post-service time. Thus, for immediate post-service work TIPS has 0.67 post-service RVUs, while 388X1 has  $45 \times 0.0224 = 1.01$  RVUs.

**REMAINING POST-SERVICE WORK:** TIPS has none since it is a 0-day global. 388X1 has a discharge visit and 2 outpatient visits. Thus,  $1.28 + 0.65 + 0.65 = 2.58$  RVUs for 388X1.

#### SUMMARY:

	37182 TIPS	3388X1 built from TIPS
Pre-service:	0.46	2.40
Intra-service:	15.84	23.76
Immed Post Service:	0.67	1.01
Remainder Inpt & OV:	0.00	6.22
Total Service RVW:	16.97 (=2005 MFS)	33.39 RVW for 3388X1 based on TIPS

Thus, building an RVW for 3388X1 from TIPS results in a value of 33.39, again justifying the median survey RVW for 3388X1 of 33.00 RVUs. The three parallel analyses result in values of 36.09, 32.22, and 33.39, bracketing the median survey. We stand by our recommended median survey value of 33.00 for 3388X1.

## RELATIVE VALUES OF ENDOVASCULAR AORTIC AND ILIAC REPAIRS

Several procedures now populate the endovascular repair family. It may be of interest to see how they relate to each other. Unfortunately, this writer cannot determine how to insert a graph on the work summary recommendation form, but the RVWs are as follows, indicating appropriateness of relativity:

CPT	Descriptor	Global	RVW
34900	Endovascular Repair Iliac artery aneurysm	90	16.36
34800	Endovascular Repair infrarenal abd aorta, tube graft	90	20.72
34804	Endovascular Repair infrarenal abd aorta, one-piece bifurcated graft	90	22.97
34802	Endovascular Repair infrarenal abd aorta, 2-component bifurcated graft	90	22.97
34803	Endovascular Repair infrarenal abd aorta, 3-component bifurcated graft	90	24.00
3388X2	Endovascular Repair thoracic aorta beyond Lt subclavian, multiple components	90	28.00
3388X1	Endovascular Repair thoracic aorta crossing Lt subclavian, multiple components	90	33.00

The multispecialty consensus panel that evaluated the two new services believe the relative positions on this ladder of services, and the relative magnitudes are appropriate.

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## 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. Physician 1 performs 3388X1 Endovascular repair of descending thoracic aorta  
Physician 1 performs 34812 Open femoral artery exposure, 0-day global with mult procedure reduction  
Physician 1 performs 36200 Catheter introduced into aorta, 0-day global with mult procedure reduction
6. Physician 2 performs 36200 Catheter introduced into aorta, percutaneously from opposite groin
7. Physician 2 performs 7595X1 Radiological S&I for 3388X1

Physician 1 earns  $33.00 + 3.37 + 1.51 = 37.88$  RVUs over the 90-day global period

Physician 2 earns  $7.00 + 1.51 = 8.51$  RVUs for the 0-day and XXX services

Physician 1 time is  $587+45+20=652$  minutes over a 90-day global period

Physician 2 time is  $140+20= 160$  minutes over a 0-day global period

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0033T

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

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

Specialty VS and IR                      How often? Sometimes

Specialty VS                              How often? Sometimes

Specialty IR                              How often? Sometimes

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

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

Specialty

	Frequency 1500	Percentage 100.00 %
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Specialty VS	Frequency 750	Percentage 50.00 %
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Specialty IR	Frequency 750	Percentage 50.00 %
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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 1000	Percentage 100.00 %
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Specialty VS	Frequency 500	Percentage 50.00 %
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Specialty IR	Frequency 500	Percentage 50.00 %
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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. 35646

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**

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CPT Code:33881 Tracking Number: II2 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **28.00**  
RUC RVU: **28.00**

CPT Descriptor: Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old male with hypertension, 50 pack-years smoking, and previous myocardial infarction is found to have a 7.0 cm diameter descending thoracic aortic aneurysm that begins several centimeters beyond the left subclavian artery origin. Risks and benefits of open surgical repair, endovascular repair, and watchful waiting have been discussed, and patient opted for endovascular repair. Perioperative risk evaluation including cardiac workup indicated suitability for an endovascular approach. Imaging studies (typically a combination of CT scan, MRI, and/or angiography) demonstrate that the aneurysm is within acceptable parameters for endovascular repair. Endovascular repair of his descending thoracic aortic aneurysm is performed. The proximal portion of the endoprosthesis does not cover the left subclavian artery origin.

NOTE: The proposed new code includes all distal extensions required to complete the typical repair. This code follows endovascular repair guidelines such that open arterial exposure, arterial catheterization, and radiological supervision and interpretation are separately reported.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 9%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Review history, physical, and all pre-operative risk assessment studies
- Perform mandated update, with special attention to cardiovascular symptoms
- Perform extensive review and measurement of imaging studies (some combination of CT , CT angiogram, CT with 3-D reconstructions, MRI, angiograms) to determine the exact measurements of aorta
- Based on measurements, determine all potential components required for repair, plus contingencies and backups
- Ensure presence of all required components
- Review operative plan, risks and benefits with patient and family
- Review informed consent and obtain patient signature
- Conduct final operative coordination and planning with anesthesia and nursing teams
- Don surgical scrubs & lead
- Position patient
- Prep, scrub, drape and wait

**Description of Intra-Service Work:**

Reporting 3388X2 will follow the detailed coding guidelines in the CPT introductory notes for Endovascular Repairs. It is important to note that 3388X2 includes deployment of as many distal extension components as required to complete the repair. The intra-service work begins after achieving arterial exposure and after initial catheter and guidewire placement have been completed. The intraservice work includes:

- Perform road-mapping arteriogram with specific attention to great vessel artery origins, celiac origin
- Image aortic arch and descending thoracic aorta in multiple projections to determine exact orthogonal coordinates
- Wait for anesthesia to insert and adjust TEE, if employed

Perform final out-of-body examination of endovascular components for correct models, diameters, lengths, etc  
 Exchange soft J-wires for superstiff wires  
 Unpackage the initial component, inspect for damage, and prepare the device for insertion  
 Anticoagulate patient with IV heparin  
 Load initial component and carrier onto superstiff wire and advance to the femoral artery  
 Introduce tip of carrier into arteriotomy  
 Open proximal vascular clamp and advance leading edge of device into artery  
 Use rubber constrictor loops to limit blood loss  
 Under fluoroscopic guidance direct first component and carrier through external iliac  
 Advance first component & carrier into common iliac, abdominal aorta, thoracic aorta up to arch  
 Advance with extreme care so nose-cone lies in arch with leading edge of component just beyond left subclavian origin  
 Repeat arteriography as needed to absolutely confirm great vessel origins wrt leading edge of device  
 Ask anesthesiologist to lower blood pressure and wait for desired effect  
 Begin deployment  
 Perform contrast injections in multiple planes to allow final exact positioning  
 Make final precise adjustments to align leading edge of component just beyond left subclavian origin  
 Deploy initial component with constant attention to exact positioning  
 Advance carrier to recapture nose-cone  
 Retract carrier and nose-cone with care not to disturb 1st component  
 Back carrier & nose-cone through descending aorta & through iliac arteries with care not to disrupt iliacs  
 Remove 1st component carrier from femoral artery, reclamp artery  
 Introduce compliant balloon under fluoro guidance, advance through iliac, abd aorta, thoracic aorta, into component  
 Warn anesthesiologist that aortic arch is about to be occluded  
 Inflate compliant balloon under constant fluoroscopic observation to expand & seat first component  
 Deflate compliant balloon and back carefully out of 1st component  
 Advance multi-sidehole catheter into aortic arch  
 Inject contrast and image graft to confirm accurate placement  
 Prepare and load second component onto superstiff wire in groin  
 Advance 2nd component into femoral artery, thru iliacs, thru abdominal aorta, into thoracic aorta  
 Observe fluoroscopically while carefully invaginating 2nd component into first  
 Adjust overlap  
 Advance multi-sidehole catheter and inject contrast to ensure distal edge hasn't covered celiac  
 Make final leading and following edge adjustments with imaging  
 Deploy 2nd component  
 Carefully retract carrier without disrupting deployed components or iliac artery  
 Remove carrier from groin, minimize blood loss  
 Advance multi-sidehole catheter and inject contrast to assess positioning of 2nd component, endoleak, etc  
 Determine need for additional distal components  
 Repeat all above steps in sequence with sufficient components to complete a hemostatic distal anastomosis above celiac  
 Introduce compliant balloon for final expansion and seating of all additional component  
 Final arteriogram to determine appropriate coverage, patency of major arteries, absence of endoleaks  
 Remove introducers, using fluoroscopic guidance to prevent disruption of graft position  
 Perform completion pressure measurements  
 Remove catheters/wires/sheaths using fluoroscopic guidance

**Description of Post-Service Work:** Post-service work begins after skin closure. Tasks include apply dressings, transfer patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he/she is fully awake. When stable, the patient is transferred to the floor. The physician makes daily visits, takes history, performs physical exam, makes assessment and plan, writes orders & notes, and communicates with patient, family, nurses, and other care givers. Discharge day management includes communicating with all support services such as

visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow up for wound checks, suture/staple removal, etc.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>		Gary Seabrook, MD Bibb Allen, MD Zachary Rattner, MD Robert Vogelzang, MD			
<b>Specialty(s):</b>		Society for Vascular Surgery American College of Radiology Society of Interventional Radiology			
<b>CPT Code:</b>		33881			
<b>Sample Size:</b>	200	<b>Resp n:</b>	41	<b>Response:</b>	%
<b>Sample Type:</b>		Random			
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		21.00	26.00	28.00	32.00
<b>Pre-Service Evaluation Time:</b>				75.0	
<b>Pre-Service Positioning Time:</b>				20.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				20.0	
<b>Intra-Service Time:</b>		60.00	150.00	200.00	220.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>		
<b>Immed. Post-time:</b>		<u>40.00</u>			
<b>Critical Care time/visit(s):</b>		<u>0.0</u>	99291x 0.0	99292x 0.0	
<b>Other Hospital time/visit(s):</b>		<u>90.0</u>	99231x 1.0	99232x 1.0	99233x 1.0
<b>Discharge Day Mgmt:</b>		<u>36.0</u>	99238x 1.00	99239x 0.00	
<b>Office time/visit(s):</b>		<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:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
34803	090	24.00

CPT Descriptor Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35646	090	30.95

CPT Descriptor 1 Bypass graft with other than vein, aortobifemoral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
37182	000	16.97

CPT Descriptor Transvenous Intrahepatic Portocaval Shunt (TIPS)

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

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

Number of respondents who choose Key Reference Code: 20      % of respondents: 48.7 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 33881</u>	<u>Key Reference CPT Code: 34803</u>
Median Pre-Service Time	115.00	110.00
Median Intra-Service Time	200.00	165.00
Median Immediate Post-service Time	40.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	90.0	49.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	46.0	38.00
Median Total Time	527.00	428.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.25	3.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.10
Urgency of medical decision making	4.15	3.80

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

Technical skill required	4.80	4.35
Physical effort required	4.45	4.10
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.95	4.20

Outcome depends on the skill and judgment of physician	4.95	4.20
Estimated risk of malpractice suit with poor outcome	4.70	4.10

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

Pre-Service intensity/complexity	4.45	4.05
Intra-Service intensity/complexity	4.60	4.25
Post-Service intensity/complexity	3.75	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.*

**SUMMARY OF ADDITIONAL RATIONALE**

Repairing a descending thoracic aortic aneurysm or dissection that requires precise deployment of the proximal component just past the origin of the left subclavian artery is an extremely complex and challenging endovascular procedure. The hemodynamic forces in the proximal descending thoracic aorta are extreme. In addition, the distal arch

and proximal descending thoracic aorta lie in a completely oblique plan between AP and true lateral, and in order to accomplish accurate device deployment the fluoroscopic imaging must identify absolutely optimal coordinates. Nevertheless, the reduction in patient morbidity and mortality accomplished by noninvasive repair of the descending thoracic aorta makes this procedure a standout in minimally invasive surgery. This brief introduction should help one understand why the recommendation for RVW is more than that for endovascular infrarenal aortic repair.

The multispecialty Consensus Panel that reviewed the survey results determined that the median survey RVW of 28.00 is appropriate and well justified by the following analyses. We compared this new service to three similarly complex procedures, all of which have been RUC surveyed. The three references we chose include the most commonly cited key reference service (an infrarenal aortic endovascular repair), plus an open aortic reconstruction, and also a complex interventional radiology procedure. Thus, our recommended median survey RVW withstands intensive comparison to these benchmark procedures performed by the two participating specialties.

#### BUILDING AN RVW FOR 388X2 FROM COMMONLY CHOSEN KEY REFERENCE SERVICE 34803

Reference service 34803, Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, using a modular bifurcated prosthesis with two docking limbs, has the following characteristics compared to new service 3388X2.

	34803	388X2
Global Period	90-days	90-days
RVW	24.00	28.00 median survey
Pre-eval:	75 min	75 min
Pre-position:	15 min	20 min
Pre-SDW:	20 min	20 min
Intra-service:	165 min	200 min
Immed Post:	30 min	40 min
Inpatient Visits:	3	4
Outpt Visit:	2	2
IWPUT from survey data	0.104	0.093

In order to construct an RVW for 388X2 from 34803, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** 34803 has 110-minutes of pre-service time according to the RUC database. New service 3388X2 has the same pre-service evaluation time, 5-minutes more positioning time, and the same scrub, prep, wait time. The difference represents 0.11 RVUs in favor of 388X2 (5x0.0224). Total Pre-service work for 34803 is 1.96 RVUs, and based on that, Pre-service work for 388X2 is 2.17 RVUs.

**INTRA-SERVICE WORK:** Intra-service time for 388X2 is 200-minutes, while 34803 intra-service time is 165-minutes. Despite the IWPUTs calculated from the survey data, the respondents rated intra-service intensity as being greater for the new service (4.60) than the reference service (4.25). Additionally, all members of our multispecialty consensus panel agreed that deployment of a thoracic endovascular prosthesis is more complex than deploying an infrarenal device. The adjustment for time is 200 minutes compared to 165 minutes. Intra-service work of 34803 is 17.09 RVUs. Intensity adjustment can be considered as 4.60/4.25. The time adjustment is 200/165. Thus, the intra-service work of 388X2 may be estimated  $(200/165) \times (4.60/4.25) \times 17.09 = 22.33$ .

**POST-SERVICE WORK:** 34803 has 30-minutes of immediate post-service time, while 388X2 has 40 minutes. 34803 has three inpt visits (232,231,238), while 3388X2 has four (233,232,231,238), with the more intense visit justified by the need for thorough neurologic evaluation for possible spinal cord ischemia, etc. Both services have two office visits, but the thoracic repair has a more complex pattern (214, 213) than the infrarenal repair (213, 212), again justified by the increased potential problems associated with the thoracic repair. Thus, 34803 has 3.65 post-service inpt RVUs and 1.08 office visit RVUs, while 388X2 has 5.39 post-service inpt RVUs and 1.73 office visit RVUs.

## SUMMARY of 388X2 built from 34803

	34803	3388X2 built from 34803
Pre-service:	1.96	2.17
Intra-service:	17.31	22.33
Remainder InPt stay:	3.65	5.39
Office Visits:	1.08	1.73
Total Service RVW	24.00 (=2005 MFS)	31.62 RVW for 3388X2 based on comparison with key ref

According to this comparison with key reference service 34803, the survey respondents median RVW actually underestimates the true value of 3388X2 by more than 3 RVUs.

## BUILDING AN RVW FOR 388X2 FROM AN OPEN AORTIC REPAIR ON THE MPC LIST

The MPC list reference is CPT 35646, Bypass with other than vein, aortobifemoral. This is an "A" service on the MPC list with the following characteristics. 35646 was evaluated by the RUC in April, 2001.

	35646	3388X2
Global Period	90-days	90-days
2005 RVW:	30.95	28.00 median survey
Pre-eval:	70 min	75 min
Pre-position	15 min	20 min
Pre-SDW	15 min	20 min
Intra-service:	210 min	200 min
Immed Post:	30 min	40 min
Inpatient Visits:	7	4
Office visits	3	2
IWPUT from survey data	0.093	0.093

In order to construct an RVW for 388X2 from 35646, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** Compared to 35646, 388X2 has 5-minutes additional evaluation time, 5-minutes more positioning time, and 5-minutes more scrub, dress, wait time. The difference represents 0.26 RVUs in favor of 388X2 ( $10 \times 0.0224 + 5 \times 0.008$ ). Total Pre-service work for 35646 is 1.95 RVUs, and based on that, Pre-service work for 388X2 is 2.21 RVUs.

**INTRA-SERVICE WORK:** Intra-service time for 388X2 is 200-minutes, while 35646 intra-service time is 210-minutes. Intra-service intensity of 388X2 according to IWPUT of the survey data is exactly equal to the reference service, so adjustment need be made only for time. Intra-service work of 35646 is 19.55 RVUs. The time adjustment is  $200/210 = 0.95$ . Thus, the intra-service work of 388X2 may be estimated at  $19.55 \times 0.95 = 18.57$ .

**POST-SERVICE WORK:** 35646 has 30-minutes of immediate post-service time, 1x99233, 2x99232, 3x99231, 1x99238, 1x99214, and 2x99212. 388X2 has 40 minutes of immediate post-service time, and one each of 99233, 99232, 99231, 99238, 99214, 99213. Calculation of inpatient post-service work is 7.50 for 35646 and 5.39 for 3388X2. Calculation of office visit work is 1.94 for 35646 and 1.73 for 3388X2

## SUMMARY of 388X2 built from 35646:

	35646	3388X2 built from 35646
Pre-service:	1.95	2.21
Intra-service:	19.56	18.57
Remainder InPt stay:	7.50	5.39
Office Visits:	1.94	1.73
Total Service RVW	30.95 (=2005 MFS)	27.90 RVW for 3388X2 based on comparison with 35646

Thus, building 3388X2 based on an established open surgical reconstruction of the infrarenal aorta, 35646, an "A" level MPC list procedure, results in an RVW of 27.90, essentially equal to the median survey value of 28.00.

#### BUILDING AN RVW FOR 3388X2 FROM INTERVENTIONAL PROCEDURE 37182 TIPS

This comparison determines an RVW for 3388X2 based on the RUC-surveyed interventional reference service CPT 37182, Transvenous Intrahepatic Portocaval Shunt (TIPS). TIPS is a complex multi-step interventional stenting procedure typically performed in ill patients with many comorbidities, much like 3388X2. The RUC surveyed TIPS in 2002.

	37182 TIPS	3388X2
Global Period:	0-days	90-days
2005 RVW:	16.97	28.00 median survey
Pre-eval:	15 min	75 min
Pre-position:	10 min	20 min
Pre-SDW:	5 min	20 min
Intra-service:	150 min	200 min
Post-service:	30 min	40 min
Inpatient visits:	0	4
Office visits:	0	2
IWPUT*	0.106	0.093 (*IWPUTs calculated from survey data)

In order to construct an RVW for 3388X2 from TIPS, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** TIPS has 30-minutes of pre-service time in the RUC database. Assuming that represents 15-minutes of evaluation, 10-minutes of positioning, and 5-minutes of scrub/prep/drape, then 3388X2 has 60-minutes additional evaluation time, 10 minutes more positioning time, and 15-minutes more scrub,dress,wait time than TIPS. The difference represents 1.68 RVUs in favor of 3388X2 ( $60 \times 0.0224 + 10 \times 0.0224 + 15 \times 0.008$ ). Total Pre-service work for TIPS is 0.46 RVUs, and based on that, Pre-service work for 3388X2 is 2.14 RVUs.

**INTRA-SERVICE WORK:** Intra-service time for 3388X2 is 200-minutes, while TIPS intra-service time is 150-minutes. Intra-service intensity of TIPS, according to calculated IWPUTs, is greater than that of 3388X2, so an adjustment for intensity must be made ( $0.093/0.106 = 0.88$ ). Intra-service work of TIPS is 15.84. Based on a time adjustment ( $200/150 = 1.30$ ) the intra-service work of 3388X2 may be estimated as  $0.88 \times 1.30 \times 15.84 = 18.12$ .

**IMMEDIATE POST-SERVICE WORK:** TIPS has 30-minutes of post-service time to complete the 0-day global. 3388X2 has 40-minutes of immediate post-service time. Thus, for immediate post-service work, TIPS has  $30 \times 0.0224 = 0.67$  RVUs, while 3388X2 has  $40 \times 0.0224 = 0.90$  RVUs.

**POST-SERVICE WORK AFTER DAY OF SERVICE:** TIPS has none since it is a 0-day global. 3388X2 has a discharge visit and 2 outpatient visits. Thus,  $1.28 + 0.65 + 0.65 = 2.58$  RVUs for 3388X2.

#### SUMMARY:

	37182 TIPS	3388X2 built from TIPS
Pre-service:	0.46	2.14
Intra-service:	15.84	18.12
Immed Post-service:	0.67	0.90
Remainder Inpt and office:	0.00	6.22
Total Service RVW	16.97 (=2005 MFS)	27.38 RVW for 3388X2 based on comparison with TIPS

Having completed 3 independent verification analyses, we find the median survey of 28.00 is justified by calculations resulting in RVWs of 31.62, 27.90, and 27.38 for the new service. We stand by our recommendation for an RVW of 28.00.

## RELATIVE VALUES OF ENDOVASCULAR AORTIC AND ILIAC REPAIRS

Several procedures now populate the endovascular repair family. It may be of interest to see how they relate to each other. Unfortunately, this writer cannot determine how to insert a graph on the work summary recommendation form, but the RVWs are as follows, indicating appropriateness of relativity:

CPT	Descriptor	Global	RVW
34900	Endovascular Repair Iliac artery aneurysm	90	16.36
34800	Endovascular Repair infrarenal abd aorta, tube graft	90	20.72
34804	Endovascular Repair infrarenal abd aorta, one-piece bifurcated graft	90	22.97
34802	Endovascular Repair infrarenal abd aorta, 2-component bifurcated graft	90	22.97
34803	Endovascular Repair infrarenal abd aorta, 3-component bifurcated graft	90	24.00
3388X2	Endovascular Repair thoracic aorta beyond Lt subclavian, multiple components	90	28.00
3388X1	Endovascular Repair thoracic aorta covering Lt subclavian, multiple components	90	33.00

The multispecialty consensus panel that evaluated the two new services believe the relative positions on this ladder of services, and the relative magnitudes are appropriate.

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## 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. Physician 1 performs 3388X2, Endovascular repair of descending thoracic aorta, beyond left sub
4. Physician 1 performs 34812 Open femoral artery exposure, 0-day global with mult procedure reduction
5. Physician 1 performs 36200 Catheter introduced into aorta, 0-day global with mult procedure reduction
6. Physician 2 performs 7595X2 Radiological S&I for 3388X1
7. Physician 2 performs 36200 Catheter introduced into aorta from opposite groin, 0-day global

Physician 1 earns  $28.00 + 3.37 + 1.51$  RVUs = 32.88 RVUs for 90-days of care  
 Physician 2 earns  $6.00 + 1.51 = 7.51$  RVUs for the 0-day and XXX services

Physician 1 time is  $542 + 45 + 20 = 607$  minutes over the 90-day global period  
 Physician 2 time is  $110 + 20 = 130$  minutes during the day of procedure



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

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CPT Code:33883 Tracking Number: II3 Global Period: 090

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

CPT Descriptor: Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); initial extension

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old male with hypertension, 50 pack-years smoking, and previous myocardial infarction underwent endovascular repair of descending thoracic aortic aneurysm one year ago. On follow-up CT scan he is found to have a proximal endoleak. Risks and benefits of endovascular endoleak repair have been discussed, and he opted to proceed. Perioperative risk evaluation including cardiac workup indicated suitability for endovascular repair. Imaging studies (typically a combination of CT scan, MRI, and/or angiography) demonstrate that the endoleak is suitable for an endovascular approach. A proximal endovascular extension is deployed.

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:**

- Review history, physical, and all pre-operative risk assessment studies
- Perform mandated update, with special attention to cardiovascular symptoms
- Perform extensive review and measurement of imaging studies (some combination of CT, CT angiogram, CT with 3-D reconstructions, MRI, angiograms) to determine the exact measurements of aorta
- Based on measurements, determine all potential components required for repair, plus contingencies and backups
- Ensure presence of all required components
- Review operative plan, risks and benefits with patient and family
- Review informed consent and obtain patient signature
- Conduct final operative coordination and planning with anesthesia and nursing teams
- Don surgical scrubs & lead
- Position patient
- Prep, scrub, drape and wait

**Description of Intra-Service Work:**

Reporting 3388X3 will follow the detailed coding guidelines in the CPT introductory notes for Endovascular Repairs. It is important to note that 3388X3 will most often be performed as a complex stand-alone procedure for endovascular repairs that develop late Type I endoleaks. The intra-service work begins after achieving arterial exposure and initial catheter and guidewire placements. Intraservice work includes:

- Perform road-mapping arteriogram with specific attention to great vessel artery origins
- Image aortic arch in multiple projections to determine exact orthogonal coordinates to deploy prosthesis
- Wait for anesthesia to insert TEE if employed
- Final out-of-body examination of endovascular components for correct models, diameters, lengths, etc
- Exchange soft J-wires for superstiff wires
- Unpackage component, inspect for damage, and prepare for insertion

Anticoagulate patient with IV heparin  
 Load proximal extension onto superstiff wire and advance to the femoral artery  
 Introduce tip of main device into arteriotomy  
 Open proximal vascular clamp and advance leading edge into artery  
 Use rubber constrictor loops to limit blood loss  
 Under fluoroscopic guidance direct proximal extension device through external iliac  
 Advance device into common iliac, abdominal aorta, to descending thoracic aorta  
 Guide device under fluoroscopy into and through previously placed components  
 Direct nose-cone of carrier carefully around aortic arch so tip lies in ascending aorta  
 Repeat arteriography in multiple projections to assure leading edge of device appropriate to great vessel origins  
 Check fluoroscopically in multiple projections to assure trailing edge overlaps previous component adequately  
 Ask anesthesiologist to check position with TEE (if used)  
 Ask anesthesiologist to lower blood pressure and wait for desired effect  
 Begin deployment  
 Inject contrast in multiple planes for final pre-deployment assessment  
 Make final precise adjustments to align leading edge of component to required position wrt great vessel origins  
 Complete deployment  
 Advance carrier to nose-cone, retract both over wire, avoid displacing new or old endovascular components  
 Retract carrier through abdominal aorta and iliacs  
 Open vascular clamp and remove carrier/nosecone from arterial system  
 Backload and introduce compliant balloon  
 Guide balloon under fluoroscopy through pelvis, abdominal and descending thoracic aorta  
 Guide balloon into newly deployed component with care not to disrupt it  
 Check balloon position in multiple fluoroscopic projections to avoid great vessel injury  
 Warn anesthesiology that aorta will be occluded, reduce BP as needed  
 Inflate balloon to fully expand and seat component  
 Perform contrast injections in multiple planes to evaluate for position, possible leaks  
 Repeat balloon steps and/or other maneuvers as required to treat leaks  
 Final arteriogram to determine appropriate coverage, patency of major arteries, absence of endoleaks  
 Remove introducers, using fluoroscopic guidance to prevent disruption of graft position  
 Note that all balloon angioplasty steps described above are included in work of this service.

#### Description of Post-Service Work:

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

#### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Gary Seabrook, MD Bibb Allen, MD Zachary Rattner, MD Robert Vogelzang, MD
<b>Specialty(s):</b>	Society for Vascular Surgery American College of Radiology Society of Interventional Radiology

<b>CPT Code:</b> 33883					
<b>Sample Size:</b> 200	<b>Resp n:</b> 39		<b>Response:</b> 19.50 %		
<b>Sample Type:</b> Random					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	4.00	16.00	20.00	24.00	38.50
<b>Pre-Service Evaluation Time:</b>			70.0		
<b>Pre-Service Positioning Time:</b>			20.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			20.0		
<b>Intra-Service Time:</b>	60.00	95.00	120.00	145.00	200.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>30.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>49.0</u>	99231x 1.0	99232x 1.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<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:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
34825	090	11.98

CPT Descriptor Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection, initial vessel

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35646	090	30.95

CPT Descriptor 1 Bypass graft with other than vein, aortobifemoral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
37182	000	16.97

CPT Descriptor Transvenous Intrahepatic Portocaval Shunt (TIPS)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 35.8 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 33883	Key Reference CPT Code: 34825
Median Pre-Service Time	110.00	80.00
Median Intra-Service Time	120.00	60.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	49.0	49.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	46.0	38.00
Median Total Time	391.00	293.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.79	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.86	4.00
Urgency of medical decision making	4.21	3.64

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

Technical skill required	4.93	4.07
Physical effort required	4.50	3.64

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	5.00	4.00
Outcome depends on the skill and judgment of physician	5.00	4.21
Estimated risk of malpractice suit with poor outcome	4.93	3.86

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

Pre-Service intensity/complexity	4.93	3.64
Intra-Service intensity/complexity	4.86	4.00
Post-Service intensity/complexity	3.86	3.21

**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**

Repairing an endoleak at the leading edge of a prior endovascular repair of the descending thoracic aortic is a daunting task that requires the utmost in precise deployment of the proximal component, which, by design will either cross the left subclavian artery origin or abut its edge. This is an extremely complex and challenging endovascular procedure, and a

reoperation as well. The hemodynamic forces across the aortic arch are extreme. In addition, the arch itself lies on a completely oblique three-dimensional plane between AP and true lateral, and in order to accomplish accurate device deployment the imaging guidance must identify the exact orthogonal coordinates. Nevertheless, the reduction in patient morbidity and mortality accomplished by noninvasive repair of the descending thoracic aorta makes this procedure a standout in minimally invasive surgery. This brief introduction should help one understand why the RVW recommendation for an extension procedure are more than those previously attained for proximal or distal endovascular extension prostheses for aortic reconstruction.

The Multispecialty Consensus Panel that reviewed the survey results determined that the median survey RVW of 20.00 is appropriate and well justified by the following analyses. We compared this new service to three similarly complex procedures, all of which have been RUC surveyed. The three references we chose include 1) the most commonly cited key reference service (a proximal or distal extension for infrarenal endograft), 2) an open aortic reconstruction, and 3) a complex interventional radiology procedure. Thus, our recommended median survey RVW withstands intensive comparison to these benchmark procedures performed by the two participating specialties.

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## BUILDING AN RVW FOR 388X3 FROM COMMONLY CHOSEN KEY REFERENCE SERVICE 34825

Key reference service 34825 (Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection, initial vessel) has the following characteristics compared to new service 3388X3. It can be seen immediately that 3388X3 is a much longer and more complex procedure than the key reference.

	34825	3388X3
Global Period	90-days	90-days
RVW	11.98	20.00 median survey
Pre-eval:	50 min	70 min
Pre-position:	15 min	20 min
Pre-SDW:	15 min	20 min
Intra-service:	60 min	120 min
Immed Post:	30 min	30 min
Inpatient Visits:	3	3
Outpt Visit:	2	2
IWPUT from survey data	0.095	0.104

In order to construct an RVW for 3388X3 from 34825, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** 34825 has 80-minutes of pre-service time according to the RUC database, with distribution assumed as noted above. New service 3388X3 has 20-minutes more pre-service evaluation time, which appropriately reflects the complexity of a proximal thoracic aortic extension. In addition, 3388X3 has 5-minutes more positioning time, and 5-minutes more same scrub, prep, wait time than the reference service, again appropriate for positioning a patient who needs thoracic aortic reconstruction. The difference represents 0.60 RVUs in favor of 3388X3 ( $25 \times 0.022 + 5 \times 0.008$ ). Total Pre-service work for 34825 is 1.58 RVUs. Based on that, Pre-service work for 3388X3 is 2.18 RVUs.

**INTRA-SERVICE WORK:** Intra-service time for 3388X3 is 120-minutes, while 34825 intra-service time is 60-minutes. The respondents rated intra-service intensity as being very high overall for the new service (4.86), substantially greater than the reference service (4.00). Additionally, all members of our multispecialty consensus panel agreed that deployment of a thoracic endovascular proximal extension prosthesis is substantially more complex than deploying an infrarenal device. The adjustment for time is 120 minutes compared to 60 minutes. Intra-service work of 34825 is 5.67 RVUs. Intensity adjustment can be considered as  $4.86/4.00 = 1.21$ . The time adjustment is  $120/60 = 2.0$ . Thus, the intra-service work of 3388X3 may be estimated as  $1.21 \times 2.0 \times 5.67 = 13.72$ .

**POST-SERVICE WORK:** 34825 and 3388X3 have the same 30-minutes of immediate post-service time. In addition, they have the same inpatient visit pattern (232,231,238). The thoracic proximal extension 3388X3 has an appropriately more complex office visit pattern (214, 213) compared to the infrarenal extension (213, 212). Our Consensus Panel felt the thoracic inpatient visit pattern underestimated reality given the complexity of the service, but the adjustment here will be linear. Thus, both services have 3.65 post-service inpt RVUs. 3388X3 has 1.73 office visit RVUs, while 34825 has 1.08 office visit RVUs.

## SUMMARY of 3388X3 built from 34825:

	34825	3388X3 built from 34825
Pre-service:	1.58	2.18
Intra-service:	5.67	13.72
Remainder InPt stay:	3.65	3.65
Office Visits:	1.08	1.73
Total Service RVW	24.00 (=2005 MFS)	21.28 RVW for 3388X3 based on comparison with 34825

According to this comparison with key reference service 34825, the survey respondents median RVW of 20.00 actually underestimated the true value of the new 3388X3 service by more than one RVU.

**BUILDING AN RVW FOR 388X2 FROM AN OPEN AORTIC REPAIR ON THE MPC LIST**

The MPC list reference is CPT 35646, Bypass with other than vein, aortobifemoral. This is an "A" service on the MPC list with the following characteristics. 35646 was evaluated by the RUC in April 2001.

	35646	3388X3
Global Period	90-days	90-days
2005 RVW:	30.95	20.00 median survey
Pre-eval:	70 min	70 min
Pre-position	15 min	20 min
Pre-SDW	15 min	20 min
Intra-service:	210 min	120 min
Immed Post:	30 min	30 min
Inpatient Visits:	7	3
Office visits	3	2
IWPUT from survey data	0.093	0.104

In order to construct an RVW for 3388X3 from 35646, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** Compared to 35646, 3388X3 has the same evaluation time, 5-minutes more positioning time, and 5-minutes more scrub, dress, wait time. The difference represents 0.15 RVUs in favor of 3388X3 ( $5 \times 0.0224 + 5 \times 0.008$ ). Total Pre-service work for 35646 is 1.95 RVUs, and based on that, Pre-service work for 3388X3 is 2.10 RVUs.

**INTRA-SERVICE WORK:** Intra-service time for 3388X3 is 120-minutes, while 35646 intra-service time is 210-minutes. Intra-service intensity of 3388X3 according to IWPUT of the survey data is 0.104, while the reference service is 0.093, so an adjustment needs to be made. Intra-service work of 35646 is 19.55 RVUs. The time adjustment is  $120/210 = 0.57$ , and the intensity adjustment is  $0.104/0.093 = 1.12$ . Thus, the intra-service work of 3388X3 may be estimated at  $19.55 \times 0.57 \times 1.12 = 12.48$ .

**POST-SERVICE WORK:** 35646 has 30-minutes of immediate post-service time, 1x99233, 2x99232, 3x99231, 1x99238, 1x99214, and 2x99212. 3388X3 also has 30 minutes of immediate post-service time, and one each of 99232, 99231, 99238, 99214, 99213. Calculation of inpatient post-service work is 7.50 for 35646 and 3.65 for 3388X3. Calculation of office visit work is 1.94 for 35646 and 1.73 for 3388X3

**SUMMARY of 388X3 built from 35646**

	35646	3388X3 built from 35646
Pre-service:	1.95	2.10
Intra-service:	19.56	12.48
Remainder InPt stay:	7.50	3.65
Office Visits:	1.94	1.73
Total Service	30.95 (=2005 MFS)	19.96 RVW for 3388X3 based on comparison with 35646

Thus, building the new service 3388X3 RVW based on an established open surgical reconstruction of the infrarenal aorta, CPT 35646, which is an "A" level MPC list procedure, results in an RVW of 19.96, within hundredths of an RVU of the median survey value of 20.00.

## BUILDING AN RVW FOR 3388X3 FROM INTERVENTIONAL PROCEDURE 37182 TIPS

This comparison determines an RVW for 3388X3 based on the RUC-surveyed interventional reference service CPT 37182, Transvenous Intrahepatic Portocaval Shunt (TIPS). TIPS is a complex multi-step interventional stenting procedure typically performed in ill patients with many comorbidities, much like 3388X3. The RUC surveyed TIPS in 2002.

	37182 TIPS	3388X3
Global Period:	0-days	90-days
2005 RVW:	16.97	20.00 median survey
Pre-eval:	15 min	70 min
Pre-position:	10 min	20 min
Pre-SDW:	5 min	20 min
Intra-service:	150 min	120 min
Post-service:	30 min	30 min
Inpatient visits:	0	3
Office visits:	0	2
IWPUT*	0.106	0.104 (*IWPUTs calculated from survey data)

In order to construct an RVW for 3388X3 from TIPS, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** TIPS has 30-minutes of pre-service time in the RUC database. Assuming that represents 15-minutes of evaluation, 10-minutes of positioning, and 5-minutes of scrub/prep/drape, then 3388X3 has 55-minute additional evaluation time, 10 minutes more positioning time, and 15-minutes more scrub,dress,wait time than TIPS. The difference represents 1.57 RVUs in favor of 3388X3 ( $55 \times 0.0224 + 10 \times 0.0224 + 15 \times 0.008$ ). Total Pre-service work for TIPS is 0.46 RVUs. Based on that, Pre-service work for 3388X3 is 2.03 RVUs.

**INTRA-SERVICE WORK:** Intra-service time for 3388X3 is 120-minutes, while TIPS intra-service time is 150-minutes. Intra-service intensity of TIPS, according to calculated IWPUTs, is very close to that of 3388X3, so a minimal adjustment for intensity is ( $0.104/0.106 = 0.98$ ). Intra-service work of TIPS is 15.84. Based on a time adjustment ( $120/150 = 0.80$ ) the intra-service work of 3388X3 may be estimated as  $0.98 \times 0.80 \times 15.84 = 12.42$ .

**IMMEDIATE POST-SERVICE WORK:** TIPS has 30-minutes of post-service time to complete the 0-day global. 3388X3 also has 30-minutes of immediate post-service time. Thus, for immediate post-service work, both services have  $30 \times 0.0224 = 0.67$  RVUs.

**REMAINDER OF POST-SERVICE WORK:** TIPS has none since it is a 0-day global. 3388X3 has 99232, 99231, 99238, 99213 and 99212, for a total of 4.71 RVUs.

## SUMMARY:

	37182 TIPS	3388X3 built from TIPS
Pre-service:	0.46	2.03
Intra-service:	15.84	12.42
Immed Post-service:	0.67	0.67
Remainder Inpt and office:	0.00	4.71
Total Service RVW	16.97 (=2005 MFS)	19.83 RVW for 3388X3 based on comparison with TIPS

Having completed 3 independent verification analyses, we find the median survey of 20.00 is justified by comparison calculations resulting in RVWs of 21.28, 19.96, and 19.83 for the new service. We stand by our recommendation for 20.00



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

Frequency 500                      Percentage 100.00 %

Specialty VS                      Frequency 250                      Percentage 50.00 %

Specialty IR                      Frequency 250                      Percentage 50.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 400

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

Specialty VS                      Frequency 200                      Percentage 50.00 %

Specialty IR                      Frequency 200                      Percentage 50.00 %

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. 35694

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**

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**Recommended Work Relative Value**Specialty Society RVU: **8.20**RUC RVU: **8.20**

- CPT Code:33884 Tracking Number: II4 Global Period: ZZZ

CPT Descriptor: Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure)

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old male with hypertension, 50 pack-years smoking, and previous myocardial infarction underwent endovascular repair of descending thoracic aortic aneurysm one year ago. On follow-up CT scan he is found to have a proximal endoleak. Placement of one proximal extension prosthesis has been performed, but the endoleak persists. An additional proximal extension is required.

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? 9%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: None. Performed as part of main repair.

**Description of Intra-Service Work:**

The intra-service work of 3388X4 begins after the initial proximal extension (3388X3) has been deployed. Reporting 3388X4 also follows the detailed coding guidelines in the CPT introductory notes for Endovascular Repair. Arterial exposure and initial catheter and guidewire placement have already been performed. Intraservice work includes:

- Perform road-mapping arteriogram with specific attention to great vessel artery origins, and prior components
- Image aortic arch in multiple projections to determine exact orthogonal coordinates to deploy additional prosthesis
- Wait for anesthesia to adjust TEE if employed
- Final examination of endovascular component for correct model, size, etc
- Ensure superstiff guidewire is in appropriate position
- Unpackage component, examine for defects, prepare it for insertion
- Check to ensure anticoagulation remains adequate
- Load proximal extension component onto superstiff wire and advance to the femoral artery
- Introduce tip of device into arteriotomy
- Open proximal vascular clamp and advance nose-cone into artery
- Use rubber constrictor loops to limit blood loss
- Under fluoroscopic guidance direct proximal component through external iliac
- Advance component into common iliac, abdominal aorta, to descending thoracic aorta
- Guide new component under fluoroscopic guidance into and through previously placed devices
- Direct new component carefully around aortic arch so tip and nose-cone lie in ascending aorta
- Repeat arteriography in multiple projections to assure leading edge of component is appropriate to great vessel origins
- Check fluoroscopically in multiple projections to assure trailing edge overlaps previous component adequately
- Ask anesthesiologist to check position with TEE (if used)
- Ask anesthesiologist to lower blood pressure and wait for desired effect
- Begin deployment
- Inject contrast for final pre-deployment assessment
- Make final precise adjustments to align leading edge to required position wrt great vessel origins

## Complete deployment

Advance carrier to nosecone, retract both over wire, avoid displacing new or old endovascular components

Retract carrier through abdominal aorta and iliacs

Open vascular clamp and remove carrier/nosecone from arterial system

Backload and introduce compliant balloon

Guide balloon under fluoroscopy through pelvis, abdominal and descending thoracic aorta

Guide balloon into newly deployed component with care not to disrupt it

Check balloon position in multiple fluoroscopic projections to avoid great vessel injury

Warn anesthesiology that aorta will be occluded, reduce BP as needed

Inflate balloon to fully expand and seat component

Perform contrast injections in multiple planes to evaluate for position, possible leaks

Repeat balloon steps and/or other maneuvers as required to treat leaks

Final arteriogram to determine appropriate coverage, patency of major arteries, absence of endoleaks

Remove introducers, using fluoroscopic guidance to prevent disruption of graft position

Note that all steps described above are included in work of this service. No additional codes are reportable.

Description of Post-Service Work: None. Add-on code.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Gary Seabrook, MD Bibb Allen, MD Zachary Rattner, MD Robert Vogelzang, MD					
<b>Specialty(s):</b>	Society for Vascular Surgery American College of Radiology Society of Interventional Radiology					
<b>CPT Code:</b>	33884					
<b>Sample Size:</b>	200	<b>Resp n:</b>	41	<b>Response:</b> 20.50 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>		4.00	6.00	7.00	8.20	28.00
<b>Pre-Service Evaluation Time:</b>				0.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		20.00	45.00	60.00	90.00	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>0.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
34826	ZZZ	4.12

CPT Descriptor Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35600	ZZZ	4.94

CPT Descriptor 1 Harvest of upper extremity artery, one segment, for coronary artery bypass procedure

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 30      % of respondents: 73.1 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 33884	Key Reference CPT Code: 34826
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	60.00	30.00
Median Immediate Post-service Time	0.00	0.00
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	30.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.33	3.90
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	3.70
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Urgency of medical decision making	4.20	4.07
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.67	4.20
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Physical effort required	4.17	3.83
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.70	4.03
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Outcome depends on the skill and judgment of physician	4.67	4.27
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Estimated risk of malpractice suit with poor outcome	4.43	3.90
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
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Intra-Service intensity/complexity	4.63	3.87
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Post-Service intensity/complexity		
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**ADDITIONAL RATIONALE**

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

This patient is really in some trouble. He's already undergone an endovascular thoracic aorta reconstruction, and a year later he developed a leak. Today he's had a proximal extension deployed at the site of the leak, but the leak persists. The patient and his physicians are running out of options. One additional cuff will be placed, perhaps encroaching even closer to the left common carotid artery origin in the middle of the aortic arch. This is truly complex, high-intensity work.

## BUILDING AN RVW FOR 3388X4 FROM KEY REFERENCE SERVICE 34826

CPT code 34826, placement of an additional proximal or distal extension in the infrarenal aorta was chosen as the key reference service by 73% of survey respondents. 34826 and the new service have the following time, RVW and IWPUT attributes:

	34826	3388X4
Global	ZZZ	ZZZ
RVW:	4.12	7.00 median survey value
Intra-time	30 min	60 min
IWPUT	0.137	0.117

An RVW for new code 3388X4 can be determined by comparing intra-time and intra-intensity of the new code with the key reference. The intensity adjustment derives from the intensity tables above, as  $4.63/3.87 = 1.20$ . Our Consensus Panel readily agreed that placing an additional proximal thoracic endovascular extension is justifiably 20% more intense than a proximal or distal additional extension in the infrarenal aorta. The time adjustment is a straightforward  $60/30 = 2.0$ . Thus, one can build the new RVW for 3388X4 as the RVW for 34826 (4.12) x intensity adjustment x time adjustment =  $4.12 \times 1.20 \times 2.0 = 9.89$ . In conclusion, this analysis not only justifies the median survey of 7.00 RVUs, but also exceeds the 75<sup>th</sup> survey percentile, which is 8.20 RVUs.

## BUILDING AN RVW FOR 3388X4 FROM AN MPC LIST SERVICE

There are only a few ZZZ global services on the MPC list. CPT 35600 was evaluated by the RUC in Feb 2000. It is an "A" player on the MPC, with a value of 4.94 RVUs and a 40-minute intra-time. There is no pre or post work associated with this add-on code. The clinical service of 35600 involves harvesting the radial artery from the forearm for use in a coronary bypass graft operation, but the service itself is simply the harvest work. One can imagine this has significant intensity, performed under loupe magnification, etc. Nevertheless, it is difficult to think harvesting radial artery could be more intense than deploying a proximal thoracic aortic extension under precisely controlled fluoroscopic guidance in a patient with a recalcitrant endoleak.

Members of our Multispecialty Consensus Panel have experience with both procedures, and they agreed that the intensity of proximal thoracic aortic extension deployment is at least that of radial artery harvest. If we therefore assume intensity equality, an RVW for the new service can be calculated purely based on a time-adjustment.

3388X4 is a 60-minute service, while 35600 is a 40-minute service. The ratio is  $60/40 = 1.5$ . RVW for 35600 is 4.94. Thus, RVW for 3388X4 should be  $4.94 \times 1.5 = 7.41$ , a value substantially greater than the median survey RVW. If we can admit that deployment of the additional thoracic aortic extension is 10% more complex than the radial artery harvest, the value of the new service should be  $4.94 \times 1.5 \times 1.1 = 8.15$ , essentially the same as the 75<sup>th</sup> percentile survey value

In conclusion, both the comparison with the key reference service, and the comparison with an MPC listed service, readily justify the 75<sup>th</sup> percentile survey RVW of 8.20. The value of 8.20 is approximately 2/3ds of the intra-service work to deploy the initial extension (12-13 RVUs, see 3388X3). We recommend the 75<sup>th</sup> percentile survey value of 8.20 for this new 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: Yes



Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty

Frequency 200                      Percentage 100.00 %

Specialty VS                      Frequency 100                      Percentage 50.00 %

Specialty IR                      Frequency 100                      Percentage 50.00 %

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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 35683

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:33886 Tracking Number: II5 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **17.00**  
RUC RVU: **17.00**

CPT Descriptor: Placement of distal extension prosthesis(es) delayed after endovascular repair of descending thoracic aorta

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old male with hypertension, 50 pack-years smoking, and previous myocardial infarction underwent endovascular repair of descending thoracic aortic aneurysm one year ago. On follow-up CT scan he is found to have a distal endoleak. Placement of a distal extension is undertaken to seal the leak

NOTE: This code CANNOT be reported during the primary thoracic aortic repair. Distal stents placed during thoracic aortic endovascular repair are INCLUDED in the primary code. This code is only reportable if distal extensions are required at some date AFTER the primary thoracic aortic repair has been completed. This differs from the abdominal aortic endovascular reporting conventions.

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:**

- Review history, physical, and all pre-operative risk assessment studies
- Perform mandated update, with special attention to cardiovascular symptoms
- Perform extensive review and measurement of imaging studies (some combination of CT, CT angiogram, CT with 3-D reconstructions, MRI, angiograms) to determine the exact measurements of aorta
- Based on measurements, determine all potential components required for repair, plus contingencies and backups
- Ensure presence of all required components
- Review operative plan, risks and benefits with patient and family
- Review informed consent and obtain patient signature
- Conduct final operative coordination and planning with anesthesia and nursing teams
- Don surgical scrubs & lead
- Position patient
- Prep, scrub, drape and wait

**Description of Intra-Service Work:**

Reporting 3388X5 will follow detailed coding guidelines in the CPT introductory notes for Endovascular Repairs. Intra-service work begins after achieving arterial exposure and following initial catheter and guidewire placements. Intraservice work includes:

- Perform road-mapping arteriogram with specific attention to device placement and location of distal endoleak
- Image descending thoracic aorta in multiple projections to determine exact orthogonal coordinates to deploy prosthes.
- Wait for anesthesia to insert TEE if employed
- Final out-of-body examination of endovascular components for correct models, diameters, lengths, etc
- Exchange soft J-wires for superstiff wires
- Unpackage component, inspect for damage, and prepare for insertion

Anticoagulate patient with IV heparin  
 Load distal extension onto superstiff wire and advance to the femoral artery  
 Introduce tip of main device into arteriotomy  
 Open proximal vascular clamp and advance leading edge into artery  
 Use rubber constrictor loops to limit blood loss  
 Under fluoroscopic guidance direct distal extension device through external iliac  
 Advance nose-cone of device into common iliac, abdominal aorta, to descending thoracic aorta  
 Guide device under fluoroscopy into the previously placed components  
 Repeat arteriography in multiple projections to assure leading edge of extension overlaps existing device adequately  
 Check fluoroscopically in multiple projections to assure trailing edge of new component does not cover celiac origin  
 Ask anesthesiologist to check position with TEE (if used)  
 Ask anesthesiologist to lower blood pressure and wait for desired effect  
 Begin deployment  
 Inject contrast in multiple planes for final pre-deployment assessment  
 Make final precise adjustments to align leading and trailing edges of component to required position  
 Complete deployment  
 Advance carrier to nose-cone, retract both over wire, avoid displacing new or old endovascular components  
 Retract carrier through abdominal aorta and iliacs  
 Open vascular clamp and remove carrier/nosecone from arterial system  
 Backload and introduce compliant balloon  
 Guide balloon under fluoroscopy through pelvis, abdominal and descending thoracic aorta  
 Guide balloon into newly deployed component with care not to disrupt it  
 Check balloon position in multiple fluoroscopic projections to avoid injury  
 Warn anesthesiology that aorta will be occluded, reduce BP as needed  
 Inflate balloon to fully expand and seat component  
 Perform contrast injections in multiple planes to evaluate for position, possible leaks  
 Repeat balloon steps and/or other maneuvers as required to treat leaks  
**ALL ABOVE STEPS ARE REPEATED IN SEQUENCE IF MORE THAN ONE COMPONENT IS NEEDED**  
 Final arteriogram to determine appropriate coverage, patency of major arteries, absence of endoleaks  
 Remove introducers, using fluoroscopic guidance to prevent disruption of graft position  
 Note that all balloon angioplasty steps described above are included in work of this service.

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

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#### **SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Gary Seabrook, MD Bibb Allen, MD Zachary Rattner, MD Robert Vogelzang, MD
<b>Specialty(s):</b>	Society for Vascular Surgery American College of Radiology Society of Interventional Radiology
<b>CPT Code:</b>	33886

<b>Sample Size:</b> 200	<b>Resp n:</b> 39	<b>Response:</b> 19.50 %			
<b>Sample Type:</b> Random					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	4.00	13.00	<b>17.00</b>	20.20	30.00
<b>Pre-Service Evaluation Time:</b>			<b>65.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>20.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>20.0</b>		
<b>Intra-Service Time:</b>	60.00	90.00	<b>100.00</b>	120.00	200.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b><u>30.00</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b><u>49.0</u></b>	99231x 1.0	99232x 1.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b><u>36.0</u></b>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b><u>46.0</u></b>	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:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
34825	090	11.98

CPT Descriptor Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35646	090	30.96

CPT Descriptor 1 Bypass graft with other than vein, aortobifemoral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 19      % of respondents: 48.7 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 33886</u>	<u>Key Reference CPT Code: 34825</u>
Median Pre-Service Time	105.00	80.00
Median Intra-Service Time	100.00	60.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	49.0	49.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	46.0	38.00
Median Total Time	<b>366.00</b>	<b>293.00</b>
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.11	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.26	3.74
Urgency of medical decision making	4.11	3.58

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

Technical skill required	4.53	3.89
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Physical effort required	4.16	3.63
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.32	3.84
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Outcome depends on the skill and judgment of physician	4.58	4.00
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Estimated risk of malpractice suit with poor outcome	4.47	3.74
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.21	3.42
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Intra-Service intensity/complexity	4.32	3.74
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Post-Service intensity/complexity	3.42	2.95
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**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**

Repairing an endoleak at the distal edge of a prior endovascular repair of the descending thoracic aortic is a complex task that requires the extreme precision. In many cases this will require more than one component, although the service can only be reported once. The hemodynamic forces in the descending thoracic aorta are substantial, and the anatomy of the

aorta can be very tortuous. This brief introduction should help one understand why the RVW recommendation for distal thoracic extensions will be greater proximal or distal infrarenal abdominal aortic endovascular extensions, but less than placement of a proximal thoracic extension.

The Multispecialty Consensus Panel that reviewed the survey results determined that the median survey RVW of 17.00 is appropriate and well justified by the following analyses. We compared this new service to three similarly complex procedures, all of which have been RUC surveyed. The three references we chose include 1) the most commonly cited key reference service (a proximal or distal extension for infrarenal endograft), 2) an open aortic reconstruction, and 3) a complex interventional radiology procedure. Thus, our recommended median survey RVW withstands intensive comparison to these benchmark procedures performed by the two participating specialties.

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## BUILDING AN RVW FOR 388X5 FROM COMMONLY CHOSEN KEY REFERENCE SERVICE 34825

Key reference service 34825 (Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection, initial vessel) has the following characteristics compared to new service 3388X5. It can be seen immediately that 3388X5 is a much longer and more complex procedure than the key reference.

	34825	3388X5
Global Period	90-days	90-days
RVW	11.98	17.00 median survey
Pre-eval:	50 min	65 min
Pre-position:	15 min	20 min
Pre-SDW:	15 min	20 min
Intra-service:	60 min	100 min
Immed Post:	30 min	30 min
Inpatient Visits:	3	3
Output Visit:	2	2
IWPUT	0.095	0.096 (calculated from survey data)

In order to construct an RVW for 3388X5 from 34825, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** 34825 has 80-minutes of pre-service time according to the RUC database, with distribution assumed as noted above. New service 3388X5 has 15-minutes more pre-service evaluation time, which appropriately reflects the complexity of a thoracic aortic extension. In addition, 3388X5 has 5-minutes more positioning time, and 5-minutes more same scrub, prep, wait time than the reference service, again appropriate for positioning a patient who needs thoracic aortic reconstruction. The difference represents 0.49 RVUs in favor of 3388X5 ( $20 \times 0.0224 + 5 \times 0.008$ ). Total Pre-service work for 34825 is 1.58 RVUs. Based on that, Pre-service work for 3388X3 is 2.07 RVUs.

**INTRA-SERVICE WORK:** Intra-service time for 3388X5 is 100-minutes, while 34825 intra-service time is 60-minutes. The respondents rated intra-service intensity as being very high overall for the new service (4.32), substantially greater than the reference service (3.74). Additionally, all members of our multispecialty consensus panel agreed that deployment of a thoracic endovascular distal extension prosthesis is substantially more complex than deploying an infrarenal device (although less complex than a proximal thoracic extension). The intra-times are 100 minutes compared to 60 minutes. Intra-service work of 34825 is 5.67 RVUs. Intensity adjustment can be considered as  $4.32/3.74 = 1.16$ . The time adjustment is  $100/60 = 1.66$ . Thus, the intra-service work of 3388X5 may be estimated as  $1.16 \times 1.66 \times 5.67 = 10.92$ .

**POST-SERVICE WORK:** 34825 and 3388X5 have the same 30-minutes of immediate post-service time. In addition, they have the same inpatient visit pattern (232,231,238). The thoracic distal extension(s) 3388X5 has an appropriately more complex office visit pattern (214, 213) compared to the infrarenal extension (213, 212). Our Consensus Panel felt the thoracic inpatient and outpatient visit pattern is appropriate. Thus, both services have 3.65 post-service inpt RVUs. 3388X5 has 1.73 office visit RVUs, while 34825 has 1.08 office visit RVUs.

## SUMMARY of 3388X5 built from 34825:

	34825	3388X5 built from 34825
Pre-service:	1.58	2.07
Intra-service:	5.67	10.92
Remainder InPt stay:	3.65	3.65
Office Visits:	1.08	1.73
Total Service RVW 24.00 (=2005 MFS)		18.37 RVW for 3388X5 based on comparison with key reference

According to this comparison with key reference service 34825, the survey respondents median RVW of 17.00 actually underestimated the true value of the new 3388X5 service by more than one RVU.

#### BUILDING AN RVW FOR 388X2 FROM AN OPEN AORTIC REPAIR ON THE MPC LIST

The MPC list reference is CPT 35646, Bypass with other than vein, aortobifemoral. This is an "A" service on the MPC list with the following characteristics. 35646 was evaluated by the RUC in April 2001.

	35646	3388X5
Global Period	90-days	90-days
2005 RVW:	30.95	17.00 median survey
Pre-eval:	70 min	50 min
Pre-position	15 min	20 min
Pre-SDW	15 min	20 min
Intra-service:	210 min	100 min
Immed Post:	30 min	30 min
Inpatient Visits:	7	3
Office visits	3	2
IWPUT from survey data	0.093	0.096

In order to construct an RVW for 3388X5 from 35646, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** Compared to 35646, 3388X5 has the 20 minutes less evaluation time, 5-minutes more positioning time, and 5-minutes more scrub, dress, wait time. The difference represents -.30 RVUs charged against 3388X5 ( $-15 \times 0.0224 + 5 \times 0.008$ ). Total Pre-service work for 35646 is 1.95 RVUs, and based on that, Pre-service work for 3388X5 is 1.65 RVUs.

**INTRA-SERVICE WORK:** Intra-service time for 3388X5 is 100-minutes, while 35646 intra-service time is 210-minutes. Intra-service intensity of 3388X5 according to IWPUT of the survey data is 0.096, while the reference service is 0.093, so an adjustment needs to be made. Intra-service work of 35646 is 19.55 RVUs. The time adjustment is  $100/210 = 0.476$ , and the intensity adjustment is  $0.096/0.093 = 1.03$ . Thus, the intra-service work of 3388X5 may be estimated at  $19.55 \times 0.476 \times 1.03 = 9.58$ .

**POST-SERVICE WORK:** 35646 has 30-minutes of immediate post-service time, 1x99233, 2x99232, 3x99231, 1x99238, 1x99214, and 2x99212. 3388X5 also has 30 minutes of immediate post-service time, and one each of 99232, 99231, 99238, 99214, 99213. Calculation of inpatient post-service work is 7.50 for 35646 and 3.65 for 3388X3. Calculation of office visit work is 1.94 for 35646 and 1.73 for 3388X3

#### SUMMARY of 388X3 built from 35646

	35646	3388X3 built from 35646
Pre-service:	1.95	2.10
Intra-service:	19.56	9.58
Remainder InPt stay:	7.50	3.65
Office Visits:	1.94	1.73
Total Service	30.95 (=2005 MFS)	17.06 RVW for 3388X5 based on comparison with 35646

Thus, building the new service 3388X5 RVW based on an established open surgical reconstruction of the infrarenal aorta, CPT 35646, which is an "A" level MPC list procedure, results in an RVW of 17.06, within hundredths of an RVU of the median survey value of 17.00.

These two independent verification analyses, resulting in estimated RVWs of 18.37 and 17.07 respectively, clearly justify the median survey RVW of 17.00. We stand by our recommendation for 17.00



Frequency	500	Percentage	100.00 %
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Specialty VS	Frequency	250	Percentage	50.00 %
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Specialty IR	Frequency	250	Percentage	50.00 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 400  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty VS	Frequency	200	Percentage	50.00 %
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Specialty IR	Frequency	200	Percentage	50.00 %
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Specialty	Frequency	Percentage	%
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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. 35694

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:33889 Tracking Number: II6 Global Period: 000

**Recommended Work Relative Value**

Specialty Society RVU: **15.92**

RUC RVU: **15.92**

CPT Descriptor: Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65-year-old female with hypertension, 50 pack-years smoking, and previous myocardial infarction is found to have a 7 cm. descending thoracic aortic aneurysm. The aneurysm originates immediately adjacent to her left subclavian artery origin, and in order to achieve a hemostatic proximal seal zone the endoprosthesis will need to be deployed across (and therefore occlude) the origin of this artery. To maintain blood flow to her left arm a subclavian to carotid transposition is performed.

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? 9%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work begins after the decision to operate, from the day before the operation until the skin incision. The patient has undergone evaluation for endovascular thoracic aneurysm repair, and it has been determined that transposition of the left subclavian artery origin is required. Pre-service work includes review of MR, CT, CT with 3D reconstructions, and arteriograms in evaluation of suitability for transposition of left subclavian artery reimplantation onto the left common carotid artery. Pre-service work also includes palpation of left brachial, radial, and ulnar pulses to ensure presence and normalcy, plus palpation of left carotid artery to ensure presence and normalcy. Upper extremity and carotid noninvasive vascular studies are reviewed. Review of procedure plus review of indications, risks and benefits is undertaken with patient and family. Pre-service work also includes ensuring all surgical instruments and materials are available for use in OR. Finally, pre-service includes changing into surgical scrubs, patient positioning, shave, prep, and drape of neck and shoulder area, plus waiting as required for adequate anesthesia.

Description of Intra-Service Work: The intra-service work of 3388X6 begins with skin incision on the neck extending towards the left arm in the supraclavicular space. Access to the carotid and subclavian arteries is achieved by dissecting through soft tissue and mobilizing a plethora of nerves and veins, all very carefully. The common carotid artery is cleared for 5-6 cm, and the left subclavian is dissected under the clavicle as closely as possible to its origin on the aorta. Soft rubber loops are passed proximally and distally around both arteries. Once adequate exposure is achieved and intravenous heparin anticoagulation administered, proximal and distal vascular clamps are applied to the subclavian near its origin. The artery is divided between clamps and the proximal stump is oversewn with fine polypropylene sutures. The proximal clamp is removed, and additional sutures are placed as required to achieve hemostasis.

Vascular clamps are then applied to the common carotid artery. The left subclavian, now free from its original origin, is mobilized and extended to meet the side of the common carotid. An arteriotomy is fashioned at an appropriate site on the carotid, and the end of subclavian artery is anastomosed to the side of the carotid using fine polypropylene sutures. All vascular clamps are removed, and additional sutures are placed as needed to achieve hemostasis. All pulses are checked and confirmed with Doppler. The wound is irrigated copiously, and closed in layers.

Description of Post-Service Work: Post-service work begins after skin closure. A sterile dressing is applied. 1 operative team waits for the patient to emerge from anesthesia, and a thorough neurologic evaluation is performed before the patient leaves the operating room to determine if the patient has suffered a stroke related to clamping the carotid artery, or related to manipulation and traction on the vertebral artery origin as the subclavian was dissected.

Additional tasks include transfer of patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Results of the procedure are discussed with the patient once he or she is fully awake. Reevaluation of the patient's neurologic status is performed in the recovery area. When stable, the patient is transferred to the floor. The physician makes postoperative visits to ensure hemostasis, normal neurological function, normal pulses and adequate perfusion of hand.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Gary Seabrook, MD					
<b>Specialty(s):</b>	Society for Vascular Surgery					
<b>CPT Code:</b>	33889					
<b>Sample Size:</b>	200	<b>Resp n:</b>	40	<b>Response:</b> 20.00 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RWV:</b>		10.00	16.90	18.00	20.00	30.00
<b>Pre-Service Evaluation Time:</b>				68.0		
<b>Pre-Service Positioning Time:</b>				20.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				20.0		
<b>Intra-Service Time:</b>		90.00	120.00	150.00	180.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>40.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
34833	000	11.98

CPT Descriptor Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
34812	000	6.74

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis; by groin incision, unilateral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
35694	090	19.13

CPT Descriptor Transposition and/or reimplantation; subclavian to carotid artery

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

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

Number of respondents who choose Key Reference Code: 29      % of respondents: 72.5 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u> 33889	<u>Key Reference CPT Code:</u> 34833
Median Pre-Service Time	108.00	75.00
Median Intra-Service Time	150.00	100.00
Median Immediate Post-service Time	40.00	27.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	18.00
Median Office Visit Time	0.0	0.00
Median Total Time	298.00	220.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.28	3.83
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.41	3.97
--	------	------

Urgency of medical decision making	3.93	3.66
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.69	4.10
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Physical effort required	4.17	3.93
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.69	3.90
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Outcome depends on the skill and judgment of physician	4.72	4.10
--	------	------

Estimated risk of malpractice suit with poor outcome	4.66	3.76
--	------	------

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

Pre-Service intensity/complexity	4.28	3.66
----------------------------------	------	------

Intra-Service intensity/complexity	4.59	3.79
------------------------------------	------	------

Post-Service intensity/complexity	3.76	3.24
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**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 Panel that evaluated this service felt compelled to ignore the median survey value as well as the first two additional rationale arguments listed below. We base our RVW recommendation of 15.92 on comparison with RUC-surveyed reference service CPT 35694.

Subclavian to carotid artery transposition in the thoracic aortic endograft patient is a complex undertaking due to the nature of the anatomy and the comorbidities of the patient. In the aneurysm population, patients are likely to have tortuous great vessel anatomy that makes this operation more complex than under ordinary conditions.

#### BUILDING AN RVW FOR 3388X6 FROM THE KEY REFERENCE SERVICE 34833

The key reference service chosen by 72% of the survey respondents was 34833, which is open iliac artery exposure during endovascular aneurysm repair, with creation of a conduit for device delivery. This service has similarities to the new service in that both involve complex major arterial dissection in a patient with overt aneurysmal disease. The iliac artery dissection is complex because it lies deep in the pelvis adjacent to huge iliac veins. The subclavian and carotid artery dissections are complex in that they lie among a plethora of important nerves. In addition, cross-clamping the common carotid artery entails a small but real risk for causing a stroke. Reference code 34833 and the new service 3388X6 have the following data elements:

	34833	3388X6
Global Period:	0-days	0-days
RVW:	11.98	18.00 median survey RVW
Pre-eval time	35 min	68 min
Pre-position:	20	20
Pre-SDW:	20	20
Intra-service:	100	150
Immed-Post:	27	22
Disch Visit	0.5 x 99238	0.5 x 99238

In order to construct an RVW for 3388X6 from 34833, adjustments must be made in all three service compartments:

**PRE-SERVICE WORK:** 34833 has 55 minutes of pre-service eval + positioning time, while the new service has minutes. Clinically the higher value is due to pre-op neurologic assessment and review of intracranial MRAs, CT, etc determine stroke risk associated with temporary interruptions of vertebral and carotid arterial blood flows. Pre-service work for 34833 is 1.39 RVUs. Pre-service work for 3388X6 can be calculated as  $1.39 + 33 \times 0.0224 = 2.13$

**INTRA-SERVICE WORK:** The new service has 150 minutes of intra-time compared to 100 minutes in the reference ( $150/100 = 1.5$ ). Intra-service intensity of the new service was rated by survey respondents at 4.59 compared to 3.79 for the reference;  $4.59/3.79 = 1.21$ . Intra-service work of 34833 is 9.35 RVUs. Thus, intra-service work for 3388X6 can be calculated from the reference as intra-work of 34833 x time adjustment x intensity adjustment, =  $9.35 \times 1.5 \times 1.21 = 16.95$ .

**POST-SERVICE WORK:** The reference service has 27 minutes of post-service time, while the new service has 22 min. of post time. Both services include 1/2 of a discharge day visit.

#### SUMMARY of 3388X6 built from 34833:

	34833	3388X6 built from 34833
Pre-service:	1.39	2.13
Intra-service:	9.35	16.97
Post-service:	1.24	1.13
<b>TOTAL RVW:</b>	<b>11.98 (= 2005 MFS)</b>	<b>20.23 = RVW for 3388X6 based on key reference</b>

Thus, based on a comparison with the most commonly chosen reference service, 3388X6 merits an RVW of 20.23, well above the median survey value of 18.00.

## BUILDING AN RVW FOR 3388X6 FROM THE MPC LIST SERVICE 34812

CPT 34812 is a 0-day global service with similarity to the new service in that both are open surgery adjuncts to endovascular aortic repairs. This service has similarities to the new service in that both involve major arterial dissection in a patient with overt aneurysmal disease. The femoral artery dissection is less complex than the new service because it does not lie deep, and while it is adjacent to nerves and veins, the proximity is less forboding. The subclavian and carotid artery dissections are complex in that they lie among a plethora of important nerves. In addition, cross-clamping the common carotid artery entails a small but real risk for causing a stroke. Reference code 34812 and the new service 3388X6 have the following data elements:

	34812	3388X6
Global Period:	0-days	0-days
RVW:	6.74	18.00 median survey RVW
Pre-eval time	35 min	68 min
Pre-position:	20	20
Pre-SDW:	20	20
Intra-service:	45	150
Immed-Post:	14	27
Disch Visit	0.5 x 99238	0.5 x 99238

In order to construct an RVW for 3388X6 from 34812, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** 34812 has 55 minutes of pre-service eval and positioning time, while the new service has 88 minutes. Clinically the higher value is due to pre-op neurologic assessment and review of intracranial MRAs, CT, etc to determine stroke risk associated with temporary interruptions of vertebral and carotid arterial blood flows. Pre-service work for 34812 is 1.39 RVUs. Pre-service work for 3388X6 can be calculated as  $1.39 + 33 \times 0.0224 = 2.13$

**INTRA-SERVICE WORK:** The new service has 150 minutes of intra-time compared to 45 minutes in the reference ( $150/45 = 3.33$ ). We have no intra-service intensity comparisons, but our consensus group assured us that the subclavian reimplantation is at least 10% more complex. Intra-service work of 34812 is 4.40 RVUs. Thus, intra-service work for 3388X6 can be calculated from the reference as intra-work of 34812 x time adjustment x complexity adjustment,  $= 4.40 \times 3.33 \times 1.10 = 16.08$ .

**POST-SERVICE WORK:** The reference service has 14 minutes of post-service time, while the new service has 22 min. Both services include 1/2 of a discharge day visit.

## SUMMARY of 3388X6 built from 34812:

	34812	3388X6 built from 34812
Pre-service:	1.39	2.13
Intra-service:	4.40	16.08
Post-service:	0.95	1.13
TOTAL RVW:	6.74 (= 2005 MFS)	19.34 = RVW for 3388X6 based on MPC reference

Thus, based on a comparison with an MPC list endovascular-related service, 3388X6 merits an RVW of 19.38, also well above the median survey value.

BUILDING AN RVW FOR 3388X6 FROM CLINICALLY RELATED SERVICE 35694

CPT 35694 is a 90-day global service with major similarity to the new service in that both are open surgery involving reimplantation of the subclavian artery. 35694 was evaluated by the RUC in April 1993. The major difference between these two services is the global period. 35694 is a stand-alone service with a 90-day global, while 3388X6 is a 0-day service because it is designed to be used in conjunction with endovascular repair of the descending thoracic aorta. In essence, we can build the RVW of 3388X6 by subtracting the inpatient and office visits from 35694.

CPT 35694 has two inpatient visits (99231 x 2), while 3388X6 has none  
 CPT 35694 has a full discharge day (99238) while 3388X6 has 1/2 discharge day  
 CPT 35694 has three 99212 office visits while 3388X6 has none.

The RVW for 35694 is 19.13

The RVW for 3388X6 based on this analysis should be  $19.13 - 1.28 (2 \times 0.64) - 0.64 (0.5 \times 99238) - 1.29 (3 \times 0.43) = 15.92$ .

**SUMMARY:** Although two of the three analyses result in RVWs that justify the median survey value of 18.00, it is difficult to ignore the direct comparison to the RUC surveyed code 35694, which is an extremely similar service. Thus, we are recommending the value of 15.92 based on comparison with 35694.

**IWPUT DATA**

IWPUT Calculator for 3388x6 subclavian carotid transposition at median survey value of 18.00

Building Block Method for Median Survey RVW of 18.00

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	68	0.0224	1.52
Same day evaluation	20	0.0224	0.45
Scrub, prep, positioning	20	0.0081	0.16
Pre-service total			2.13
Intra-service	Time	IWPUT	(=time x intensity)
	150	0.098	14.73
Post-service	Time	Intensity	(=time x intensity)
Immediate post	22	0.0224	0.49
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
Discharge 99238	0.5	1.28	0.64
Post-service total			1.13

IWPUT Calculator for 3388X6 at recommended RVW of 15.92 (based on comparison to CPT 35694)

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	68	0.0224	1.52
Same day evaluation	20	0.0224	0.45
Scrub, prep, positioning	20	0.0081	0.16
Pre-service total			2.13
Intra-service	Time	IWPUT	(=time x intensity)
	150	0.084	12.65
Post-service	Time	Intensity	(=time x intensity)
Immediate post	22	0.0224	0.49
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
Discharge 99238	0.5	1.28	0.64
Post-service total			1.13

WPUT for reference service 35694 subclavian to carotid transposition with RVW 19.13

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	80	0.0224	1.79
Same day evaluation	20	0.0224	0.45
Scrub, prep, positioning	20	0.0081	0.16
Pre-service total			2.40
Intra-service	Time	IWPUT	(=time x intensity)
	180	0.069	12.39
Post-service	Time	Intensity	(=time x intensity)
Immediate post	22	0.0224	0.49
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99231	2.0	0.64	1.28
Discharge 99238	1.0	1.28	1.28
Office 99212	3.0	0.43	1.29
Post-service total			4.34

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**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.

- 1.
2. Physician 1 performs 3388X1 Endovascular repair of descending thoracic aorta
3. Physician 1 performs 34812 Open femoral artery exposure, 0-day global with multiple procedure reduction
4. Physician 1 performs 36200 Catheter introduced into aorta, 0-day global with multiple procedure reduction
5. Physician 1 performs 3388X6, subclavian reimplantation, 0-day global with multiple procedure reduction
6. Physician 2 performs 36200 Catheter introduced into aorta, percutaneously from opposite groin
7. Physician 2 performs 7595X1 Radiological S&I for 3388X1
- 8.
9. Physician 1 earns  $33.00 + 3.37 + 1.51 + 7.86 = 45.74$  RVUs over the 90-day global period
10. Physician 2 earns  $7.00 + 1.51 = 8.51$  RVUs for the 0-day and XXX services
- 11.
12. Physician 1 time is  $587 + 45 + 20 + 298 = 950$  minutes over a 90-day global period  
Physician 2 time is  $140 + 20 = 160$  minutes over a 0-day global period

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0037T

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

Specialty VS 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? 500

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

Specialty VS Frequency 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? 400  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty  
VS  
                                    Frequency 400                      Percentage 100.00 %

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 35694

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**Specialty Society RVU: **20.00**RUC RVU: **20.00**

CPT Code:33891 Tracking Number: II7 Global Period: XXX

CPT Descriptor: Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65-year-old female with hypertension, 50 pack-years smoking, and previous myocardial infarction is found to have a 7 cm. descending thoracic aortic aneurysm. The aneurysm originates immediately beyond her left common carotid artery origin. In order to achieve a hemostatic proximal seal zone the endoprosthesis will need to be deployed across (and therefore occlude) the origin of this vessel. To maintain blood flow to her brain a cross-neck carotid-carotid bypass is performed using synthetic conduit.

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? 9%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work begins after the decision to operate, from the day before the operation until the skin incision. The patient has undergone evaluation for endovascular thoracic aneurysm repair, and it has been determined that her left common carotid artery origin will need to be covered in order to gain a hemostatic proximal seal zone. A cross-neck carotid-carotid bypass is required to maintain brain circulation. Pre-service work includes review of MR, CT, CT with 3D reconstructions, and arteriograms in evaluation of suitability for this procedure. Pre-service work also includes palpation of both carotid artery pulses to ensure presence and normalcy. Upper extremity and carotid noninvasive vascular studies are reviewed. Review of procedure plus review of indications, risks and benefits is undertaken with patient and family. A final baseline neurological exam is performed just before surgery. Pre-service work also includes ensuring all surgical instruments and materials are available for use in OR. Finally, pre-service includes changing into surgical scrubs, patient positioning, shave, prep, and drape of neck and shoulder area, plus waiting as required for adequate anesthesia.

Description of Intra-Service Work: The intra-service work of 3388X7 begins with bilateral neck skin incisions. Access to the common carotid arteries is achieved by dissecting through soft tissue and mobilizing a plethora of nerves and veins, all very carefully. Each common carotid artery is cleared for 5-6 cm. Soft rubber loops are passed proximally and distally around both arteries. Very careful dissection is performed to create a soft tissue tunnel from one side of the neck to the other behind the pharynx. An appropriately sized synthetic conduit is passed through the tunnel. Once adequate exposure is achieved and intravenous heparin anticoagulation administered, proximal and distal vascular clamps are applied to the right common carotid artery. The artery is opened longitudinally and the proximal anastomosis of the bypass is sewn with fine polypropylene sutures. The anastomosis is flushed to remove debris prior to completion of the suture line. Extreme care is taken to avoid air or other embolus from traveling up the carotid artery. A vascular clamp is applied to the graft, and clamps are then removed from the carotid. Anastomotic leaks are sealed with additional sutures. The left common carotid artery is then clamped. An arteriotomy is created, and the distal anastomosis is sewn with the end of the bypass conduit applied to the side of the carotid artery. The anastomosis is flushed to remove debris and the suture line completed. Extreme care is taken to prevent emboli from traveling up the carotid artery into the brain. Clamps are removed and leaks are sealed with additional sutures. All pulses are checked and flow is confirmed with a Doppler. The left common carotid artery just proximal to the anastomosis may be suture ligated at this point to help maintain patency of the carotid-carotid bypass graft. The wounds are irrigated copiously, and closed in layers.

Description of Post-Service Work: Post-service work begins after skin closure. A sterile dressing is applied. The operative team waits for the patient to emerge from anesthesia, and a thorough neurologic evaluation is performed before

the patient leaves the operating room to determine if the patient has suffered a stroke related to clamping the carotid arteries. Additional tasks include transfer of patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Results of the procedure are discussed with the patient once he or she is fully awake. When stable, the patient is transferred to the floor. The physician makes postoperative visits to ensure hemostasis and normal neurological function and smooth recovery.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Gary Seabrook, MD				
<b>Specialty(s):</b>	Society for Vascular Surgery				
<b>CPT Code:</b>	33891				
<b>Sample Size:</b>	200	<b>Resp n:</b>	40	<b>Response:</b>	%
<b>Sample Type:</b> Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		12.00	18.00	20.00	22.25
<b>Pre-Service Evaluation Time:</b>				70.0	
<b>Pre-Service Positioning Time:</b>				20.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				20.0	
<b>Intra-Service Time:</b>		90.00	120.00	173.00	203.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>40.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
34833	000	11.98

CPT Descriptor Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
34812	000	6.74

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis; by groin incision, unilateral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
35510	090	22.97

CPT Descriptor Bypass graft, with vein; carotid-brachial

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

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

Number of respondents who choose Key Reference Code: 29      % of respondents: 72.5 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u> 33891	<u>Key Reference CPT Code:</u> 34833
Median Pre-Service Time	110.00	75.00
Median Intra-Service Time	173.00	100.00
Median Immediate Post-service Time	40.00	27.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	18.00
Median Office Visit Time	0.0	0.00
Median Total Time	323.00	220.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.34	3.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.48	3.97
Urgency of medical decision making	4.00	3.66

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

Technical skill required	4.83	4.14
Physical effort required	4.28	3.97
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.72	3.90
Outcome depends on the skill and judgment of physician	4.86	4.14
Estimated risk of malpractice suit with poor outcome	4.69	3.76

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

Pre-Service intensity/complexity	4.34	3.62
Intra-Service intensity/complexity	4.69	3.79
Post-Service intensity/complexity	3.90	3.31

**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.*

Transcervical retropharyngeal carotid-carotid bypass is a complex undertaking due to the plethora of major arteries, nerves and veins in the neck. In addition, the patient may suffer a stroke if any plaque, or even an air embolus, is allowed to traverse up the carotid into the brain. The intensity of this procedure is understandably high. The Consensus Panel that evaluated this service felt the median survey value of 20.00 RVUs is justified, based on time and intensity considerations. The following analysis compares the new service to 1) the most commonly cited key reference

service, 2) an MPC list service, and 3) a recently RUC-evaluated bypass graft that also involves dissection of the common carotid artery.

#### BUILDING AN RVW FOR 3388X7 FROM THE KEY REFERENCE SERVICE 34833

The key reference service chosen by 72% of the survey respondents was 34833, which is open iliac artery exposure during endovascular aneurysm repair, with creation of a conduit for device delivery. This service has similarities to the new service in that both involve complex major arterial dissection in a patient with overt aneurysmal disease. The iliac artery dissection has high intensity because it lies deep in the pelvis adjacent to the huge iliac veins. The carotid artery dissections are complex in that they lie adjacent to the jugular veins, and vagus nerves. In addition, cross-clamping the common carotid artery entails a small but real risk of resultant stroke. Reference code 34833 and the new service 3388X7 have the following data elements:

	34833	3388X7
Global Period:	0-days	0-days
RVW:	11.98	20.00 median survey value, recommended RVW
Pre-eval time	35 min	70 min
Pre-position:	20	20
Pre-SDW:	20	20
Intra-service:	100	173
Immed-Post:	27	22
Disch Visit	0.5 x 99238	0.5 x 99238

In order to construct an RVW for 3388X7 from 34833, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** 34833 has 55 minutes of pre-service eval and positioning time, while the new service has 70 minutes. Clinically the higher value is due to pre-op neurologic assessment and review of extracranial and intracranial MRAs, CTAs, etc to determine stroke risk associated with temporary interruptions of carotid arterial blood flow. Pre-service work for 34833 is 1.39 RVUs. Pre-service work for 3388X7 can be calculated as  $1.39 + (35 \times 0.0224) = 2.17$

**INTRA-SERVICE WORK:** The new service has 173 minutes of intra-time compared to 100 minutes in the reference ( $173/100 = 1.73$ ). Intra-service intensity of the new service was rated at 4.69 by survey respondents compared to 3.79 for the reference;  $4.69/3.79 = 1.24$ . Intra-service work of 34833 is 9.34 RVUs. Thus, intra-service work for 3388X7 can be calculated from the reference as intra-work of 34833 x time adjustment x intensity adjustment,  $= 9.34 \times 1.73 \times 1.24 = 20.04$ .

**POST-SERVICE WORK:** The reference service has 27 minutes of post-service time, while the new service has 22 min. of intra time. Both services include 1/2 of a discharge day visit.

#### SUMMARY of 3388X7 built from 34833:

	34833	3388X7 built from 34833
Pre-service:	1.39	2.17
Intra-service:	9.34	20.04
Post-service:	1.24	1.13
TOTAL RVW:	11.98 (= 2005 MFS)	23.34 = RVW for 3388X7 based on key reference

Thus, based on a comparison with the most commonly chosen reference service, 3388X7 merits an RVW of 23.34, well above the median survey value of 20.00.

## BUILDING AN RVW FOR 3388X7 FROM THE MPC LIST SERVICE 34812

CPT 34812 is a 0-day global service with similarity to the new service in that both are open surgery adjuncts to endovascular aortic repairs. Both involve major arterial dissection in a patient with overt aneurysmal disease. The carotid artery dissection is more complex than the femoral artery dissection because the adjacent nerves and veins lie in closer proximity and hold more severe clinical consequences if injured. In addition, the carotid artery dissection carries a risk of stroke, making it significantly intense. Reference code 34812 and the new service 3388X7 have the following data elements:

	34812	3388X7
Global Period:	0-days	0-days
RVW:	6.74	20.00 median survey value & recommended RVW
Pre-eval time	35 min	70 min
Pre-position:	20	20
Pre-SDW:	20	20
Intra-service:	45	173
Immed-Post:	14	22
Disch Visit	0.5 x 99238	0.5 x 99238

In order to construct an RVW for 3388X7 from 34812, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** 34812 has 55 minutes of pre-service eval and positioning time, while the new service has 90 minutes. Clinically the higher value is due to pre-op neurologic assessment and review of extracranial and intracranial MRAs, CTs, etc to determine stroke risk associated with temporary interruptions of carotid arterial blood flow. Pre-service work for 34812 is 1.39 RVUs. Pre-service work for 3388X7 can be calculated as  $1.39 + (35 \times 0.0224) = 2.17$

**INTRA-SERVICE WORK:** The new service has 173 minutes of intra-time compared to 45 minutes in the reference ( $173/45 = 3.84$ ). We have no intra-service intensity comparisons, but our consensus group was unanimous in concluding that the carotid artery bypass operation is certainly at least as complex as the femoral exposure. Thus, we assumed equality and used a complexity ratio of 1.00. Intra-service work of 34812 is 4.39 RVUs. Thus, intra-service work for 3388X7 can be calculated from the reference as intra-work of 34812 x time adjustment x complexity adjustment, =  $4.40 \times 3.83 \times 1.00 = 16.86$ .

**POST-SERVICE WORK:** The reference service has 14 minutes of post-service time, while the new service has 22 min. of intra time. Both services include 1/2 of a discharge day visit.

## SUMMARY of 3388X7 built from 34812:

	34812	3388X7 built from 34812
Pre-service:	1.39	2.17
Intra-service:	4.39	16.86
Post-service:	0.95	1.13
TOTAL RVW:	6.74 (= 2005 MFS)	20.16 = RVW for 3388X7 based on MPC reference

Thus, based on a comparison with an MPC list endovascular-related service, 3388X7 merits an RVW essentially equal to the median survey value of 20.00.

## BUILDING AN RVW FOR 3388X7 FROM CLINICALLY SIMILAR SERVICE 35510

CPT 35510 is a 90-day global service that the RUC evaluated in April 2003. Defined as "Bypass graft, with vein; carotid-brachial", 35510 is similar to 3388X7 in that it involves dissection of the common carotid artery as the origination site for a bypass graft. 35510 also includes subsequent elements of brachial artery dissection, vein harvest for conduit, tunnel development, and finally, creation of the proximal and distal anastomoses. Of all these steps, dissection of the carotid artery, and sewing an anastomosis to the carotid artery, are the most intense and complex steps. In new code 35587X, there are two rather than one carotid artery dissection steps, and both anastomoses are sewn to carotid arteries. Thus, 3388X7 has a double dose of complex carotid dissection and anastomosis while 35510 has only one. Reference code 35510 and the new service 3388X7 have the following data elements:

	35510	3388X7
Global Period:	90-days	0-days
RVW:	22.97	20.00 median survey value & recommended RVW
Pre-eval time	65 min	70 min
Pre-position:	10	20
Pre-SDW:	28	20
Intra-service:	180	173
Immed-Post:	30	22
Hosp Visits:	99232 x 2	none
	99213 x 1	none
Disch Visit	99238 x 1	99238 x 0.5
Office Visits:	99213 x 2	none

In order to construct an RVW for 3388X7 from 35510, adjustments must be made in all service compartments:

**PRE-SERVICE WORK:** 35510 has 75 minutes of pre-service eval and positioning time, while the new service has 90 minutes. Clinically the higher value is due to the bilateral nature of the pre-op neurologic assessment for 3388X7, as well as bilateral review of extracranial and intracranial MRAs, CTs, etc to determine stroke risk associated with temporary interruptions of carotid arterial blood flow. Pre-service scrub, dress, wait time is 8-minutes more for the reference service than the new. Pre-service work for 35510 is 1.91 RVUs. Pre-service work for 3388X7 can be calculated as  $1.91 + (15 \times 0.0224) - (8 \times 0.008) = 2.18$

**INTRA-SERVICE WORK:** The new service has 173 minutes of intra-time compared to 180 minutes in the reference ( $173/180 = 0.96$ ). We have no intra-service intensity comparisons, but our consensus group was unanimous in concluding that the carotid-carotid bypass operation has twice as much very high intensity work (i.e. dissecting and anastomosing to the common carotid artery) as 35510. This is confirmed by IWPUTs of the two services, at 0.096 for the new service survey data, compared to 0.084 for the reference service. Taking a ratio of the two IWPUTs ( $0.096/0.084 = 1.14$ ) results a form of intensity ratio. Intra-service work of 35510 is 15.05 RVUs. Thus, intra-service work for 3388X7 can be calculated from the reference as intra-work of 35510 x time adjustment x complexity adjustment, =  $15.05 \times 0.96 \times 1.14 = 16.47$ .

**POST-SERVICE WORK:** The reference service has 30 minutes of immediate post-service time, while the new service has 22 min. of immediate post-time. The reference service has three inpatient visits, one full discharge visit, and two level-3 office visits. Since the new service is a -day procedure it has no further inputs after the half discharge day.

## SUMMARY of 3388X7 built from 35510:

	35510	3388X7 built from 35510
Pre-service:	1.91	2.18
Intra-service:	15.05	16.47
Post-service:	6.01	1.13
TOTAL RVW:	6.74 (= 2005 MFS)	19.78 = RVW for 3388X7 based on 35510 reference

CONCLUSION: In summary, we performed comparisons of the new service to three benchmark procedures. One benchmark was the most commonly cited key reference from the survey respondents. Based on that, the new service should be valued at 23.34 RVUs. Comparison to an MPC list service resulted in a calculated value of 20.16 for the new service. Finally, comparison to a service that includes the same carotid artery dissection and anastomosis results in a new service value of 19.78 RVUs. With these three solid comparisons, we believe the best RVW for 3388X7 is the median survey value, 20.00.

## IWPUT DATA

### IWPUT 3388X7 CCA-CCA transervical bypass

Building Block Method	RVW median survey 20.00		
	Pre-service Time	Intensity	(=time x intensity)
Day prior evaluation	70	0.0224	1.57
Same day evaluation	20	0.0224	0.45
Scrub, prep, positioning	20	0.0081	0.16
Pre-service total			2.18
	Intra-service Time	IWPUT	(=time x intensity)
	173	0.096	16.69
	Post-service Time	Intensity	(=time x intensity)
Immediate post	22	0.0224	0.49
	Subsequent visits: Visit n	E/M RVU	(=n x E/M RVU)
Discharge 99238	0.5	1.28	0.64
Post-service total			1.13

### IWPUT for Reference Service 34833

Building Block Method	CPT 34833	RVW 11.98	
	Pre-service Time	Intensity	(=time x intensity)
Day prior evaluation	35	0.0224	0.78
Same day evaluation	20	0.0224	0.45
Scrub, prep, positioning	20	0.0081	0.16
Pre-service total			1.39
	Intra-service Time	IWPUT	(=time x intensity)
	100	0.093	9.34
	Post-service Time	Intensity	(=time x intensity)
Immediate post	27	0.0224	0.60
	Subsequent visits: Visit n	E/M RVU	(=n x E/M RVU)
Discharge 99238	0.5	1.28	0.64

Post-service total 1.24

Building Block Method 35510 RVW 22.97

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	65	0.0224	1.46
Same day evaluation	10	0.0224	0.22
Scrub, prep, positioning	28	0.0081	0.23
Pre-service total			1.91

Intra-service	Time	IWPUT	(=time x intensity)
	180	0.084	15.05

Post-service	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67

Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
99232	2.0	1.06	2.12
99231	1.0	0.64	0.64

Discharge 99238 1.0 1.28 1.28

Office	Time	E/M RVU	(=time x intensity)
99213	2.0	0.65	1.30
Post-service total			6.01

**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 provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

- 3.
- 4. Physician 1 performs 3388X1 Endovascular repair of descending thoracic aorta
- 5. Physician 1 performs 34812 Open femoral artery exposure, 0-day global with multiple procedure reduction



If no, please select another crosswalk and provide a brief rationale. 35694

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**

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CPT Code:75956 Tracking Number: II8 Global Period: XXX

**Recommended Work Relative Value  
Specialty Society RVU: 7.00  
RUC RVU: 7.00**

CPT Descriptor: Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old male with hypertension, 50 pack-years smoking, and previous myocardial infarction is found to have a 7.0 cm diameter descending thoracic aortic aneurysm that begins immediately beyond the origin of left subclavian artery. Risks and benefits of open surgical repair, endovascular repair, and watchful waiting have been discussed, and patient has chosen endovascular repair. Perioperative risk evaluation including cardiac workup indicated suitability for the endovascular approach. Imaging studies (typically a combination of CT scan, MRI, and/or angiography) demonstrate that the aneurysm is within acceptable parameters for endovascular repair if the left subclavian artery origin is covered by the endoprosthesis. Endovascular repair of the descending thoracic aortic aneurysm is performed. The proximal extent of the endoprosthesis covers the left subclavian artery origin.

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? 7%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Physician Pre-service work includes:

- Check suite/OR to ensure proper function and configuration of the imaging equipment
- Ensure compliance with all radiation safety issues is assessed and assured.
- Ensure all technical personnel have been familiarized with the technique and all required devices.
- Supervise selection of all equipment, including catheters, wires, balloons, stents, sheaths, contrast material,
- Locate and review all prior relevant films/studies
- Suit up in Radiation protection
- Position patient (or supervise proper positioning)

Description of Intra-Service Work:

- Direct technical personnel throughout procedure
- Interpret imaging of the vessel being treated, including complete views of the target vessel in all projections necessary
- Ensure accurate radiological views, exposures, shielding, image size, injection sequences,
- Manage radiation protection 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, opening balloons, assessing post-op success and complications.
- Quantitative measurement of lesion, target vessel & landing zones to confirm appropriate prosthesis and balloon sizes
- Continuous fluoroscopic imaging during all catheter/stent manipulations to assess proper position

Description of Post-Service Work:

- 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

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Robert Vogelzang, MD Bibb Allen, MD Zachary Rattner, MD Gary Seabrook, MD					
<b>Specialty(s):</b>	Society of Interventional Radiology Society for Vascular Surgery American College of Radiology					
<b>CPT Code:</b>	75956					
<b>Sample Size:</b>	200	<b>Resp n:</b>	39	<b>Response:</b> 19.50 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RWV:</b>		1.50	5.50	7.00	8.00	21.00
<b>Pre-Service Evaluation Time:</b>				30.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		10.00	30.00	90.00	120.00	360.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>20.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
75952	XXX	4.49

CPT Descriptor Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
	XXX	

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 28      % of respondents: 71.7 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 75956</u>	<u>Key Reference CPT Code: 75952</u>
Median Pre-Service Time	30.00	20.00
Median Intra-Service Time	90.00	60.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	140.00	95.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.68	4.00
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.64	3.89
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Urgency of medical decision making	3.82	3.39
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.79	4.11
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Physical effort required	3.79	3.46
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.82	3.96
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Outcome depends on the skill and judgment of physician	4.89	4.21
--	------	------

Estimated risk of malpractice suit with poor outcome	4.57	3.82
--	------	------

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

Pre-Service intensity/complexity	4.71	3.79
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Intra-Service intensity/complexity	4.79	3.89
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Post-Service intensity/complexity	3.93	3.32
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**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.*

Repairing a descending thoracic aortic aneurysm or dissection that requires precise deployment of the proximal component right across the origin of the left subclavian artery is the most complex and challenging endovascular procedure yet devised. The hemodynamic forces across the aortic arch are extreme. In addition, the arch itself lies on a completely oblique three-dimensional plane between AP and true lateral, and in order to accomplish accurate device deployment the fluoroscopic imaging must identify the exact orthogonal coordinates. Nevertheless, the reduction in

patient morbidity and mortality accomplished by noninvasive repair of the descending thoracic aorta makes this procedure a standout in minimally invasive surgery. This brief introduction should help one understand why the request for a radiological S&I RVW is substantially more than those previously recommended for infrarenal aortic repairs.

The multispecialty Consensus Panel that reviewed the survey results determined that the median survey RVW of 7.00 is appropriate and fully justified. We provide herein analysis and comparisons with other RBRVS services to substantiate our recommendation.

**BUILDING AN RVW FOR 7595X1 FROM KEY REFERENCE SERVICE 75952**

CPT 75952, Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation, was chosen by 28 of 39 survey respondents (71%) as the key reference service. This is entirely logical on a clinical basis since 75952 is the S&I code used to report endovascular infrarenal aortic repair (corresponding surgical procedure codes 34802 and 34803).

The time and intensity profiles of the new service 7595X1 and the reference 75952 are listed above. In order to build an RVW for the new service from the reference, adjustments must be made in all service compartments.

**PRE-SERVICE WORK:** Survey respondents judged the time and intensity of the new service to be substantially greater than the 75952. The time element is 30 minutes for the new service compared to 20 for 75952. This is understandable based on the anatomic complexity of the aortic arch in three-dimensional space. Although survey respondents identified a significant pre-service intensity discrepancy, greater for the new service (4.71 compared to 3.79), there really is no traditional pre-service intensity adjustment. Pre-service work for the reference is 0.45 RVUs. Pre-service work for the new service is  $(30/20) \times 0.45 = 0.67$  RVUs.

**INTRA-SERVICE WORK:** The new service has 50% more intra-service time than the reference (90 minutes compared to 60), consistent with the much greater magnitude and overall duration of the service. Respondents also identified the intra-service intensity as being substantially greater than the reference (4.79 compared to 3.89), and our multispecialty Consensus Panel agrees that there is an overt increment in complexity when the endovascular repair extends into the aortic arch, crossing the left subclavian origin. The adjustment for time is  $90/60 = 1.5$ . The adjustment for complexity is  $4.79/3.89 = 1.23$ . Intra-work of 75952 is 3.70 RVUs. Thus, intra-work of the new service can be built from the reference as  $3.70 \times 1.5 \times 1.23 = 6.84$ .

**POST-SERVICE WORK:** The new service has 20 minutes of post-time compared to 15 minutes for the reference, resulting in an increment of  $20/15 = 1.33$ . Post-work of 75952 is 0.34 RVUs. By extrapolation, Post-work of 7595X1 is  $0.34 \times 1.33 = 0.45$  RVUs.

**SUMMARY OF 7495X1 built from 75952**

	75952	7595X1 built from 75952
Pre-service work:	0.45 RVUs	0.67
Intra-service work:	3.70	6.84
Post-service work:	0.34	0.45
<b>TOTAL RVW:</b>	<b>4.49 (=2005 MFS)</b>	<b>7.96 based on comparison with 75952 key reference</b>

**IN CONCLUSION,** this service-period by service-period comparison of time and intensity suggests that the survey respondents actually underestimated the true physician work of 7595X1. This is especially true if one considers the relative intensity of pre-service work, which is not adjusted for in this model. We feel this fully justifies use of the median survey RVW of 7.00 for 7595X1.

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**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. Physician 1 performs 3388X2, Endovascular repair of descending thoracic aorta, beyond left
4. Physician 1 performs 34812 Open femoral artery exposure, 0-day global with mult procedure reduction
5. Physician 1 performs 36200 Catheter introduced into aorta, 0-day global with mult procedure reduction
6. Physician 2 performs 7595X2 Radiological S&I for 3388X1
7. Physician 2 performs 36200 Catheter introduced into aorta from opposite groin, 0-day global
- 8.
9. Physician 1 earns  $28.00 + 3.37 + 1.51$  RVUs = 32.88 RVUs for 90-days of care
10. Physician 2 earns  $7.00 + 1.51 = 8.51$  RVUs for the 0-day and XXX services
- 11.
12. Physician 1 time is  $542 + 45 + 20 = 607$  minutes over the 90-day global period
13. Physician 2 time is  $140 + 20 = 160$  minutes during the day of procedure

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**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0038T

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

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

Specialty IR                      How often? Sometimes

Specialty VS                      How often? Sometimes

Specialty                          How often?

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

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

Specialty IR                      Frequency 750                      Percentage                      %

Specialty VS	Frequency 750	Percentage	%
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Specialty	Frequency 0	Percentage	%
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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 IR	Frequency 500	Percentage	%
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Specialty VS	Frequency 500	Percentage	%
--------------	---------------	------------	---

Specialty	Frequency 0	Percentage	%
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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**

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CPT Code:75957 Tracking Number: II9 Global Period: XXX	<b>Recommended Work Relative Value</b>
	Specialty Society RVU: <b>6.00</b>
	RUC RVU: <b>6.00</b>

CPT Descriptor: Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old male with hypertension, 50 pack-years smoking, and previous myocardial infarction is found to have a 7.0 cm diameter descending thoracic aortic aneurysm that begins several centimeters beyond the left subclavian artery origin. Risks and benefits of open surgical repair, endovascular repair, and watchful waiting have been discussed, and patient opted for endovascular repair. Perioperative risk evaluation including cardiac workup indicated suitability for an endovascular approach. Imaging studies (typically a combination of CT scan, MRI, and/or angiography) demonstrate that the aneurysm is within acceptable parameters for endovascular repair. Endovascular repair of his descending thoracic aortic aneurysm is performed. The proximal portion of the endoprosthesis does not cover the left subclavian artery origin.

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? 7%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Check suite/OR to ensure proper function and configuration of the imaging equipment
- Ensure compliance with all radiation safety issues is assessed and assured.
- Ensure all technical personnel have been familiarized with the technique and all required devices.
- Supervise selection of all equipment, including catheters, wires, balloons, stents, sheaths, contrast material,
- Locate and review all prior relevant films/studies
- Suit up in Radiation protection
- Position patient (or supervise proper positioning)

**Description of Intra-Service Work:**

- Direct technical personnel throughout procedure
- Interpret imaging of the vessel being treated, including complete views of the target vessel in all projections necessary
- Ensure accurate radiological views, exposures, shielding, image size, injection sequences,
- Manage radiation protection 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, opening balloons, assessing post-op success and complications.
- Quantitative measurement of lesion, target vessel & landing zones to confirm appropriate prosthesis and balloon sizes
- Continuous fluoroscopic imaging during all catheter/stent manipulations to assess proper position

**Description of Post-Service Work:**

- 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

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Robert Vogelzang, MD Bibb Allen, MD Zachary Rattner, MD Gary Seabrook, MD				
<b>Specialty(s):</b>	Society of Interventional Radiology Society for Vascular Surgery American College of Radiology				
<b>CPT Code:</b>	75957				
<b>Sample Size:</b>	200	<b>Resp n:</b>	39	<b>Response:</b> 19.50 %	
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>
<b>Survey RWV:</b>		2.00	5.00	6.00	6.90
<b>Pre-Service Evaluation Time:</b>				30.0	
<b>Pre-Service Positioning Time:</b>				0.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0	
<b>Intra-Service Time:</b>		10.00	30.00	60.00	105.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>20.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
75952	XXX	4.49

CPT Descriptor Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
	XXX	

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 29      % of respondents: 74.3 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 75957</u>	<u>Key Reference CPT Code: 75952</u>
Median Pre-Service Time	30.00	20.00
Median Intra-Service Time	60.00	60.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	110.00	95.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.34	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.31	3.79
Urgency of medical decision making	3.76	3.38

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

Technical skill required	4.52	4.07
Physical effort required	3.66	3.38
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.55	3.93

Outcome depends on the skill and judgment of physician	4.66	4.17
Estimated risk of malpractice suit with poor outcome	4.28	3.72

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

Pre-Service intensity/complexity	4.31	3.72
Intra-Service intensity/complexity	4.48	3.83
Post-Service intensity/complexity	3.76	3.28

**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.*

Repairing a descending thoracic aortic aneurysm or dissection that requires precise deployment of the proximal component just past the origin of the left subclavian artery is an extremely complex and challenging endovascular procedure. The hemodynamic forces in the proximal descending thoracic aorta are extreme. In addition, the distal arch and proximal descending thoracic aorta lie in a completely oblique plan between AP and true lateral, and in order to accomplish accurate device deployment the fluoroscopic imaging must identify the optimal coordinates. Nevertheless,

the reduction in patient morbidity and mortality accomplished by noninvasive repair of the descending thoracic aorta makes this procedure a standout in minimally invasive surgery. This brief introduction should help one understand why the request for radiological S&I RVW is more than that for infrarenal procedures.

The multispecialty Consensus Panel that reviewed the survey results determined that the median survey RVW of 6.00 is appropriate and fully justified. We provide herein analysis and comparisons with other RBRVS services to substantiate our recommendation.

#### BUILDING AN RVW FOR 7595X2 FROM KEY REFERENCE SERVICE 75952

CPT 75952, Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation, was chosen by 29 of 39 survey respondents (74%) as the key reference service. This is entirely logical on a clinical basis since 75952 is the S&I code used to report endovascular infrarenal aortic repairs (corresponding surgical procedure codes 34802 and 34803).

The time and intensity profiles of the new service 7595X2 and the reference 75952 are listed above. In order to build an RVW for the new service from the reference, adjustments must be made in all service compartments.

**PRE-SERVICE WORK:** Survey respondents judged the time and intensity of the new service to be substantially greater than the 75952. The time element is 30 minutes for the new service compared to 20 for the reference. This is reasonable based on the need to conceptualize the three-dimensional nature of the distal aortic arch and proximal descending thoracic aorta as one plans for the surgical procedure. Although survey respondents identified a significant pre-service intensity discrepancy, greater for the new service (4.31 compared to 3.72), there really is no traditional pre-service intensity adjustment. Pre-service work for the reference is 0.45 RVUs. Pre-service work for the new service is  $(30/20) \times 0.45 = 0.67$  RVUs.

**INTRA-SERVICE WORK:** The new service and the reference have equal intra-service time (60 minutes), but respondents identified the intra-service intensity as being substantially greater than the reference (4.79 compared to 3.89), and our multispecialty Consensus Panel agrees that there is an overt increment in complexity when the endovascular repair extends into the aortic arch, crossing the left subclavian origin. The adjustment for time is  $90/60 = 1.5$ . The adjustment for complexity is  $4.48/3.83 = 1.17$ . Intra-work of 75952 is 3.70 RVUs. Thus, intra-work of the new service can be built from the reference as  $3.70 \times 1.17 = 4.32$ .

**POST-SERVICE WORK:** The new service has 20 minutes of post-time compared to 15 minutes for the reference, resulting in an increment of  $20/15 = 1.33$ . Post-work of 75952 is 0.34 RVUs. By extrapolation, Post-work of 7595X2 is  $0.34 \times 1.33 = 0.45$  RVUs.

#### SUMMARY OF 7595X2 built from 75952

	75952	7595X2 built from 75952
Pre-service work:	0.45 RVUs	0.67
Intra-service work:	3.70	4.32
Post-service work:	0.34	0.45
<b>TOTAL RVW:</b>	<b>4.49</b>	<b>5.44 RVW for 7595X2 based on 75952</b>

**IN CONCLUSION,** this service-period by service-period comparison of time and intensity supports an RVW very close to the median survey of 6.00. The difference can be accounted for by the extra intensity of the pre-service work when one is evaluating a descending thoracic aortic aneurysm or dissection. This standard building block model considers pre-service time at one-third less than standard Evaluation and Management. For the very complex planning required for descending thoracic aortic reconstruction our Consensus Panel believes the intensity of pre-service should exceed the standard 0.0224 IWPUT of pre-service work. This would push the ultimate value of 7595X2 very close to the 6.00 RVW median survey.



Specialty IR	Frequency 750	Percentage 50.00 %
Specialty vs	Frequency 750	Percentage 50.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients nationally** in a one-year period?  
 1,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty IR	Frequency 500	Percentage 50.00 %
Specialty VS	Frequency 500	Percentage 50.00 %
Specialty	Frequency	Percentage %

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

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? 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**

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CPT Code:75958 Tracking Number: II10 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: **4.00**  
RUC RVU: **4.00**

CPT Descriptor: Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); radiological supervision and interpretation

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old male with hypertension, 50 pack-years smoking, and previous myocardial infarction underwent endovascular repair of descending thoracic aortic aneurysm one year ago. On follow-up CT scan he is found to have a proximal endoleak. Risks and benefits of endovascular endoleak repair have been discussed, and he opted to proceed. Perioperative risk evaluation including cardiac workup indicated suitability for endovascular repair. Imaging studies (typically a combination of CT scan, MRI, and/or angiography) demonstrate that the endoleak is suitable for an endovascular approach. A proximal endovascular extension is deployed.

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? 7%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Check suite/OR to ensure proper function and configuration of the imaging equipment
- Ensure compliance with all radiation safety issues is assessed and assured.
- Ensure all technical personnel have been familiarized with the technique and all required devices.
- Supervise selection of all equipment, including catheters, wires, balloons, stents, sheaths, contrast material,
- Locate and review all prior relevant films/studies
- Suit up in Radiation protection
- Position patient (or supervise proper positioning)

## Description of Intra-Service Work:

- Direct technical personnel throughout procedure
- Interpret imaging of the vessel being treated, including complete views of the target vessel in all projections necessary
- Ensure accurate radiological views, exposures, shielding, image size, injection sequences,
- Manage radiation protection 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, opening balloons, assessing post-op success and complications.
- Quantitative measurement of lesion, target vessel & landing zones to confirm appropriate prosthesis and balloon sizes
- Continuous fluoroscopic imaging during all catheter/stent manipulations to assess proper position

## Description of Post-Service Work:

- 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

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Robert Vogelzang, MD Bibb Allen, MD Zachary Rattner, MD Gary Seabrook, MD					
<b>Specialty(s):</b>	Society of Interventional Radiology Society for Vascular Surgery American College of Radiology					
<b>CPT Code:</b>	75958					
<b>Sample Size:</b>	200	<b>Resp n:</b>	31	<b>Response:</b> 15.50 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		1.80	3.00	4.00	6.70	20.00
<b>Pre-Service Evaluation Time:</b>				30.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		30.00	40.00	60.00	90.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>20.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
75952	XXX	4.49

CPT Descriptor Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 11      % of respondents: 35.4 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 75958</u>	<u>Key Reference CPT Code: 75952</u>
Median Pre-Service Time	30.00	20.00
Median Intra-Service Time	60.00	60.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	110.00	95.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.36	3.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.18	3.91
Urgency of medical decision making	4.00	3.64

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

Technical skill required	4.64	4.18
Physical effort required	3.91	3.73

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.91	3.73
Outcome depends on the skill and judgment of physician	4.91	4.09
Estimated risk of malpractice suit with poor outcome	4.45	3.64

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

Pre-Service intensity/complexity	4.55	3.82
Intra-Service intensity/complexity	4.64	4.00
Post-Service intensity/complexity	3.73	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.*

Repairing a proximal endoleak after a prior endovascular descending thoracic aortic aneurysm or dissection repair requires precise delineation of the anatomy and ultimately accurate deployment of the proximal component. It is one of the most complex and challenging endovascular procedure yet devised. The hemodynamic forces across the aortic arch are extreme. In addition, the arch itself lies on a completely oblique three-dimensional plane between AP and true lateral, and in order to accomplish accurate device deployment the fluoroscopic imaging must identify the exact

orthogonal coordinates. Nevertheless, the reduction in patient morbidity and mortality accomplished by noninvasive repair of the descending thoracic aorta and any subsequent endoleaks makes this procedure a standout in minimally invasive surgery. This brief introduction should help one understand why the request for a radiological S&I RVW is substantially more than those previously recommended for proximal cuff placement.

#### BUILDING AN RVW FOR 7595X3 FROM KEY REFERENCE SERVICE 75952

CPT 75952, Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation, was chosen by 11 survey respondents (35%) as the key reference service. This is entirely logical on a clinical basis since 75952 is the S&I code used to report endovascular infrarenal aortic repair, and the intensity of 75952 is much more similar to deployment of a proximal thoracic extension than any other endovascular S&I code.

The time and intensity profiles of the new service 7595X3 and the reference 75952 are listed above. In order to build an RVW for the new service from the reference, adjustments must be made in all service compartments.

**PRE-SERVICE WORK:** Survey respondents judged the time of the new service to be 10 minutes greater than the 75952. This is reasonable on a clinical basis due to the need for three-dimensional evaluation of the aortic arch and proximal descending thoracic aorta as one plans for the endovascular procedure. Pre-service work for the reference is 0.45 RVUs. Pre-service work for the new service is  $(30/20) \times 0.45 = 0.67$  RVUs.

**INTRA-SERVICE WORK:** The new service and the reference have exactly the same intra-service time (60 minutes), but respondents appropriately identified the intra-service intensity of the new service as being greater than the reference (4.64 compared to 4.00), and our multispecialty Consensus Panel agrees that there is an increment in complexity because the proximal extension is deployed adjacent to, or crosses, the left subclavian origin. The adjustment for complexity is  $4.64/4.00 = 1.16$ . Intra-work of 75952 is 3.70 RVUs. Thus, intra-work of the new service can be built from the reference as  $3.70 \times 1.16 = 4.29$ .

**POST-SERVICE WORK:** The new service has 20 minutes of post-time compared to 15 minutes for the reference, resulting in an increment of  $20/15 = 1.33$ . Post-work of 75952 is 0.34 RVUs. By extrapolation, Post-work of 7595X3 is  $0.34 \times 1.33 = 0.45$  RVUs.

#### SUMMARY OF 7595X3 built from 75952

	75952	7595X3 built from 75952
Pre-service work:	0.45 RVUs	0.67
Intra-service work:	3.70	4.29
Post-service work:	0.34	0.45
TOTAL RVW:	4.49	5.41 RVW for 7595X3 based on 75952

**IN CONCLUSION,** this service-period by service-period comparison of time and intensity with the key reference service substantiates the median survey RVW of 4.00. We believe 4.00 to be an appropriate RVW for new service 7595X3.

#### 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.



Specialty	Frequency	0	Percentage	%
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Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:75959 Tracking Number: II11 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: **3.50**  
RUC RVU: **3.50**

CPT Descriptor: Placement of distal extension prosthesis(es) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin; radiological supervision and interpretation

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old male with hypertension, 50 pack-years smoking, and previous myocardial infarction underwent endovascular repair of descending thoracic aortic aneurysm one year ago. On follow-up CT scan he is found to have a distal endoleak. Placement of a distal extension is undertaken to seal the leak.

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? 13%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Check suite/OR to ensure proper function and configuration of the imaging equipment
- Ensure compliance with all radiation safety issues is assessed and assured.
- Ensure all technical personnel have been familiarized with the technique and all required devices.
- Supervise selection of all equipment, including catheters, wires, balloons, stents, sheaths, contrast material,
- Locate and review all prior relevant films/studies
- Suit up in Radiation protection
- Position patient (or supervise proper positioning)

**Description of Intra-Service Work:**

- Direct technical personnel throughout procedure
- Interpret imaging of the vessel being treated, including complete views of the target vessel in all projections necessary
- Ensure accurate radiological views, exposures, shielding, image size, injection sequences,
- Manage radiation protection 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, opening balloons, assessing post-op success and complications.
- Quantitative measurement of lesion, target vessel & landing zones to confirm appropriate prosthesis and balloon sizes
- Continuous fluoroscopic imaging during all catheter/stent manipulations to assess proper position

**Description of Post-Service Work:**

- 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

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Robert Vogelzang, MD Bibb Allen, MD Zachary Rattner, MD Gary Seabrook, MD				
<b>Specialty(s):</b>	Society of Interventional Radiology Society for Vascular Surgery American College of Radiology				
<b>CPT Code:</b>	75959				
<b>Sample Size:</b>	200	<b>Resp n:</b>	40	<b>Response:</b>	%
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		1.40	2.04	3.50	5.00
<b>Pre-Service Evaluation Time:</b>				20.0	
<b>Pre-Service Positioning Time:</b>				0.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0	
<b>Intra-Service Time:</b>		10.00	30.00	45.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>20.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
75952	XXX	4.49

CPT Descriptor Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 30.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 75959</u>	<u>Key Reference CPT Code: 75952</u>
Median Pre-Service Time	20.00	20.00
Median Intra-Service Time	45.00	60.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	85.00	95.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.25	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	3.92
Urgency of medical decision making	3.92	3.67

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

Technical skill required	4.58	4.00
Physical effort required	3.75	3.50

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.50	3.75
Outcome depends on the skill and judgment of physician	4.83	4.25
Estimated risk of malpractice suit with poor outcome	4.33	3.75

**INTENSITY/COMPLEXITY MEASURES**

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

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.50	3.83
Intra-Service intensity/complexity	4.33	3.92
Post-Service intensity/complexity	3.92	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.*

Repairing a distal endoleak after a prior endovascular descending thoracic aortic aneurysm or dissection repair requires precise delineation of the anatomy and ultimately accurate deployment of the new component. It is very a complex and challenging endovascular procedure. The descending thoracic aorta tends to be very tortuous just above the diaphragm in aneurysm patients, and accurate device deployment depends on skilled fluoroscopic imaging to identify the exact orthogonal coordinates. This brief introduction should help one understand why the request for a radiological S&I RVW

is more than those previously recommended for proximal cuff placement. The time and intensity of the work is actually much closer to that of 75952, S&I for infrarenal AAA repair.

#### BUILDING AN RVW FOR 7595X4 FROM KEY REFERENCE SERVICE 75952

CPT 75952, Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation, was chosen by 12 survey respondents (30%) as the key reference service. This is entirely logical on a clinical basis since 75952 is the S&I code used to report endovascular infrarenal aortic repair, and the intensity of 75952 is vastly more similar to deployment of a proximal thoracic extension than any other endovascular S&I code.

The time and intensity profiles of the new service 7595X4 and the reference 75952 are listed above. In order to build an RVW for the new service from the reference, adjustments must be made in all service compartments.

**PRE-SERVICE WORK:** Survey respondents judged the time of the new service to equal that of 75952. This is reasonable on a clinical grounds. Pre-service work for both services is therefore 0.45 RVUs.

**INTRA-SERVICE WORK:** The new service has 45 minutes of intra-tima, and the reference has 60 minutes. Respondents identified the intra-service intensity of the new service as being greater than the reference (4.33 compared to 3.92), and our multispecialty Consensus Panel agrees that there is an increment in complexity due to aortic tortuosity and the large device size. The adjustment for complexity is  $4.33/3.92 = 1.10$ . Intra-work of 75952 is 3.70 RVUs. Thus, intra-work of the new service can be built from the reference service using a time and intensity adjustment, as  $3.70 \times (45/60) \times 1.10 = 3.05$ .

**POST-SERVICE WORK:** The new service has 20 minutes of post-time compared to 15 minutes for the reference, resulting in an increment of  $20/15 = 1.33$ . Post-work of 75952 is 0.34 RVUs. By extrapolation, Post-work of 7595X4 is  $0.34 \times 1.33 = 0.45$  RVUs.

#### SUMMARY OF 7595X4 built from 75952

	75952	7595X4 built from 75952
Pre-service work:	0.45 RVUs	0.45
Intra-service work:	3.70	3.05
Post-service work:	0.34	0.45
TOTAL RVW:	4.49	3.95 RVW for 7595X4 based on 75952

IN CONCLUSION, this service-period by service-period comparison of time and intensity with the key reference service results in an RVW for the new service of 3.95, more than justifying the median survey RVW of 3.50. We believe 3.50 is the appropriate RVW for new service 7595X4.

#### 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)



**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
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		33880		33881	
2				II1		II2	
3				EVAR of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption), involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin		EVAR of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin	
4				090		090	
5				Code	StaffType	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	144	N/A	144
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60		60
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12		12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		72		72
10	<b>PRE-SERVICE</b>						
11	<i>Start: After visit for procedure/service</i>						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7
18	<i>End: Pt. enters site for procedure/service</i>						
19	<b>SERVICE PERIOD</b>						
40	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12		12
41	Other Clinical Activity (please specify)						
42	<i>End: Patient leaves site of procedure/service</i>						
43	<b>POST-SERVICE Period</b>						
44	<i>End: Patient leaves site of procedure/service</i>						
45	Conduct phone calls/call in prescriptions						
46	<i>List Number and Level of Office Visits</i>						
47	99211 16 minutes	L037D	RN/LPN/MTA				
48	99212 27 minutes	L037D	RN/LPN/MTA				
49	99213 36 minutes	L037D	RN/LPN/MTA		2		2
50	99214 53 minutes	L037D	RN/LPN/MTA				
51	99215 63 minutes	L037D	RN/LPN/MTA				
52	<b>Total Office Visit Time</b>			0	72	0	72
53	Other:						
54	<i>End: Last office visit in global period</i>						
55	<b>MEDICAL SUPPLIES</b>						
56	pack, minimum multi-specialty visit	SA048	pack		2		2
57	pack, post-op incision care (suture & staple)	SA053	pack		1		1
58							
59	<b>Equipment</b>						
60	table, power	EF031			72		72
61	light, exam	EQ168			72		72

	A	B	C	H	I	J	K
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		33883		33886	
2				I13		I15	
3				Placement of proximal extension prosthesis for EVAR of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); initial extension		Placement of distal extension prosthesis(es) delayed after EVAR of descending thoracic aorta	
4				090		090	
5				Code	StaffType	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	144	N/A	144
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60		60
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12		12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		72		72
10	<b>PRE-SERVICE</b>						
11	<i>Start: After visit for procedure/service</i>						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7
18	<i>End: Pt. enters site for procedure/service</i>						
19	<b>SERVICE PERIOD</b>						
40	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		12		12
41	Other Clinical Activity (please specify)						
42	<i>End: Patient leaves site of procedure/service</i>						
43	<b>POST-SERVICE Period</b>						
44	<i>End: Patient leaves site of procedure/service</i>						
45	Conduct phone calls/call in prescriptions						
46	<i>List Number and Level of Office Visits</i>						
47	99211 16 minutes	L037D	RN/LPN/MTA				
48	99212 27 minutes	L037D	RN/LPN/MTA				
49	99213 36 minutes	L037D	RN/LPN/MTA		2		2
50	99214 53 minutes	L037D	RN/LPN/MTA				
51	99215 63 minutes	L037D	RN/LPN/MTA				
52	<b>Total Office Visit Time</b>			0	72	0	72
53	Other:						
54	<i>End: Last office visit in global period</i>						
55	<b>MEDICAL SUPPLIES</b>	Code	Unit				
56	pack, minimum multi-specialty visit	SA048	pack		2		2
57	pack, post-op incision care (suture & staple)	SA053	pack		1		1
58							
59	<b>Equipment</b>	Code					
60	table, power	EF031			72		72
61	light, exam	EQ168			72		72

	A	B	C	L	M	N	O
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		33889		33891	
2				116		117	
3				Open subclavian to carotid artery transposition performed in conjunction with EVAR of descending thoracic aorta, by neck incision, unilateral		Bypass graft, with other than ven, transcervical retropharyngeal carotid-carotid, performed in conjunction with EVAR of descending thoracic aorta, by neck incision	
4				000		000	
5		Code	StaffType	NF	FAC	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0		0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0		0
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0		0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0		0
10	<b>PRE-SERVICE</b>						
11	<i>Start: After visit for procedure/service</i>						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		10		10
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5		5
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA				
18	<i>End: Pt. enters site for procedure/service</i>						
19	<b>SERVICE PERIOD</b>						
40	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA				
41	Other Clinical Activity (please specify)						
42	<i>End: Patient leaves site of procedure/service</i>						
43	<b>POST-SERVICE Period</b>						
44	<i>End: Patient leaves site of procedure/service</i>						
45	Conduct phone calls/call in prescriptions				3		3
46	<i>List Number and Level of Office Visits</i>						
47	99211 16 minutes	L037D	RN/LPN/MTA				
48	99212 27 minutes	L037D	RN/LPN/MTA				
49	99213 36 minutes	L037D	RN/LPN/MTA				
50	99214 53 minutes	L037D	RN/LPN/MTA				
51	99215 63 minutes	L037D	RN/LPN/MTA				
52	<b>Total Office Visit Time</b>						
53	Other:						
54	<i>End: Last office visit in global period</i>						
55	<b>MEDICAL SUPPLIES</b>	Code	Unit				
56	pack, minimum multi-specialty visit	SA048	pack				
57	pack, post-op incision care (suture & staple)	SA053	pack				
58							
59	<b>Equipment</b>	Code					
60	table, power	EF031					
61	light, exam	EQ168					

	A	B	C	P	Q
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		33884	
2				II4 Placement of proximal extension prosthesis for EVAR of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption), each additional proximal extension	
3					
4				ZZZ	
5		Code	StaffType	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0
10	<b>PRE-SERVICE</b>				
11	<i>Start: After visit for procedure/service</i>				
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		0
18	<i>End: Pt. enters site for procedure/service</i>				
19	<b>SERVICE PERIOD</b>				
40	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		0
41	Other Clinical Activity (please specify)				
42	<i>End: Patient leaves site of procedure/service</i>				
43	<b>POST-SERVICE Period</b>				
44	<i>End: Patient leaves site of procedure/service</i>				
45	Conduct phone calls/call in prescriptions				
46	List Number and Level of Office Visits				
47	99211 16 minutes	L037D	RN/LPN/MTA		
48	99212 27 minutes	L037D	RN/LPN/MTA		
49	99213 36 minutes	L037D	RN/LPN/MTA		
50	99214 53 minutes	L037D	RN/LPN/MTA		
51	99215 63 minutes	L037D	RN/LPN/MTA		
52	<b>Total Office Visit Time</b>				
53	Other:				
54	<i>End: Last office visit in global period</i>				
55	<b>MEDICAL SUPPLIES</b>	Code	Unit		
56	pack, minimum multi-specialty visit	SA048	pack		
57	pack, post-op incision care (suture & staple)	SA053	pack		
58					
59	<b>Equipment</b>	Code			
60	table, power	EF031			
61	light, exam	EQ168			

	A	B	C	R	S	T	U
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		75956		75957	
2				118		119	
3				EVAR of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological S&I		EVAR of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption), not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological S&I	
4				XXX		XXX	
5				Code	StaffType	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	0	N/A	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0		0
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0		0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0		0
10	<b>PRE-SERVICE</b>						
11	<i>Start: After visit for procedure/service</i>						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		0		0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		0		0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		0		0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		0		0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		0		0
18	<i>End: Pt. enters site for procedure/service</i>						
19	<b>SERVICE PERIOD</b>						
40	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		0		0
41	Other Clinical Activity (please specify)						
42	<i>End: Patient leaves site of procedure/service</i>						
43	<b>POST-SERVICE Period</b>						
44	<i>End: Patient leaves site of procedure/service</i>						
45	Conduct phone calls/call in prescriptions						
46	<i>List Number and Level of Office Visits</i>						
47	99211 16 minutes	L037D	RN/LPN/MTA				
48	99212 27 minutes	L037D	RN/LPN/MTA				
49	99213 36 minutes	L037D	RN/LPN/MTA				
50	99214 53 minutes	L037D	RN/LPN/MTA				
51	99215 63 minutes	L037D	RN/LPN/MTA				
52	<b>Total Office Visit Time</b>						
53	Other:						
54	<i>End: Last office visit in global period</i>						
55	<b>MEDICAL SUPPLIES</b>	Code	Unit				
56	pack, minimum multi-specialty visit	SA048	pack				
57	pack, post-op incision care (suture & staple)	SA053	pack				
58							
59	<b>Equipment</b>	Code					
60	table, power	EF031					
61	light, exam	EQ168					

	A	B	C	V	W	X	Y
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		75958		75959	
2				II10		II11	
3				Placement of proximal extension prosthesis for EVAR of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); radiological S&I		Placement of distal extension prosthesis(es) after EVAR of descending thoracic aorta, as needed, to level of celiac origin; radiological supervision and interpretation S&I	
4				XXX		XXX	
5				Code	StaffType	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	0	N/A	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0		0
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0		0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0		0
10	<b>PRE-SERVICE</b>						
11	<i>Start: After visit for procedure/service</i>						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		0		0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		0		0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		0		0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		0		0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		0		0
18	<i>End: Pt. enters site for procedure/service</i>						
19	<b>SERVICE PERIOD</b>						
40	Discharge day management 99238 -12 minutes	L037D	RN/LPN/MTA		0		0
41	Other Clinical Activity (please specify)						
42	<i>End: Patient leaves site of procedure/service</i>						
43	<b>POST-SERVICE Period</b>						
44	<i>End: Patient leaves site of procedure/service</i>						
45	Conduct phone calls/call in prescriptions						
46	List Number and Level of Office Visits						
47	99211 16 minutes	L037D	RN/LPN/MTA				
48	99212 27 minutes	L037D	RN/LPN/MTA				
49	99213 36 minutes	L037D	RN/LPN/MTA				
50	99214 53 minutes	L037D	RN/LPN/MTA				
51	99215 63 minutes	L037D	RN/LPN/MTA				
52	<b>Total Office Visit Time</b>						
53	Other:						
54	<i>End: Last office visit in global period</i>						
55	<b>MEDICAL SUPPLIES</b>	Code	Unit				
56	pack, minimum multi-specialty visit	SA048	pack				
57	pack, post-op incision care (suture & staple)	SA053	pack				
58							
59	<b>Equipment</b>	Code					
60	table, power	EF031					
61	light, exam	EQ168					

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Repair of Pulmonary Artery Arborization Anomaly**

CPT created two new codes and deleted two existing codes because the current codes do not adequately describe the procedure that is typically performed. The presenters stated that in most cases, the children undergoing this procedure have arborization abnormalities of the branch pulmonary arteries that need to be brought to a more central confluence (unifocalization) prior to complete repair of the heart defects. Usually, this unifocalization is performed as a staged procedure (first one side, then the other, if necessary) through a thoracotomy incision without the use of cardiopulmonary bypass. A systemic-to-pulmonary artery shunt may be constructed at the same time. Thus, it is uncommon for the actual cardiac portion of the defect (pulmonary atresia with ventricular septal defect) to be dealt with at this operation as is described in the current codes.

The RUC noted that the specialty society provided Harvard time data rather than RUC data for the reference code 33503 *Repair of anomalous coronary artery; by graft, without cardiopulmonary bypass* (work RVU = 21.75, intra-service time 240 minutes), therefore the IWPUT calculations for the reference service is invalid. In spite of using the incorrect reference service time data, the RUC felt that the 25<sup>th</sup> percentile value of 29.50 adequately represented the physician work involved in code 33925. The code was compared to MPC codes 35631 *Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU = 33.95, intra-service time = 225 minutes) and code 35531 *Bypass graft, with vein; aortoceliac or aortomesenteric* (work RVU = 36.15, intra-service time = 240 minutes)

For code 33926 *Repair of pulmonary, artery arborization anomalies by unifocalization; with cardiopulmonary bypass* the RUC concluded that the median survey value of 42.00 RVUs appropriately valued the additional work involved in performing the procedure with cardiopulmonary bypass, which takes an additional hour.

**The RUC recommends 29.50 work RVUs for code 33925.**

**The RUC recommends 42.00 work RVUs for code 33926.**

Practice Expense

The RUC recommends the standard inputs for 90 day global porcedures performed in the facility setting with the exception of using the RN staff type rather than the standard staff blend.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(D) 33918		<del>Repair of pulmonary atresia with ventricular septal defect, artery arborization anomalies by unifocalization of pulmonary arteries; without cardiopulmonary bypass</del>	090	N/A
(D) 33919		<del>with cardiopulmonary bypass</del> (33918, 33919 have been deleted. To report, see ● 33925, ● 33926)	090	N/A
● 33925	G1	Repair of pulmonary, artery arborization anomalies by unifocalization; without cardiopulmonary bypass	090	29.50
● 33926	G2	with cardiopulmonary bypass (Do not report 33925, 33926 with 33697)	090	42.00

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

CPT Code:33925 Tracking Number: G1 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **29.50**  
RUC RVU: **29.50**

CPT Descriptor: Repair of pulmonary, artery arborization anomalies by unifocalization; without cardiopulmonary bypass

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 3 month old child presents with cyanosis and is found to have a tetralogy of Fallot with pulmonary atresia, diminutive central pulmonary arteries, and several large aorto-pulmonary collaterals which supply over 50% of the lung mass.

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? 100%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write pre-operative orders for peri-operative medications

- Review pre-operative work-up
- Review Radiology
- Review Cardiac Catheterization and ECHO Cardiograms
- Review Laboratory findings
- Obtain informed consent
- Review planned incisions and procedure
- Confirm OR start time - notify patient and family
- Arrange for surgical assistant
- Change into scrub clothes
- Check with lab - check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown
- Available in operating room during insertion of monitoring lines and induction of anesthesia

Description of Intra-Service Work: This operation is typically done through thoracotomy or sternotomy and colateral vessels (MAPCA'S) are dissected out and mobilized at their origin from the descending aorta. The intraparenchymal or hiler pulmonary artery segment which is most appropriate for MAPCA implantation is mobilized and branch vessels are controlled. The MAPCA or MAPCA'S are then divided off the aorta and the aortic end is oversewn. The distal end of the MAPCA(S) is then sewn to the appropriate segment(s) of the true pulmonary artery. Clamps on the pulmonary artery branches and the MAPCA are released and hemeostaisis is obtained. Chest tubes are placed and the incision is closed. Careful monitoring of the oxygen saturation is maintained throughout the procedure.

Description of Post-Service Work: • Apply dressings

- Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Review recovery room care and medications with staff

- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Write post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Remain with patient in ICU 1-3 hours until patient is hemodynamically stable and there is no evidence of postoperative bleeding
- Visit ICU 2-3 times (15-20 minutes each) and before leaving hospital at the end of the day
- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Examine and talk with patient
- Check wounds and patient progress
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- Examine and talk with patient
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathir management of wound, return appointment to office, etc.
- Check wounds and patient progress
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes
- Examine and talk with patient Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

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**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Kirk Kanter
<b>Specialty(s):</b>	Society of Thoracic Surgeons/American Association for Throacic Surgery

<b>CPT Code:</b> 33925					
<b>Sample Size:</b> 40	<b>Resp n:</b> 21		<b>Response:</b> %		
<b>Sample Type:</b> Random					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	25.00	29.50	35.00	40.50	100.00
<b>Pre-Service Evaluation Time:</b>			90.0		
<b>Pre-Service Positioning Time:</b>			15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			30.0		
<b>Intra-Service Time:</b>	90.00	180.00	180.00	240.00	420.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>60.00</u>				
<b>Critical Care time/visit(s):</b>	<u>63.0</u>	99291x 1.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>117.0</u>	99231x 4.0	99232x 0.0	99233x 1.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>23.0</u>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
33503	090	21.75

CPT Descriptor Repair of anomalous coronary artery; by graft, without cardiopulmonary bypass

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35631	090	33.95

CPT Descriptor 1 Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorena

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
35531	090	36.15

CPT Descriptor 2 Bypass graft, with vein; aortoceliac or aortomesenteric

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
33916	090	25.79

CPT Descriptor Pulmonary endarterectomy, with our without emoblectomy, with cardiopulmonary bypass

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

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

Number of respondents who choose Key Reference Code: 6      % of respondents: 28.5 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 33925</u>	<u>Key Reference CPT Code: 33503</u>
Median Pre-Service Time	135.00	120.00
Median Intra-Service Time	180.00	240.00
Median Immediate Post-service Time	60.00	420.00
Median Critical Care Time	63.0	0.00
Median Other Hospital Visit Time	117.0	0.00
Median Discharge Day Management Time	36.0	0.00
Median Office Visit Time	23.0	118.00
Median Total Time	614.00	898.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	5.00	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
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	5.00	4.00
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Physical effort required	4.00	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	5.00	4.00
---	------	------

Outcome depends on the skill and judgment of physician	5.00	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	4.00	3.00
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**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.*

r. Kanter/Dr. Mayer please provide additional rationale here:

The 25<sup>th</sup> Percentile RVW was selected as it was more in line with this service in comparison with other similar services and the with bypass procedure then the median.



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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 33916 Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypass is a more appropriate crosswalk as it has a similar work RVU.

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

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

CPT Code:33926 Tracking Number: G2 Global Period: 090

**Recommended Work Relative Value**Specialty Society RVU: **42.00**RUC RVU: **42.00**

CPT Descriptor: Repair of pulmonary, artery arborization anomalies by unifocalization; with cardiopulmonary bypass

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 6 month old child is referred with cyanosis and echocardiogram and catheterization show a tetralogy of Fallot with pulmonary atresia. The central pulmonary arteries are discontinuous, and the blood supply to the left lung comes from a ductus like collateral vessel. The right lung is supplied by three large collateral vessels arising from the descending aorta.

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? 100%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write pre-operative orders for peri-operative medications

- Review pre-operative work-up
- Review Radiology
- Review Cardiac Catheterization and ECHO Cardiograms
- Review Laboratory findings
- Obtain informed consent
- Review planned incisions and procedure
- Confirm OR start time - notify patient and family
- Arrange for surgical assistant
- Change into scrub clothes
- Check with lab - check on availability of blood and/or x-ray match
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown
- Available in operating room during insertion of monitoring lines and induction of anesthesia

Description of Intra-Service Work: This operation is typically done through mediansternotomy and colateral vessels (MAPCA'S) are dissected out and mobilized at their origin from the descending aorta or brachiocephalic vessels. The patient is placed on cardiopulmonary bypass with aortic and venous cannulation. The intraparenchymal or hiler pulmonary artery segment which is most appropriate for MAPCA implantation is mobilized and branch vessels are controlled. The MAPCA or MAPCA'S are then divided off the aorta and the aortic end is oversewn. The distal end of the MAPCA(S) is then sewn to the appropriate segment(s) of the true pulmonary artery. Clamps on the pulmonary artery branches and the MAPCA are released and hemeostasis is obtained. The patient is then weaned from cardiopulmonary bypass and after removal of the venous cannulas protamine is given. After hemostasis is achieved the arterial cannula removed and the cannulation site repaired. Chest tubes are placed and the incision is closed. Careful monitoring of oxygen saturation are maintained throughout the post bypass period.

Description of Post-Service Work: • Apply dressings

- Dictate operative note for patients chart
  - Sign OR forms, indicating pre and post-op diagnoses, operation performed
  - Write orders for post-op labs, films, medications, diet, and patient activity
  - Review recovery room care and medications with staff
  - Discuss procedure outcome with family
  - Discuss procedure outcome with patient after emergence from anesthesia
  - Write post-op report
  - Discuss procedure outcome with referring physician
  - Coordinate care with other physicians
  - Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
  - Remain with patient in ICU 1-3 hours until patient is hemodynamically stable and there is no evidence of postoperative bleeding
  - Visit ICU 2-3 times (15-20 minutes each) and before leaving hospital at the end of the day
  - Examine patient, check wounds and patient progress
  - Review nursing/other staff patient chart notes
  - Answer patient family questions
  - Answer nursing/other staff questions
  - Write orders for following day's labs, films, medications, diet, and patient activity
  - Chart patient progress notes
  - Examine and talk with patient
  - Check wounds and patient progress
  - Discuss patient progress with referring physician (verbal and written)
  - Coordinate care with other physicians
  - Review nursing/other staff patient chart notes
  - Answer patient/family questions
  - Answer nursing/other staff questions (verbal and written)
  - Answer insurance staff questions
  - Write orders for post-op labs, films, medications, diet, and patient activity
  - Chart patient progress notes
  - Examine and talk with patient
  - Check final pathology/lab/film reports and discuss with patient
  - Carefully explain to patient and a family member dietary management, activities permitted, bathing, management of wound, return appointment to office, etc.
  - Check wounds and patient progress
  - Coordinate care with other physicians
  - Review nursing/other staff patient chart notes
  - Review post-discharge wound care and activity limitations with patient
  - Answer patient/family questions
  - Answer nursing/other staff questions
  - Answer insurance staff questions
  - Write orders for post-discharge labs, films, and medications
  - Chart patient discharge notes
  - Examine and talk with patient Check wounds and patient progress
  - Answer patient/family questions
  - Answer insurance staff questions
  - Discuss patient progress with referring physician (verbal and written)
  - Coordinate care with other physicians
  - Write orders for medications
  - Review post-discharge labs/films
  - Discuss progress with patient/family
  - Remove sutures/drains
  - Dictate patient progress notes for medical chart
-

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Kirk Kanter					
<b>Specialty(s):</b>	Society of Thoracic Surgeons/American Association for Throacic Surgery					
<b>CPT Code:</b>	33926					
<b>Sample Size:</b>	40	<b>Resp n:</b>	19	<b>Response:</b> 47.50 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		28.00	40.00	42.00	45.00	100.00
<b>Pre-Service Evaluation Time:</b>				90.0		
<b>Pre-Service Positioning Time:</b>				20.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				30.0		
<b>Intra-Service Time:</b>		180.00	210.00	240.00	300.00	450.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>60.00</u>					
<b>Critical Care time/visit(s):</b>	<u>63.0</u>	99291x 1.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>242.0</u>	99231x 9.0	99232x 1.0	99233x 1.0		
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>23.0</u>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
33619	090	44.93

CPT Descriptor Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35631	090	33.95

CPT Descriptor 1 Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorena

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
35531	090	36.15

CPT Descriptor 2 Bypass graft, with vein; aortoceliac or aortomesenteric

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
33412	090	41.94

CPT Descriptor Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)

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

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

Number of respondents who choose Key Reference Code: 5      % of respondents: 26.3 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u> 33926	<u>Key Reference CPT Code:</u> 33619
Median Pre-Service Time	140.00	45.00
Median Intra-Service Time	240.00	205.00
Median Immediate Post-service Time	60.00	52.50
Median Critical Care Time	63.0	0.00
Median Other Hospital Visit Time	242.0	280.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	23.0	98.00
Median Total Time	804.00	716.50
5		

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

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

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

Technical skill required	5.00	4.00
Physical effort required	5.00	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	5.00	5.00
Outcome depends on the skill and judgment of physician	5.00	5.00
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	5.00	3.00
Intra-Service intensity/complexity	5.00	3.00
Post-Service intensity/complexity	5.00	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.*

**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) 33919

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

Specialty cardiothoracic surgery                      How often? Rarely

Specialty    How often?

Specialty    How often?

Estimate the number of times this service might be provided nationally in a one-year period? 400  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency	Percentage 0.00 %
Specialty	Frequency	Percentage 0.00 %
Specialty	Frequency	Percentage %

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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 33412 Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) is a more appropriate crosswalk as it has a similar work RVU.

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-ONLY Direct Inputs**

CPT	DESCRIPTION	GLOBAL
33925 G1	Repair of pulmonary, artery arborization anomalies by unifocalization; without cardiopulmonary bypass	090
33926 G2	Repair of pulmonary, artery arborization anomalies by unifocalization; with cardiopulmonary bypass	090

**CLINICAL STAFF TIME: RN Staff**

**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 12 minutes (as supported by the PEAC) relative to coding of 99238 for discharge management for inpatient services has been applied.

**Post-service period clinical staff time:** Standard EM postop OFFICE visit times for clinical staff have been applied as appropriate.

**SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:**

Standard PEAC minimum multispecialty office visit supplies and incision care have been applied.

	A	B	C	D	E	F	G
1				33925		33926	
2				G1		G2	
3	Meeting Date: April 2005 Specialty:			Repair of pulmonary, artery arborization anomalies by unifocalization; without cardiopulmonary bypass		Repair of pulmonary, artery arborization anomalies by unifocalization; with cardiopulmonary bypass	
4				090		090	
5		Code	StaffType	NF	FAC	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L051A	RN	N/A	108	N/A	108
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN		60		60
8	TOTAL INTRA CLINICAL LABOR TIME	L051A	RN		12		12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN		36		36
10	<b>PRE-SERVICE</b>						
11	<i>Start: After visit for procedure/service</i>						
12	Complete pre-service diagnostic & referral forms	L051A	RN		5		5
13	Coordinate pre-surgery services	L051A	RN		20		20
14	Schedule space and equipment in facility	L051A	RN		8		8
15	Provide pre-service education/obtain consent	L051A	RN		20		20
16	Follow-up phone calls & prescriptions	L051A	RN		7		7
18	<i>End: Pt. enters site for procedure/service</i>						
19	<b>SERVICE PERIOD</b>						
40	Discharge day management 99238 --12 minutes	L051A	RN		12		12
41	Other Clinical Activity (please specify)						
42	<i>End: Patient leaves site of procedure/service</i>						
43	<b>POST-SERVICE Period</b>						
44	<i>End: Patient leaves site of procedure/service</i>						
45	Conduct phone calls/call in prescriptions						
46	List Number and Level of Office Visits						
47	99211 16 minutes	L051A	RN				
48	99212 27 minutes	L051A	RN				
49	99213 36 minutes	L051A	RN		1		1
50	99214 53 minutes	L051A	RN				
51	99215 63 minutes	L051A	RN				
52	<b>Total Office Visit Time</b>				36		36
53	Other:						
54	<i>End: Last office visit in global period</i>						
55	<b>MEDICAL SUPPLIES</b>	Code	Unit				
56	pack, minimum multi-specialty visit	SA048	pack		1		1
57	pack, post-op incision care (suture & staple)	SA053	pack		1		1
58							
59	<b>Equipment</b>	Code					
60	table, power	EF031			36		36
61	light, exam	EQ168			36		36

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Radiologic Venous Catheter Evaluation**

In 2004, the CPT Editorial Panel significantly changed the family of codes describing central venous access procedures. However, the radiological evaluation of an existing venous access device was not addressed. New code, 36598 *Contrast injection(s) for radiologic evaluation of existing venous access device, including fluoroscopy, image documentation and report* will be added to delineate the radiological evaluation and maintenance of existing venous access within the CPT.

The RUC discussed the possibility of code 36598 being billed with de-clotting procedures such as 36595 *Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access* (Work RVU = 3.59) or 36596 *Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen* (Work RVU = 0.75). RUC members commented that a parenthetical should be placed in CPT for the code not to be billed with these codes.

The RUC reviewed and compared the work of this code to reference code 50394 *Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter* (000 day global, Work RVU= 0.76) and to code 49424 *Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)* (000 day global, Work RVU = 0.76) . The RUC believed that the physician work was closely aligned with both codes 50394 and 49424, considering there was more time spent in the pre and post time periods. The RUC also believed that the 25<sup>th</sup> percentile survey results were consistent with the physician work involved, and therefore **recommends a relative work value of 0.74 for code 36598.**

**Practice Expense**

The RUC made some modifications to the specialty's original practice expense recommendation. Specifically, the clinical labor activity time was reduced on the following lines:

- Review Charts, line 25
- Provide pre-service education/obtain consent, line 28
- Assist physician in performing the procedure, line 34

In addition, the RUC increased the quantity of the exam table paper by one foot. The modified practice expense inputs recommended by the RUC are attached.

**Physician Liability Crosswalk**

The RUC recommends that an appropriate crosswalk code for the physician liability is its reference code 50394 *Injection procedure for pyelography (as nephrostrom, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter.*

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 36598	P1	Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report  <u>(Do not report 36598 in conjunction with 76000)</u>  <u>(Do not report 36598 in conjunction with 36595, 36596)</u>  <u>(For complete diagnostic studies, see 75820, 75825, 75827)</u>	000	0.74

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

CPT Code:36598 Tracking Number: P1 Global Period: 000

**Recommended Work Relative Value**  
Specialty Society RVU: **0.88**  
RUC RVU: **0.74**

CPT Descriptor: Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report

(Do not report 76000 in conjunction with 36598, for complete diagnostic studies, see 75820, 75825, 75827)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45 year old patient with Hodgkin's lymphoma is undergoing several weeks of chemotherapy, and a Hickman catheter was previously placed to allow for ongoing intravenous chemotherapy and frequent blood draws. However, after two months, the oncology staff is no longer able to draw blood from the catheter. It is not clear whether the catheter tip remains in the vein, and the oncology staff is unable to administer the chemotherapy without knowing the location of the catheter tip. The patient is referred for imaging of the catheter to determine its position, patency, and if anything can be done to restore ability to draw blood from the catheter.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 89%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician:

- Reviews any previous imaging studies, patient history, and lab tests.
- Discusses the procedure with the patient and obtains informed consent.
- Confirms set-up of imaging equipment, patient positioning, and presence of the necessary procedural supplies.

Description of Intra-Service Work:

- The physician performs a quick physical inspection of the catheter site.
- If the catheter is not dislodged or kinked, the physician then exposes and preps the external port of the catheter in sterile fashion.
- Fluoroscopic evaluation of the catheter is performed by the physician, confirming that the tip of the catheter lies in the central vein as intended, and has not migrated into the heart or been pulled back into a peripheral vein or out of the vein. Fluoroscopy also determines if the catheter has been fractured or kinked.
- The physician aspirates the catheter and indwelling Heparin is discarded if possible.
- Contrast is then injected by the physician with imaging of the catheter tip and the vein where the catheter tip is positioned. If necessary, imaging is performed along the course of the catheter to determine if there is a leak in the catheter. (Once imaging is completed, any procedures that are done to try to restore function of the catheter, if necessary, are coded separately.)
- The catheter is flushed with saline and may be locked with Heparin solution.

Description of Post-Service Work:

- The physician issues instructions given to the staff and to the patient as to appropriate use or non-use of the catheter.
- A report is dictated for the referring physician and call made to the oncology unit.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2005
Presenter(s):	Bibb Allen, Jr., MD, ACR Robert L. Vogelzang, MD, SIR

<b>Specialty(s):</b>	American College of Radiology Society of Interventional Radiology				
<b>CPT Code:</b>	36598				
<b>Sample Size:</b>	230	<b>Resp n:</b>	29	<b>Response:</b> 12.60 %	
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.25	0.74	0.88	1.14	4.50
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			5.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.0		
<b>Intra-Service Time:</b>	2.00	5.00	10.00	10.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>10.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u> 50394	<u>Global</u> 000	<u>Work RVU</u> 0.76
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CPT Descriptor Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1 See Attachment 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u> 75902	<u>Global</u> XXX	<u>Work RVU</u> 0.39
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CPT Descriptor Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation

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

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

Number of respondents who choose Key Reference Code: 9      % of respondents: 31.0 %

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 36598	Key Reference CPT Code: 50394
Median Pre-Service Time	15.00	16.00
Median Intra-Service Time	10.00	19.00
Median Immediate Post-service Time	10.00	13.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	35.00	48.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	2.14	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.86	1.78
Urgency of medical decision making	2.31	2.22

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

Technical skill required	1.83	1.22
Physical effort required	1.63	1.33

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	1.66	1.44
Outcome depends on the skill and judgment of physician	2.24	1.78
Estimated risk of malpractice suit with poor outcome	1.97	1.67

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

Pre-Service intensity/complexity	1.79	1.44
Intra-Service intensity/complexity	2.04	1.78
Post-Service intensity/complexity	1.76	1.56

**ADDITIONAL RATIONALE**

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

The ACR and SIR believe that the recommended RVW of 0.88 for code 3659X is commensurate with the physic work associated with the procedure.

First, the recommended RVW is lower than the sum of the codes used currently to describe the procedure. The three dominate ways this service is or was reported are: (1) 36005 (RVW=0.95) + 76000 (RVW=0.17); total RVW of 1.12, (2) 75825-52 (RVW=1.14 without reduction), or (3) 75827-52 (RVW=1.14 without reduction).

Second the recommended RVW of 0.88 for 3659X results in an IWPUT of 0.0392, found in the following manner:

## IWPUT ANALYSIS

Survey CPT code: 3659X  
MEDIAN Svy RVW: 00.88

Pre-service	Survey Data		RUC Standard	RVW
	Time	Intensity	(=time x intensity)	
Pre-service eval & positioning	10	0.0224		0.224
Pre-service scrub, dress, wait	5	0.0081		0.0405
Pre-service total	15			0.2645
Post-service	Time	Intensity		
Immediate post	10	0.0224		0.224
Subsequent visits:NONE				
Post-service total	10			0.224
	Time	IWPUT	INTRA-RVW	
Intra-service:	10	0.03915		0.3915

In comparison to its key reference service (code 50394), code 3659X contains several elements that represent additional physician work. First of all, code 3659X includes fluoroscopic imaging that is exclusive of code 50394. Next, there is substantially more physical effort and labor associated with code 3659X over that for code 50394. The requirement for absolute sterility when doing an injection evaluation of an implanted central venous catheter is much greater than that for contrast nephrostogram, as inadvertent contamination of the catheter can result in loss of the access due to tunnel infection. Because many patients present for evaluation with catheters covered with sticky dressing tape residue and glue, time and effort must be expended in removing this residue and adherent glue from all surfaces of the catheter, otherwise efforts to sterilize it are futile. Then once the dressing residue is removed, the catheter, with all its interstices and regular surface shapes, must be meticulously scrubbed prior to applying the sterile prep solution.

Finally, the recommended RVW for 3659X falls within the range of RVWs from 0.60 (code 76005) to 1.36 (code 99382) for codes on the MPC having total physician time of 35 minutes. See Appendix 1 for a listing of MPC codes with 35 minutes of total physician time.

## 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)

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. Code 3659X is typically (approximately 60 percent of instances) reported by itself.



	A	B	C	D	E
1					
2					CPT Code 35598
3	RUC Recommendation				Code Descriptor: Contrast injection(s) for radiologic evaluation of existing venous access device,
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
5	GLOBAL PERIOD			0	0
6	TOTAL CLINICAL LABOR TIME			34.0	
7	TOTAL RN/LPN/MTA CLINICAL LABOR TIME	L037D	RN/LPN/MTA	15.0	0.0
8	TOTAL RT CLINICAL LABOR TIME	L041B	RT	19.0	0.0
9	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	12.0	0.0
11	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L041B	RT	19.0	0.0
12	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3.0	0.0
13	<b>Start. Following visit when decision for surgery or procedure made</b>				
14	Start. Following visit when decision for surgery or procedure made				
15	Complete pre-service diagnostic & referral forms				
16	Coordinate pre-surgery services				
17	Schedule space and equipment in facility				
18	Provide pre-service education/obtain consent				
19	Follow-up phone calls & prescriptions				
20	Other Clinical Activity (please specify)				
21	End When patient enters office/facility for surgery/procedure				
22	<b>Start When patient enters office/facility for surgery/procedure</b>				
23	Start When patient enters office/facility for surgery/procedure				
24	Pre-service services				
25	Review charts	L041B	RT	3	
26	Greet patient and provide gowning	L037D	RN/LPN/MTA	3	
27	Obtain vital signs	L037D	RN/LPN/MTA	3	
28	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3	
29	Prepare room, equipment, supplies	L041B	RT	2	
30	Setup scope (non facility setting only)				
31	Prepare and position patient/ monitor patient	L041B	RT	2	
32	Sedate/apply anesthesia				
33	Intra-service				
34	Assist physician in performing procedure/acquiring images RT present 100%	L041B	RT	7	
35	Assist physician with image acquisition (76060 only)				
36	Assist physician with imaging during the procedure (76080 only)				
37	Post-Service				
38	Monitor pt following service/check tubes, monitors, drains				
39	Clean room/equipment by physician staff	L041B	RT	3	
40	Clean Scope				
41	Clean Surgical Instrument Package				
42	Complete diagnostic forms, lab & X-ray requisitions				
43	Review/read X-ray, lab, and pathology reports				
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
45	Discharge day management 99238 -12 minutes 99239 -15 minutes				
46	Other Clinical Activity (please specify)				
47	Process images, complete data sheet, present images and data to the interpreting physician	L041B	RT	2	
48	Instruct patient about catheter maintenance and proper flushing technique	L037D	RN/LPN/MTA	3	
49	End Patient leaves office				
50	<b>Start Patient leaves office/facility</b>				
51	Start Patient leaves office/facility				
52	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	
53	Office visits				
54	List Number and Level of Office Visits				
55	99211 16 minutes			16	
56	99212 27 minutes			27	
57	99213 36 minutes			36	
58	99214 53 minutes			53	
59	99215 63 minutes			63	
60	Other				
61					
62	Total Office Visit Time			0	0
63	Other Activity (please specify)				
64	End with last office visit before end of global period				

	A	B	C	D	E
2				CPT Code: 36598	
3	RUC Recommendation			Code Descriptor: Contrast Injection(s) for radiologic evaluation of existing venous access device,	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
65					
66	bandage, Kling, sterile 4"	SG020	item	1	
67	biohazard bag	SM004	item	1	
68	cap surgical	SB001	item	1	
69	drape, sterile, c-arm, fluoro	SB008	item	1	
70	gloves, sterile	SB024	pair	2	
71	gown, patient	SB026	item	1	
72	hepenn lock flush solution	SH040	item	1	
73	hepenn, 1000 ml	SH039	ml	5	
74	mask, surgical	SB033	item	1	
75	pack, basic injection	SA041	item	1	
76	paper, exam table	SB036	foot	7	
77	shoe covers, surgical	SB039	pair	2	
78	sodium chloride 0.9% flush syringe	SH065	item	2	
79	syringe, 3 cc	SC055	item	1	
80	x-ray envelope	SK091	item	1	
81	film 14 x 17	SK034	item	1	
82	x-ray developer solution	SK089	oz	0.5	
83	x-ray fixer solution	SK092	oz	0.5	
84	disinfectant spray	SM012	ml	30	
85					
86					
87	Radiographic/fluoroscopic room	E51005		17	
88	film alternator			X	
89	laser printer for CT angiography			X	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

**Mechanical Thrombectomy**

The CPT Editorial Panel created four new codes because current CPT codes describe procedures that alter the anatomy of the artery by modification of the arterial wall or removal of a portion of a plaque and not the removal of thrombus within the lumen of a vessel. The new codes describe a group of related procedures that use unique percutaneous methods of fragmenting/macerating and/or removal of clots. Therefore, the creation of these codes will help ensure patient access to all methods of thrombus removal, allowing the optimal method to be chosen for each patient.

The RUC reviewed specialty society recommendations for the four new mechanical thrombectomy codes for work and practice expense. Each of the new codes were evaluated against their key reference service and other comparable codes across specialties. The RUC discussed each code recommendation with the specialty society and assisted in revising the specialty recommendation prior to the full RUC meeting to reflect the typical patient encounter. These revisions included a reduction in the pre-service time and a reduction in the work relative value recommendations. The RUC further agreed with the specialty who believed the work intensity for the family of codes was similar to the intensity of RUC reviewed add-on code 92973 *Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure)* (Work RVU= 3.28) of 0.082. The details of each of these RUC recommendations are shown below.

**37184**

The RUC reviewed code 37184 *Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel* for its physician time and intensity against its key reference service, RUC surveyed 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* (090 day global, Work RVU = 5.15). The RUC also compared the code to RUC surveyed, MPC list code 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)* (090 day global, Work RVU = 11.27), and backed out all post operative time to reflect a 000 day global procedure. The RUC believed that the value of the new code is less intense than 58660, and believed the intensity of this new code is comparable to code 92973 *Percutaneous transluminal coronary thrombectomy* (Work RVU= 3.28). The RUC applied a building block approach using the intensity of 92973 after reducing the physician time in the pre-service to a total of 40 minutes from 60 minutes to reflect the typical patient encounter. **The RUC recommends a work relative value of 8.66 for code 37184.**

### 37185

The RUC reviewed add-on code 37185 *Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family* for its physician time and intensity against its key reference service, RUC surveyed 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* (090 day global, Work RVU = 5.15). The RUC also compared the 37185 to RUC surveyed code 92973 *Percutaneous transluminal coronary thrombectomy* (Work RVU= 3.28), as it utilizes the same technology. The RUC applied a building block approach using the intensity of 92973. **The RUC recommends a work relative value of 3.28 for code 37185.**

### 37186

The RUC reviewed add-on code 37186 *Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); secondary percutaneous transluminal thrombectomy (eg, non-primary mechanical, snare basket, suction technique) non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy* for its physician time and intensity against its key reference service, RUC surveyed 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* (090 day global, Work RVU = 5.15). The RUC also compared the 37186 to RUC surveyed code 92973 *Percutaneous transluminal coronary thrombectomy* (Work RVU= 3.28), and to 37184. The RUC applied a building block approach using the intensity of 92973 and 37184 and 60 minutes from the specialty survey. **The RUC recommends a work relative value of 4.92 for code 37186.**

### 37187

The RUC reviewed code 37187 *Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance* for its physician time and intensity against its key reference service, RUC surveyed 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* (090 day global, Work RVU = 5.15). It was understood by the RUC that code 37187 involved more intra-service time than its reference code and that it is more complex and intense. The RUC also compared the code to RUC surveyed, MPC list code 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)* (090 day global, Work RVU = 11.27), and backed out all post operative time to reflect a 000 day global procedure. The RUC believed that the value of the new code is less intense than 58660, and believed the intensity of this new code is comparable to code 92973 *Percutaneous transluminal coronary thrombectomy* (Work RVU= 3.28). The RUC applied a building block approach using

the intensity of 92973 after reducing the physician time in the pre-service to a total of 40 minutes from 73 minutes to reflect the typical patient encounter. **The RUC recommends a work relative value of 8.03 for code 37187.**

**37188**

The RUC reviewed code 37188 *Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy* for its physician time and intensity against its key reference service, RUC surveyed 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* (090 day global, Work RVU = 5.15). The RUC also compared the code to RUC surveyed, MPC list code 46262 *Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy* (090 day global, Work RVU = 7.49), and backed out all post operative time to reflect a 000 day global procedure. The RUC believed that the value of the new code was similar to the post operatively stripped 46262 code, and believed the intensity of this new code is comparable to code 92973 *Percutaneous transluminal coronary thrombectomy* (Work RVU= 3.28). The RUC applied a building block approach using the intensity of 92973 after reducing the physician time in the pre-service to a total of 35 minutes from 50 minutes to reflect the typical patient encounter. **The RUC recommends a work relative value of 5.71 for code 37188.**

**In summary, the RUC recommends the following revisions to pre-service time and work relative values:**

<b>New Code</b>	<b>Pre-Service Time</b>	<b>Recommended Work RVU</b>
<b>37184</b>	<b>40</b>	<b>8.66</b>
<b>37185</b>	<b>0</b>	<b>3.28</b>
<b>37186</b>	<b>0</b>	<b>4.92</b>
<b>37187</b>	<b>40</b>	<b>8.03</b>
<b>37188</b>	<b>35</b>	<b>5.71</b>

**Practice Expense**

The RUC accepted the specialty society’s practice expense recommendations after careful review and minor typographical corrections.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p><i>Codes for catheter placement and the radiologic supervision and interpretation should also be reported, in addition to the code(s) for the therapeutic aspect of the procedure.</i></p> <p><b>Mechanical Thrombectomy</b></p> <p>Code(s) for catheter placement(s), diagnostic studies and other percutaneous interventions (eg, percutaneous transluminal balloon angioplasty, stent placement) provided are separately reportable.</p> <p>Codes 37184-37188 specifically include intraprocedural fluoroscopic radiological supervision and interpretation services for the guidance of the procedure.</p> <p>Intraprocedural injection(s) of a thrombolytic agent is an included service and not separately reportable in conjunction with mechanical thrombectomy. However, subsequent or prior continuous infusion of thrombolytic is not an included service and is separately reportable (see 37201, 75896, 75898).</p> <p>For coronary mechanical thrombectomy, use 92973.</p> <p>For mechanical thrombectomy for dialysis fistula, use 36870.</p> <p><b>Arterial Mechanical Thrombectomy</b></p> <p>Arterial mechanical thrombectomy may be performed as a “primary” transcatheter procedure with pre-treatment planning, performance of the procedure, and post-procedure evaluation focused on providing this service. Primary mechanical thrombectomy is reported per vascular family using 37184 for the initial vessel treated, and 37185 for second or all subsequent vessel(s) within the same vascular family. To report mechanical thrombectomy of an additional vascular family treated through a separate access site, use modifier 51 in conjunction with 37184-37185. Do NOT report 37184-37185 for mechanical thrombectomy performed for treatment of thrombus/embolus complicating other percutaneous interventional procedures, see 37186.</p> <p>Arterial mechanical thrombectomy is considered a “secondary” transcatheter procedure for removal/retrieval of short segments of thrombus/embolus when performed either before or after another percutaneous intervention (eg, percutaneous transluminal balloon angioplasty, stent placement). Secondary mechanical thrombectomy is reported using 37186. Do NOT report 37186 in conjunction with 37184-37185.</p> <p><b>Venous Mechanical Thrombectomy</b></p> <p>Use code 37187 to report the initial application of venous mechanical thrombectomy. To report bilateral venous mechanical thrombectomy performed through a separate access site(s), use modifier 50 in conjunction with 37187. For repeat treatment on a subsequent day during a course of thrombolytic therapy, use 37188.</p>				



CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Arterial Mechanical Thrombectomy</b>				
◎●37184	KK1	Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel  (Do not report 37184 in conjunction with 76000, 76001, 90783, 99141, 99142)	000	8.66
◎●+37185	KK2	second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure) (Use 37185 in conjunction with 37184)  (Do not report 37185 in conjunction with 76000, 76001, 90783)	ZZZ	3.28

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
©●+37186	KK3	<p>secondary percutaneous transluminal thrombectomy (eg, non-primary mechanical, snare basket, suction technique) non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)</p> <p>(Do not report 37186 in conjunction with 76000, 76001, 90783)</p>	ZZZ	4.92
<b>Venous Mechanical Thrombectomy</b>				
©●37187	KK4	<p>Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance</p> <p>(Do not report 37187 in conjunction with 76000, 76001, 90784)</p>	000	8.03
©●37188	KK5	<p>Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat</p>	000	5.71

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		treatment on subsequent day during course of thrombolytic therapy (Do not report 37188 in conjunction with 76000, 76001, 90784)		
<b>Other Procedures</b>				
37195		<i>Thrombolysis, cerebral, by intravenous infusion</i>	XXX	N/A
37200		<i>Transcatheter biopsy</i> (For radiological supervision and interpretation, <i>see use 75970</i> )	000	3.55  (No Change)
▲37209		Exchange of a previously placed <del>arterial</del> <u>intravascular</u> catheter during thrombolytic therapy  (For radiological supervision and interpretation, <i>see use 75900</i> )	000	2.27  (No Change)
▲75900		Exchange of a previously placed <del>arterial</del> <u>intravascular</u> catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation	XXX	0.49  (No Change)

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

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<p>CPT Code:37184 Tracking Number: KK1 Global Period: 000</p> <p>CPT Descriptor: Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel (Do not report 37XX1 in conjunction with 76000, 76001, 90783, 99141, 99142)</p>	<p><b>Recommended Work Relative Value</b> Specialty Society RVU: <b>8.66</b> RUC RVU: <b>8.66</b></p>
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#### Mechanical Thrombectomy

Code(s) for catheter placement(s), diagnostic studies and other percutaneous interventions (eg, percutaneous transluminal balloon angioplasty, stent placement) provided are separately reportable.

Codes 37XX1-37XX5 specifically include intraprocedural fluoroscopic radiological supervision and interpretation services for the guidance of the procedure.

Intraprocedural injection(s) of a thrombolytic agent is an included service and not separately reportable in conjunction with mechanical thrombectomy. However, subsequent or prior continuous infusion of thrombolytic is not an included service and is separately reportable (see 37201, 75896, 75898).

For coronary mechanical thrombectomy, use 92973.

For mechanical thrombectomy for dialysis fistula, use 36870.

#### Arterial Mechanical Thrombectomy

Arterial mechanical thrombectomy may be performed as a primary transcatheter procedure with pre-treatment planning, performance of the procedure, and post-procedure evaluation focused on providing this service. Primary mechanical thrombectomy is reported per vascular family using 37XX1 for the initial vessel treated, and 37XX2 for second or all subsequent vessel(s) within the same vascular family. To report mechanical thrombectomy of an additional vascular family treated through a separate access site, use modifier 51 in conjunction with 37XX1-37XX2. Do NOT report 37XX1-37XX2 for mechanical thrombectomy performed for treatment of thrombus/embolus complicating other percutaneous interventional procedures, see 37XX3.

Arterial mechanical thrombectomy is considered a secondary transcatheter procedure for removal/retrieval of short segments of thrombus/embolus when performed either before or after another percutaneous intervention (eg, percutaneous transluminal balloon angioplasty, stent placement). Secondary mechanical thrombectomy is reported using 37XX3. Do NOT report 37XX3 in conjunction with 37XX1-37XX2.

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#### **CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: The patient is a 75-year-old female with history of recent stroke who presents with acute onset of lower limb ischemia, beginning earlier the same day. At presentation to the emergency room, the foot is cool and pale. There is no rest pain, but a light hypesthesia of the forefoot is noted. The patient has a history of previous synthetic femoral-popliteal bypass graft in the left leg. Physical exam reveals a normal left femoral pulse, but no pulse palpable in the bypass graft, the popliteal artery, or pedal or tibial arteries. The emergency room physician refers patient to the vascular specialist on-call, who orders an emergent diagnostic angiogram (reported separately), which demonstrates a patent common femoral artery and profunda femoral artery, but total occlusion of the femoral popliteal bypass graft is confirmed. There is reconstitution of the popliteal artery below the level of the distal anastomosis, and delayed run-off is identified in the peroneal and posterior tibial arteries. After considering all treatment options, the

physician decides to use an endovascular approach for treatment. Because of the history of recent stroke, the patient is felt to be a poor surgical candidate, and is not a candidate for pharmacologic thrombolysis. Mechanical thrombectomy is offered to try to re-establish flow to the foot.

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: The physician:

- Discusses procedure with patient, family, and referring physician and informed consent is obtained.
- Supervises room set up, including sterile preps and drapes, proper patient positioning is confirmed.
- Selects the appropriate equipment such as catheters, sheaths, guidewires, and mechanical thrombectomy device.
- Directs Staff to prepare for the procedure.

Description of Intra-Service Work: The physician:

- Orders medications for conscious sedation.
- Punctures the common femoral artery in an antegrade fashion, and a wire is used to select the occluded bypass graft (separately reported). The guide wire is positioned, under fluoroscopy, across the occlusion, and an appropriate-sized sheath is placed at the groin.
- Administers heparin.
- Advances the mechanical thrombolysis device over the wire, into the thrombus, and into the lower limit of the occlusion. Positions the device optimally under fluoroscopy.
- Activates the device and passed across the site (often several times), macerating the thrombus. All fluoroscopy and angiograms performed to guide the therapy and monitor the progress of the therapy are included. If residual thrombus is documented, the mechanical thrombolytic device is again activated for further thrombus removal. Lytic agent may be administered, as necessary. Fluoroscopy is again used to direct the device. If a small fragment of thrombus is not removed by the thrombectomy device, it may be removed with aspiration through the sheath or through a large-bore catheter placed to the remaining thrombus.
- Performs a final completion angiogram to confirm that the entire volume of occlusive material has been removed and that flow has been restored.
- Removes the mechanical thrombectomy device, catheters, and guidewires are removed.
- Applies compression is for hemostasis.

Description of Post-Service Work: The physician:

- Reviews all final fluoroscopic images
- Dictates and reviews the procedure report.
- Apprises referring physician of procedure outcome.

## SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	Bibb Allen, MD Robert Vogelzang, MD Zachary Rattner, MD Gary Seabrook, MD				
Specialty(s):	American College of Radiology Society of Interventional Radiology Society for Vascular Surgery				
CPT Code:	37184				
Sample Size:	150	Resp n:	32	Response:	21.33 %
Sample Type:	Random				
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>
					<u>High</u>

<b>Survey RVW:</b>	5.50	7.38	<b>9.88</b>	12.00	19.85
<b>Pre-Service Evaluation Time:</b>			<b>20.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.0</b>		
<b>Intra-Service Time:</b>	30.00	60.00	<b>90.00</b>	113.00	150.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b><u>30.00</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
36870	090	5.15

CPT Descriptor Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
58660	090	11.27

CPT Descriptor 1 Laparocopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

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

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 37.5 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 37184	Key Reference CPT Code: 36870
Median Pre-Service Time	40.00	20.00
Median Intra-Service Time	90.00	60.00
Median Immediate Post-service Time	30.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	0.0	15.00
Median Total Time	160.00	146.00
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	3.73	2.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	2.50
Urgency of medical decision making	4.53	2.63

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

Technical skill required	4.13	3.25
Physical effort required	3.73	3.00
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.40	2.75
Outcome depends on the skill and judgment of physician	4.53	3.63
Estimated risk of malpractice suit with poor outcome	3.87	2.50

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

Pre-Service intensity/complexity	3.88	2.63
Intra-Service intensity/complexity	4.31	2.88
Post-Service intensity/complexity	3.63	2.50

**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 most common reference service chosen by respondents was 36870, percutaneous thrombectomy of a hemodialysis access. This is a good choice because 36870 includes mechanical thrombus extraction, essentially the same technique employed in new code 37XX1. 36870, however, is a shorter and less intense service than the new code. Code 36870 is subcutaneous, thus access is easier to achieve. Also, AV percutaneous thrombectomy is less likely to require the use of lytic agents. Use of lytic agents increase the risk of hemorrhage, both locally and systemically. Clot in AV accesses tend

to be shorter and more focally. Conversely, arterial percutaneous thrombectomy carries increased risk of bad outcomes. Arterial thrombectomy is more apt to use lytic agents and in greater concentrations. Arterial thrombectomy may dislodge particulate clot which may lodge more distally increasing the risk of amputation. There are fewer alternatives to arterial thrombectomy and cases tend to be more emergent than with AV thrombectomy. Arterial segments of clot tend to be longer than AV.

Respondents judged the new code to be 50% more intense (intra-service intensity 4.31 compared to 2.88 = 1.50). In addition, intra-service time for the new code is 93 minutes compared to 60 minutes for 36870. The intra-service work of the reference code is 2.80 RVUs (per IWPUT analysis). If we start with this intraservice work of 2.80, then adjust for the increased time of the new code (93/60) then adjust for the intensity of the new code (4.31/2.88), the intraservice work of the new code is 6.51. If one then adds in the pre-service work 1.17 RVUs, the immediate post-service 0.27 RVUs, and the standard half discharge day accorded to 0-day global services, 0.64 RVUs, the total work value, based on the most common reference service, is 8.59 RVUs

Comparison to an MPC list service is 58660, Laparoscopy, surgical, lysis of adhesions. This is an "A" service on the MPC list with an RVW of 11.27. The comparison service is a 90-day global, which includes one discharge day service (99238) and one outpatient visit (99213). Intra-service time for the comparison service is slightly shorter (90 min) compared to 93 minutes for the new service. The new service has 65 min of pre time compared to 48 min for 58660. Immediate post-service time is 18 min longer in the MPC ref service. Intensity of the new service, lysing thrombus in major arteries of the body, is similar to that of the reference, lysing adhesions in the abdomen. The relative value of the new service can therefore be calculated as the RVW of the reference 11.27, less 1/2 of a discharge day (-0.64), less the outpatient visit (-0.65), plus the adjustment for pre and immediate post service (net one min, -0.02). Based on comparison with an "A" class MPC reference the value of the new service should be 11.27, less 0.64, less 0.65, less 0.02 = 9.96.

IWPUT Calculator      37XX1 Mechanical thrombectomy

Building Block Method Proposed RVW 9.88

Pre-service	Time	Intensity (=time x intensity)
Day prior evaluation	0	0.0224 0.00
Same day evaluation	45	0.0224 1.01
Scrub, prep, positioning	20	0.0081 0.16
Pre-service total		1.17

	Time	IWPUT(=time x intensity)
Intra-service	93	0.084 7.80

Post-service	Time	Intensity	(=time x intensity)
Immediate post	12	0.0224	0.27
Discharge 99238	18	0.5	1.28
Post-service total			0.91

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## 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.)



**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. 36831

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**

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CPT Code:37185 Tracking Number: KK2 Global Period: ZZZ

**Recommended Work Relative Value**  
Specialty Society RVU: **3.28**  
RUC RVU: **3.28**

**CPT Descriptor:**

Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure) (Use 37XX2 in conjunction with 37XX1)

(Do not report 37XX2 in conjunction with 76000, 76001, 90783)

**Introductory Text:**

**Mechanical Thrombectomy**

Code(s) for catheter placement(s), diagnostic studies and other percutaneous interventions (eg, percutaneous transluminal balloon angioplasty, stent placement) provided are separately reportable.

Codes 37XX1-37XX5 specifically include intraprocedural fluoroscopic radiological supervision and interpretation services for the guidance of the procedure.

Intraprocedural injection(s) of a thrombolytic agent is an included service and not separately reportable in conjunction with mechanical thrombectomy. However, subsequent or prior continuous infusion of thrombolytic is not an included service and is separately reportable (see 37201, 75896, 75898).

For coronary mechanical thrombectomy, use 92973.

For mechanical thrombectomy for dialysis fistula, use 36870.

**Arterial Mechanical Thrombectomy**

Arterial mechanical thrombectomy may be performed as a primary transcatheter procedure with pre-treatment planning, performance of the procedure, and post-procedure evaluation focused on providing this service. Primary mechanical thrombectomy is reported per vascular family using 37XX1 for the initial vessel treated, and 37XX2 for second or all subsequent vessel(s) within the same vascular family. To report mechanical thrombectomy of an additional vascular family treated through a separate access site, use modifier 51 in conjunction with 37XX1-37XX2. Do NOT report 37XX1-37XX2 for mechanical thrombectomy performed for treatment of thrombus/embolus complicating other percutaneous interventional procedures, see 37XX3.

Arterial mechanical thrombectomy is considered a secondary transcatheter procedure for removal/retrieval of short segments of thrombus/embolus when performed either before or after another percutaneous intervention (eg, percutaneous transluminal balloon angioplasty, stent placement). Secondary mechanical thrombectomy is reported using 37XX3. Do NOT report 37XX3 in conjunction with 37XX1-37XX2.

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Patient is a 75-year-old female with history of recent stroke who presents with acute onset of lower limb ischemia, beginning earlier the same day. At presentation to the emergency room, the foot is cool and pale. There is no rest pain, but a light hypesthesia of the forefoot is noted. The patient has a history of previous synthetic femoral-popliteal bypass graft in the left leg. Physical exam reveals a normal left femoral pulse, but no pulse is palpable

in the bypass graft, the popliteal artery, or pedal or tibial arteries. The emergency room physician refers the patient to the vascular specialist on-call, who orders an emergent diagnostic angiogram (reported separately), which demonstrates a patent common femoral artery and profunda femoral artery, but total occlusion of the femoral popliteal bypass graft is confirmed. There is reconstitution of the popliteal artery several centimeters below the level of the distal anastomosis, with thrombus extending below the graft into the native popliteal artery. After thrombectomy of the bypass graft (coded separately) a distal embolus occluding the common peroneal trunk is noted requiring additional mechanical thrombectomy.

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: None

Description of Intra-Service Work:

Once the femoral popliteal graft has been clear of thrombus using mechanical thrombectomy as described in the vignette for 37XX1, a wire is used by the physician to cross the thrombus extending into the native popliteal artery and through the embolus in the common peroneal artery. The mechanical thrombectomy device is advanced by physician into the common peroneal trunk, activated and pulled back through the thrombus in the common peroneal trunk and in the popliteal artery. Fluoroscopy is used to position the device optimally. All fluoroscopy and angiograms performed to guide the therapy and monitor the progress of the therapy are included. If residual thrombus is documented, the mechanical thrombolytic device is again activated for further thrombus removal. Fluoroscopy is again used to direct the device. A bolus of 1mg tPA is also given by physician to help clear any small fragments, which could have embolized more distally. If a small fragment of thrombus is not removed by the thrombectomy device, it may be removed by the physician with aspiration through the sheath or through a large-bore catheter placed to the remaining thrombus. A final completion angiogram is performed to confirm that the entire occlusive material has been removed and that flow has been restored.

Description of Post-Service Work: None

#### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Bibb Allen, MD Robert Vogelzang, MD Zachary Rattner, MD Robert Zwolak, MD				
<b>Specialty(s):</b>	American College of Radiology Society of Interventional Radiology Society for Vascular Surgery				
<b>CPT Code:</b>	37185				
<b>Sample Size:</b>	150	<b>Resp n:</b>	30	<b>Response:</b> 20.00 %	
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.00	5.00	8.00	9.00	17.10
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		

<b>Intra-Service Time:</b>		20.00	30.00	<b>40.00</b>	89.00	160.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>0.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
36870	090	5.15

CPT Descriptor Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35600	ZZZ	4.94

CPT Descriptor 1 Harvest of upper extremity artery, one segment, for coronary artery bypass procedure

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
35474	000	7.35

CPT Descriptor Transluminal balloon angioplasty, percutaneous; femoral-popliteal

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

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

Number of respondents who choose Key Reference Code: 9      % of respondents: 30.0 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 37185	Key Reference CPT Code: 36870
Median Pre-Service Time	0.00	20.00
Median Intra-Service Time	60.00	60.00
Median Immediate Post-service Time	0.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	0.0	15.00
Median Total Time	60.00	146.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.85	2.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	2.80
Urgency of medical decision making	4.54	2.80

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

Technical skill required	4.23	3.40
Physical effort required	3.54	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.38	3.33
Outcome depends on the skill and judgment of physician	4.38	3.83
Estimated risk of malpractice suit with poor outcome	3.93	2.83

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

Pre-Service intensity/complexity	3.17	3.00
Intra-Service intensity/complexity	4.23	3.17
Post-Service intensity/complexity	3.43	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 most common reference service chosen by respondents was 36870, percutaneous thrombectomy of a hemodialysis access. This is a good choice because 36870 includes mechanical thrombus extraction, essentially the same technique employed in new code 37XX2. Code 36870, however, is a shorter and less intense service than the new code. Code 36870 is subcutaneous, thus access is easier to achieve. Also, AV percutaneous thrombectomy is less likely to require the use of lytic agents. Use of lytic agents increase the risk of hemorrhage, both locally and systemically. Clot in AV

accesses tend to be shorter and more focally. Conversely, arterial percutaneous thrombectomy carries increased risk of bad outcomes. Arterial thrombectomy is more apt to use lytic agents and in greater concentrations. Arterial thrombectomy may dislodge particulate clot which may lodge more distally increasing the risk of amputation. There are fewer alternatives to arterial thrombectomy and cases tend to be more emergent than with AV thrombectomy. Arterial segments of clot tend to be longer than AV. Code 36870, by its nature of having a 90-day global, includes a discharge day (99238) and office visit (99212), not included in 37XX3.

The recommended RVW for 37XX2 (3.28) is supported by several different approaches.

First, applying the IWPUT (0.84) from primary code 37XX1 to the intraservice time for code 37XX2 (40 minutes) results in a RVW of 3.36.

Second, coronary mechanical thrombectomy (code 92973; RVW of 3.28) utilizes the same technology as 37XX2 and has the same intraservice time.

Turning to the MPC comparator, code 37XX2 and 35600 are both ZZZ global codes and have the same intraservice time of 40 minutes. Code 35600 has a value of 4.94.

## 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. 37XX1

## 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 (2002 Medicare frequency of 3,685)

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

Specialty Interventional radiology

How often? Sometimes

Specialty Radiology

How often? Sometimes



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

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CPT Code:37186 Tracking Number: KK3 Global Period: ZZZ

**Recommended Work Relative Value**  
Specialty Society RVU: **4.92**  
RUC RVU: **4.92**

CPT Descriptor: Secondary percutaneous transluminal thrombectomy (eg, non-primary mechanical, snare basket, suction technique) non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)

(Do not report 37XX3 in conjunction with 76000, 76001, 90783)

Introductory Text:

**Mechanical Thrombectomy**

Code(s) for catheter placement(s), diagnostic studies and other percutaneous interventions (eg, percutaneous transluminal balloon angioplasty, stent placement) provided are separately reportable.

Codes 37XX1-37XX5 specifically include intraprocedural fluoroscopic radiological supervision and interpretation services for the guidance of the procedure.

Intraprocedural injection(s) of a thrombolytic agent is an included service and not separately reportable in conjunction with mechanical thrombectomy. However, subsequent or prior continuous infusion of thrombolytic is not an included service and is separately reportable (see 37201, 75896, 75898).

For coronary mechanical thrombectomy, use 92973.

For mechanical thrombectomy for dialysis fistula, use 36870.

**Arterial Mechanical Thrombectomy**

Arterial mechanical thrombectomy may be performed as a primary transcatheter procedure with pre-treatment planning, performance of the procedure, and post-procedure evaluation focused on providing this service. Primary mechanical thrombectomy is reported per vascular family using 37XX1 for the initial vessel treated, and 37XX2 for second or all subsequent vessel(s) within the same vascular family. To report mechanical thrombectomy of an additional vascular family treated through a separate access site, use modifier 51 in conjunction with 37XX1-37XX2. Do NOT report 37XX1-37XX2 for mechanical thrombectomy performed for treatment of thrombus/embolus complicating other percutaneous interventional procedures, see 37XX3.

Arterial mechanical thrombectomy is considered a secondary transcatheter procedure for removal/retrieval of short segments of thrombus/embolus when performed either before or after another percutaneous intervention (eg, percutaneous transluminal balloon angioplasty, stent placement). Secondary mechanical thrombectomy is reported using 37XX3. Do NOT report 37XX3 in conjunction with 37XX1-37XX2.

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Note: Code 37XX3 is intended for removal/retrieval of short segments thrombus/embolus treated either before or after (but during the same operative session) another percutaneous intervention such as PTA/stent placement, where a small amount of clot is present in the lesion and needs to be removed prior to PTA/stent or where

thrombus/embolus has complicated a PTA/stent procedure, requiring removal of the thrombus/embolus to complete the procedure. The primary intervention(s) is reported separately.

The patient is a 75-year-old female who presents with rest pain of the left lower extremity. Work-up documents decreased perfusion to the limb, and non-invasive studies suggest superficial femoral arterial stenosis/occlusion. A diagnostic angiogram (reported separately) shows a focal high-grade stenosis of the distal SFA. All potential therapies are considered, and the patient is referred for SFA PTA and/or stent. The procedure is performed percutaneously, with balloon angioplasty of the lesion done (reported separately). Follow-up angiography shows patency of the PTA site, but stagnant column of contrast with no run-off, and distal imaging shows a filling defect at the popliteal artery bifurcation. The foot is cool and pale with no palpable pulse. Reconstitution of the trifurcations vessels is documented, with only the short focal occlusion representing distal embolus found. Mechanical thrombectomy of the popliteal is employed.

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: None

Description of Intra-Service Work: Wire access is maintained across the PTA site to ensure that further catheters are not passed subintimally. The existing sheath is upsized to allow placement of a larger-bore catheter. A bolus of tPA is given into the distal popliteal artery, and additional Heparin is given intravenously. Over a wire, a guiding catheter is advanced into the popliteal artery distally, taking care not to dislodge the distal embolus. The tip of the guiding catheter is carefully placed at the level of the embolus, and a 30cc syringe is attached to the catheter, placing suction to the embolus. The embolus is engaged within the tip of the guiding catheter, and with continued suction continuously applied, the guiding catheter is removed through the sheath at the vessel access, pulling the embolus from the vessel. Follow-up angiography is done. If the embolus was completely removed, final angiography and physical exam are done prior to removal of the sheath. If there is persistent embolus, further passes with the same guiding catheter or with another catheter/device are done to allow complete removal of the embolus before the sheaths are removed and hemostasis obtained.

Description of Post-Service Work: None

## **SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Bibb Allen, MD Robert Vogelzang, MD Zachary Rattner, MD Robert Zwolak, MD				
<b>Specialty(s):</b>	American College of Radiology Society of Interventional Radiology Society for Vascular Surgery				
<b>CPT Code:</b>	37186				
<b>Sample Size:</b>	150	<b>Resp n:</b>	31	<b>Response:</b>	%
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.50	6.25	8.00	9.50	18.10
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		10.00	30.00	<b>60.00</b>	80.00	160.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>0.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
36870	090	5.15

CPT Descriptor Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
35600	ZZZ	4.94

CPT Descriptor 1 Harvest of upper extremity artery, one segment, for coronary artery bypass procedure

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
35474	000	7.35

CPT Descriptor Transluminal balloon angioplasty, percutaneous; femoral-popliteal

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

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

Number of respondents who choose Key Reference Code: 8      % of respondents: 25.8 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u> 37186	<u>Key Reference CPT Code:</u> 36870
Median Pre-Service Time	0.00	20.00
Median Intra-Service Time	60.00	60.00
Median Immediate Post-service Time	0.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	0.0	15.00
Median Total Time	60.00	146.00
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	2.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.27	3.29
Urgency of medical decision making	4.40	4.14

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

Technical skill required	4.33	3.29
Physical effort required	3.67	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.47	2.71
Outcome depends on the skill and judgment of physician	4.40	3.29
Estimated risk of malpractice suit with poor outcome	4.20	2.57

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

Pre-Service intensity/complexity	3.00	2.86
Intra-Service intensity/complexity	4.00	3.00
Post-Service intensity/complexity	3.50	2.57

**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.*

The most common reference service chosen by respondents was 36870, percutaneous thrombectomy of a hemodialysis access. This is a good choice because 36870 includes mechanical thrombus extraction, essentially the same technique employed in new code 37XX2. Code 36870, however, is a shorter and less intense service than the new code. Code 36870 is subcutaneous, thus access is easier to achieve. Also, AV percutaneous thrombectomy is less likely to require the use of lytic agents. Arterial thrombectomy is more apt to use lytic agents and in greater concentrations. Use of lytic

agents increase the risk of hemorrhage, both locally and systemically. Arterial percutaneous thrombectomy carries increased risk of bad outcomes. Arterial thrombectomy may dislodge particulate clot which may lodge more distally increasing the risk of amputation. There are fewer alternatives to arterial thrombectomy and cases tend to be more emergent than with AV thrombectomy. Code 36870, by its nature of having a 90-day global, includes a discharge / (99238) and office visit (99212), not included in 37XX3.

The recommended RVW for 37XX3 was determined using the IWPUT for 37XX1 (0.84) and the intrasevice time for 37XX3 of 60 minutes, which resulted in the value of 5.04.

Turning to the MPC comparator, code 37XX3 and 35600 are both ZZZ global codes, but code 37XX3 has 20 minutes more intraservice time. Code 35600 has a value of 4.94.

## 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. 36247, 75710-59, 35474, 75962, 37XX3

Code	Global period	RVW	Pre	Intra	Post	Total
35474	000	7.35		80		186 minutes
37XX3	ZZZ	5.04		60		60 minutes
36247	000	6.29 (3.15)		86		86 minutes
75710	XXX	1.14				22 minutes
75962	XXX	0.54				12 minutes

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 Unlisted procedure, vascular surgery (2002 Medicare frequency of 3,685)

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

Specialty Interventional radiology

How often? Sometimes

Specialty Radiology How often? Sometimes

Specialty Vascular surgery 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 Interventional radiology	Frequency 667	Percentage	%
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Specialty Radiology	Frequency 666	Percentage	%
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Specialty Vascular surgery	Frequency 666	Percentage	%
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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 Interventional radiology	Frequency 334	Percentage	%
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Specialty Radiology	Frequency 333	Percentage	%
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Specialty Vascular surgery	Frequency 333	Percentage	%
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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. 35474

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**

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CPT Code:37187 Tracking Number: KK4 Global Period: 000

**Recommended Work Relative Value**  
Specialty Society RVU: **8.03**  
RUC RVU: **8.03**

CPT Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance

(Do not report 37XX4 in conjunction with 76000, 76001, 90784)

Introductory Text:

**Mechanical Thrombectomy**

Code(s) for catheter placement(s), diagnostic studies and other percutaneous interventions (eg, percutaneous transluminal balloon angioplasty, stent placement) provided are separately reportable.

Codes 37XX1-37XX5 specifically include intraprocedural fluoroscopic radiological supervision and interpretation services for the guidance of the procedure.

Intraprocedural injection(s) of a thrombolytic agent is an included service and not separately reportable in conjunction with mechanical thrombectomy. However, subsequent or prior continuous infusion of thrombolytic is not an included service and is separately reportable (see 37201, 75896, 75898).

For coronary mechanical thrombectomy, use 92973.

For mechanical thrombectomy for dialysis fistula, use 36870.

**Venous Mechanical Thrombectomy**

Use code 37XX4 to report the initial application of venous mechanical thrombectomy. To report bilateral venous mechanical thrombectomy performed through a separate access site(s), use modifier 50 in conjunction with 37XX4. For repeat treatment on a subsequent day during a course of thrombolytic therapy, use 37XX5.

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 42 year old woman with no significant past medical history presents to the emergency department with a two day history of left lower extremity pain and swelling. She has no history of injury to the leg, does not smoke, and exercises regularly. She is on no medications. Physical examination reveals severe swelling of the entire left lower extremity. The right lower extremity exam is normal. The pulses in both extremities are palpable throughout.

The remainder of the physical exam is unremarkable. The emergency room physician refers the patient to the vascular specialist on-call, who orders a Doppler ultrasound examination which reveals acute occlusive thrombus in the left deep venous system, beginning at the level of the popliteal vein and extending to the visualized portion of the left external iliac vein. The patient is admitted to the hospital. Initial treatment consists of intravenous heparin for anticoagulation and a workup for hypercoagulability ensues. Over the course of the next 24 hours, the patient experiences minimal symptomatic improvement. After considering all treatment options, the physician discusses treatment options with the patient, family, and referring physician, and chooses an endovascular approach. Because there has been little improvement with systemic anticoagulation and to try to decrease the incidence of postthrombotic chronic venous disease, mechanical thrombectomy of the large iliofemoral DVT possibly followed by pharmacologic thrombolysis (separately reportable if provided) is offered.

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: The physician:

- Discusses procedure with patient, family, and referring physician and informed consent is obtained.
- Supervises room set up, including sterile preps and drapes, proper patient positioning is confirmed.
- Selects the appropriate equipment such as catheters, sheaths, guidewires, and mechanical thrombectomy device.
- Directs Staff is to prepare for the procedure.

Description of Intra-Service Work: The physician:

- Orders medications for conscious sedation.
- Assesses the popliteal vein is assessed with ultrasound imaging and is punctured in a retrograde fashion with direct ultrasound visualization (separately coded using appropriate catheterization code).
- Advances a guidewire, under fluoroscopic guidance, and a sheath is placed into the popliteal vein. Separately reportable diagnostic venography is performed with attention to the profunda and saphenous system.
- Activates and advances the mechanical thrombolysis device over the wire to macerate the thrombus, often performed numerous times. All fluoroscopy and venograms performed to guide the therapy and monitor the progress of the therapy are included. Venography is performed demonstrating residual thrombus. This scenario is repeated with multiple passes of the device being performed with the device activated with each pass and repeat venography intermittently performed to determine progress of thrombus removal. Venography demonstrates residual thrombus and occlusion at the level of the left common iliac vein origin. Attempts to advance a wire across the occlusion are not successful. In order to treat the residual thrombus and to facilitate treatment of the occlusion, (separately reportable) pharmacologic thrombolysis is begun with the diagnostic catheter exchanged for a multisided-hole infusion catheter, positioned under fluoroscopic guidance along the length of the residual thrombus to the level of the occlusion. The catheter and sheath are secured in position.

Description of Post-Service Work: The physician:

- Dictates and reviews the procedure report.
- Apprises referring physician of procedure outcome.

## SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Bibb Allen, MD Zachary Rattner, MD Robert Vogelzang, MD Robert Zwolak, MD				
<b>Specialty(s):</b>	American College of Radiology Society of Interventional Radiology Society for Vascular Surgery				
<b>CPT Code:</b>	37187				
<b>Sample Size:</b>	150	<b>Resp n:</b>	32	<b>Response:</b>	21.33 %
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	5.50	7.38	9.00	10.63	22.50
<b>Pre-Service Evaluation Time:</b>			26.0		
<b>Pre-Service Positioning Time:</b>			5.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			9.0		

<b>Intra-Service Time:</b>	30.00	60.00	85.00	110.00	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>20.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
36870	090	5.15

CPT Descriptor Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
58660	090	11.27

CPT Descriptor 1 Laparocopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
35476	000	6.03

CPT Descriptor Transluminal balloon angioplasty, percutaneous; venous

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

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

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

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u> 37187	<u>Key Reference CPT Code:</u> 36870
Median Pre-Service Time	40.00	20.00
Median Intra-Service Time	85.00	60.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	0.0	15.00
Median Total Time	145.00	146.00
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	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	2.67
Urgency of medical decision making	3.73	3.22

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

Technical skill required	4.13	3.67
Physical effort required	3.67	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.80	2.89
Outcome depends on the skill and judgment of physician	4.07	3.67
Estimated risk of malpractice suit with poor outcome	3.60	2.78

**INTENSITY/COMPLEXITY MEASURES**

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

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.80	2.44
Intra-Service intensity/complexity	4.20	3.00
Post-Service intensity/complexity	3.73	2.56

**ADDITIONAL RATIONALE**

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

The most common reference service chosen by respondents was 36870, percutaneous thrombectomy of a hemodialysis access. This is a good choice because 36870 includes mechanical thrombus extraction, essentially the same technique employed in new code 37XX4. 36870, however, is a shorter and less intense service than the new code. Code 36870 is subcutaneous, thus access is easier to achieve. Also, AV percutaneous thrombectomy is less likely to require the use of lytic agents. Use of lytic agents increase the risk of hemorrhage, both locally and systemically. Clot in AV accesses tend

to be shorter and more focally. Conversely, venous percutaneous thrombectomy carries increased risk of bad outcomes. Arterial thrombectomy is more apt to use lytic agents and in greater concentrations. Venous thrombectomy may dislodge particulate clot which may lodge more distally increasing the risk of amputation. There are fewer alternatives to venous thrombectomy and cases tend to be more emergent than with AV thrombectomy. Venous segments of clot tend to be longer than AV.

Respondents judged the new code to be 50% more intense (intra-service intensity 4.31 compared to 2.88 = 1.50). In addition, intra-service time for the new code is 90 minutes compared to 60 minutes for 36870. The intra-service work of the reference code is 2.80 RVUs (per IWPUT analysis). If we start with this intraservice work of 2.80, then adjust for the increased time of the new code (90/60) then adjust for the intensity of the new code (4.31/2.88), the intraservice work of the new code is 6.51. If one then adds in the pre-service work 1.17 RVUs, the immediate post-service 0.27 RVUs, and the standard half discharge day accorded to 0-day global services, 0.64 RVUs, the total work value, based on the most common reference service, is 8.59 RVUs

The recommended RVW (9.0) for 37XX4 appropriately reflects the difference in physician work between primary arterial (code 37XX1; RVW=9.88) and venous percutaneous thrombectomy. The risk of a poor outcome with venous mechanical thrombectomy is less than arterial mechanical thrombectomy. For instance, venous mechanical thrombectomy carries reduced risk of loss of limb in comparison to arterial mechanical thrombectomy. Also, if venous mechanical thrombectomy fails to resolve DVT, support hose and anti-coagulative therapy may offer some relief.

Comparison to an MPC list service is 58660, Laparoscopy, surgical, lysis of adhesions. This is an "A" service on the MPC list with an RVW of 11.27. The comparison service is a 90-day global, which includes one discharge day service (99238) and one outpatient visit (99213). Intra-service time for the comparison service is slightly shorter (90 min) compared to 93 minutes for the new service. The new service has 65 min of pre time compared to 48 min for 58660. Immediate post-service time is 18 min longer in the MPC ref service. Intensity of the new service, lysing thrombus in major arteries of the body, is similar to that of the reference, lysing adhesions in the abdomen. The relative value of the new service can therefore be calculated as the RVW of the reference 11.27, less 1/2 of a discharge day (-0.64), less the outpatient visit (-0.65), plus the adjustment for pre and immediate post service (net one min, -0.02). Based on comparison with an "A" class MPC reference the value of the new service should be 11.27, less 0.64, less 0.65, less 0.02 = 9.96.

IWPUT Calculator 37XX4 Mechanical thrombectomy

Building Block Method Proposed RVW 9.00

Pre-service	Time	Intensity (=time x intensity)
Day prior evaluation	0	0.0224 0.00
Same day evaluation	40	0.0224 0.90
Scrub, prep, positioning	23	0.0081 0.19
Pre-service total		1.09

	Time	IWPUT (=time x intensity)
Intra-service	90	0.084 7.56
Post-service		
Immediate post	20	0.0224 0.45
Discharge 99238	18	0.5 1.28 0.64
Post-service total		1.09

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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 Interventional radiology	Frequency 667	Percentage	%
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Specialty Radiology	Frequency 667	Percentage	%
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Specialty Vascular surgery	Frequency 667	Percentage	%
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Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 36831

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**

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CPT Code:37188 Tracking Number: KK5 Global Period: 000

**Recommended Work Relative Value**  
Specialty Society RVU: **5.71**  
RUC RVU: **5.71**

CPT Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy

(Do not report 37XX5 in conjunction with 76000, 76001, 90784)

Introductory Text:

**Mechanical Thrombectomy**

Code(s) for catheter placement(s), diagnostic studies and other percutaneous interventions (eg, percutaneous transluminal balloon angioplasty, stent placement) provided are separately reportable.

Codes 37XX1-37XX5 specifically include intraprocedural fluoroscopic radiological supervision and interpretation services for the guidance of the procedure.

Intraprocedural injection(s) of a thrombolytic agent is an included service and not separately reportable in conjunction with mechanical thrombectomy. However, subsequent or prior continuous infusion of thrombolytic is not an included service and is separately reportable (see 37201, 75896, 75898).

For coronary mechanical thrombectomy, use 92973.

For mechanical thrombectomy for dialysis fistula, use 36870.

**Venous Mechanical Thrombectomy**

Use code 37XX4 to report the initial application of venous mechanical thrombectomy. To report bilateral venous mechanical thrombectomy performed through a separate access site(s), use modifier 50 in conjunction with 37XX4. For repeat treatment on a subsequent day during a course of thrombolytic therapy, use 37XX5.

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Venography reveals persistent residual thrombus of the left external iliac vein in a 42 year old woman who presented three days ago with acute occlusive thrombus in the left deep venous system, beginning at the level of the popliteal vein and extending to the visualized portion of the left external iliac vein. Mechanical thrombectomy was performed two days ago macerating a significant portion of the thrombus (reported separately), which was followed by pharmacologic thrombolysis therapy (reported separately). Treatment options including the benefits and potential complications of repeat mechanical thrombectomy are discussed with the patient, family, and referring physician. In an effort to reduce the patients exposure to, and overall dose of, thrombolytic agent required to completely resolve the thrombus, the physician elects to repeat mechanical thrombectomy.

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: The physician:**

Discusses procedure with patient, family, and referring physician and informed consent is obtained.

Supervises room set up, including sterile preps and drapes, proper patient positioning is confirmed.

Selects the appropriate equipment such as catheters, sheaths, guidewires, and mechanical thrombectomy device.

Directs Staff is to prepare for the procedure.

**Description of Intra-Service Work:** The physician orders medications for conscious sedation. The popliteal vein is accessed through the existing catheter in place for pharmacologic thrombolysis therapy. Under fluoroscopic guidance, a guidewire is advanced and a sheath is placed into the distal external iliac vein. The mechanical thrombolysis device is advanced over the wire and activated to macerate the residual thrombus, often several times. All fluoroscopy and venograms performed to guide the therapy and monitor the progress of the therapy are included. Venography is performed demonstrating persistent residual thrombus. This scenario is repeated with multiple passes of the device being performed with the device activated with each pass and repeat venography intermittently performed to determine progress of thrombus removal. A final completion venogram is performed to confirm that the entire occlusive material has been removed and that flow has been restored. The mechanical thrombectomy device, catheters, and guidewires are removed and compression is applied for hemostasis.

**Description of Post-Service Work: The physician:**

Dictates and reviews the procedure report.

Apprises referring physician of procedure outcome.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>		Bibb Allen, MD Zachary Rattner, MD Robert Vogelzang, MD Robert Zwolak, MD			
<b>Specialty(s):</b>		American College of Radiology Society of Interventional Radiology Society for Vascular Surgery			
<b>CPT Code:</b>		37188			
<b>Sample Size:</b>	150	<b>Resp n:</b>	30	<b>Response:</b> 20.00 %	
<b>Sample Type:</b>		Random			
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		3.50	5.50	7.00	7.79
<b>Pre-Service Evaluation Time:</b>				18.0	
<b>Pre-Service Positioning Time:</b>				7.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		15.00	34.00	58.00	60.00
<b>Post-Service</b>		<b>Total Min** CPT code / # of visits</b>			
<b>Immed. Post-time:</b>		<b>20.00</b>			
<b>Critical Care time/visit(s):</b>		<b>0.0</b> 99291x 0.0 99292x 0.0			
<b>Other Hospital time/visit(s):</b>		<b>0.0</b> 99231x 0.0 99232x 0.0 99233x 0.0			
<b>Discharge Day Mgmt:</b>		<b>0.0</b> 99238x 0.00 99239x 0.00			
<b>Office time/visit(s):</b>		<b>0.0</b> 99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0			

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

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
36870	090	5.15

CPT Descriptor Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
46262	090	7.49

CPT Descriptor 1 Hemorrhoidectomy, internal and external, complex or extensive

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
35476	000	6.03

CPT Descriptor Transluminal balloon angioplasty, percutaneous; venous

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

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

Number of respondents who choose Key Reference Code: 9      % of respondents: 30.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 37188	Key Reference CPT Code: 36870
Median Pre-Service Time	35.00	20.00
Median Intra-Service Time	58.00	60.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	0.0	15.00
Median Total Time	113.00	146.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	2.86
Urgency of medical decision making	3.29	3.14

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

Technical skill required	3.57	3.57
Physical effort required	3.36	3.14

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.43	3.00
Outcome depends on the skill and judgment of physician	3.86	3.86
Estimated risk of malpractice suit with poor outcome	3.29	2.71

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

Pre-Service intensity/complexity	3.07	2.86
Intra-Service intensity/complexity	3.40	3.14
Post-Service intensity/complexity	3.20	2.71

**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 most common reference service chosen by respondents was 36870, percutaneous thrombectomy of a hemodialysis access. This is a good choice because 36870 includes mechanical thrombus extraction, essentially the same technique employed in new code 37XX4. 36870, however, is a shorter and less intense service than the new code. Code 36870 is subcutaneous, thus access is easier to achieve. Also, AV percutaneous thrombectomy is less likely to require the use of lytic agents. Use of lytic agents increase the risk of hemorrhage, both locally and systemically. Clot in AV accesses tend

to be shorter and more focally. Conversely, venous percutaneous thrombectomy carries increased risk of bad outcomes. Arterial thrombectomy is more apt to use lytic agents and in greater concentrations. Venous thrombectomy may dislodge particulate clot which may lodge more distally increasing the risk of amputation. There are fewer alternatives to venous thrombectomy and cases tend to be more emergent than with AV thrombectomy. Venous segments of clot tend to be longer than AV.

IWPUT Calculator 37XX5 Mechanical thrombectomy

Building Block Method Proposed RVW 6.72

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	25	0.0224	0.56
Scrub, prep, positioning	25	0.0081	0.20
Pre-service total			0.76

	Time	IWPUT	(=time x intensity)
Intra-service	58	0.084	4.87

Post-service	Time	Intensity	(=time x intensity)
Immediate post	20	0.0224	0.45
Discharge 99238	18	0.5	1.28
Post-service total			1.09

Turning to the MPC, code 46262 (Hemorrhoidectomy, internal and external, complex or extensive) has a 90-day glof and a work value of 7.49. After subtracting the discharge day (1/2 code 99238; RVW = 0.64; 18 minutes), two 9921 (RVW = 0.45 each; 15 minutes each) and one 99213 (RVW = 0.67; 23 minutes), code 46262 is left with 5.28 RVWs and 105 minutes of which 45 minutes is intraservice. This compares well with 37XX5's total time of 128 minutes and 58 minutes of intraservice time.

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## 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. 37XX4



	A	B	C	D	E	F	G
1							
2				CPT Code: 37184		CPT Code: 37185	
3	Meeting Date: April 2005			Code Descriptor: Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel (Do not report 37XX1 in conjunction with 76000, 76001, 90783, 99141, 99142)		Code Descriptor: Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure) (Use 37XX2 in conjunction with 37XX1) (Do not report 37XX2 in conjunction with 76000)	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			0	0	zzz	zzz
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	30.0	26.0	0.0	0.0
7	TOTAL CLINICAL LABOR TIME	L041B	RT	79.0	0.0	32.0	0.0
8	TOTAL CLINICAL LABOR TIME	L051A	RN	110.0	3.0	40.0	0.0
9	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	9.0	23.0	0.0	0.0
10	TOTAL PRE-SERV CLINICAL LABOR TIME	L041B	RT	0.0	0.0	0.0	0.0
11	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN	0.0	0.0	0.0	0.0
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	18.0	0.0	0.0	0.0
13	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L041B	RT	79.0	0.0	32.0	0.0
14	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	107.0	0.0	40.0	0.0
15	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3.0	3.0	0.0	0.0
16	TOTAL POST-SERV CLINICAL LABOR TIME	L041B	RT	0.0	0.0	0.0	0.0
17	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN	3.0	3.0	0.0	0.0
18							
19	Start: Following visit when decision for surgery or procedure made						
20	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	5		
21	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	10		
22	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5		
23	Provide pre-service education/obtain consent						
24	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3		
25	Other Clinical Activity (please specify)						
26	End:When patient enters office/facility for surgery/procedure						
27							
28	Start. When patient enters office/facility for surgery/procedure						
29	Pre-service services						
30	Review charts	L037D	RN/LPN/MTA	2			
31	Greet patient and provide gowning	L037D	RN/LPN/MTA	3			
32	Obtain vital signs	L037D	RN/LPN/MTA	5			
33	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5			
34	Prepare room, equipment, supplies	L041B	RT	2			
35	Setup scope (non facility setting only)						
36	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	2			
37	Sedate/apply anesthesia	L051A	RN	2			
38	Intra-service						
39	Assist physician in performing procedure at 80 percent	L041B	RT	72		32	
40	Assist physician in performing procedure (CS)	L051A	RN	90		40	
41	Post-service						
42	Monitor pt following service/check tubes, monitors, drains	L051A	RN	15			

	A	B	C	D	E	F	G
2	Meeting Date: April 2005			CPT Code: 37184		CPT Code: 37185	
3				Code Descriptor: Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel (Do not report 37XX1 in conjunction with 76000, 76001, 90783, 99141, 99142)		Code Descriptor: Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure) (Use 37XX2 in conjunction with 37XX1)	
						(Do not report 37XX2 in conjunction with 76000)	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
43	Clean room/equipment by physician staff	L041B	RT	3			
44	Clean Scope						
45	Clean Surgical Instrument Package						
46	Complete diagnostic forms, lab & X-ray requisitions						
47	Review/read X-ray, lab, and pathology reports						
48	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3			
49	Discharge day management 99238 –12 minutes						
49	99239 –15 minutes						
50	Other Clinical Activity (please specify)						
51	End: Patient leaves office						
52							
53	Start: Patient leaves office/facility						
54	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3		
55	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						
56	List Number and Level of Office Visits						
57	99211 16 minutes		16				
58	99212 27 minutes		27				
59	99213 36 minutes		36				
60	99214 53 minutes		53				
61	99215 63 minutes		63				
62	Other						
63							
64	Total Office Visit Time			0	0	0	0
65	Other Activity (please specify)						
66	End: with last office visit before end of global period						

	A	B	C	D	E	F	G
2	Meeting Date: April 2005			<b>CPT Code: 37184</b> Code Descriptor: Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel (Do not report 37XX1 in conjunction with 76000, 76001, 90783, 99141, 99142)		<b>CPT Code: 37185</b> Code Descriptor: Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure) (Use 37XX2 in conjunction with 37XX1)  (Do not report 37XX2 in conjunction with 76000)	
3							
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
67							
68	pack, minimum multi-specialty visit	SA048	pack	1			
69	pack, conscious sedation	SA044	pack	1			
70	gown, surgical, sterile [one included with CS pack]	SB028	item	2			
71	gloves, sterile [one pair included with CS pack]	SB024	pair	2			
72	mask, surgical, with face shield	SB034	item	3			
73	cap, surgical	SB002	item	3			
74	shoe covers, surgical	SB039	pair	3			
75	drape-towel, sterile 18inx26in	SB019	item	2			
76	drape, sterile, three-quarter sheet	SB014	item	1			
77	drape, sterile, fenestrated 16in x 29in	SB011	item	1			
78	povidone soln (Betadine)	SJ041	ml	10			
79	guidewire, hydrophilic (Glidewire)	SD089	item	1		1	
80	guidewire, steerable (Hi-Torque)	SD174	item	1		1	
81	guidewire (Magic Torque)	SD176	item	1		1	
82	Arrow (Trenotola) thrombectomy device	SA015	item	1			
83	guidewire, low profile (SpartaCore)	SD173	item	1		1	
84	suture device for vessel closure (Perclose A-T)	SD207	item	1			
85	gauze, sterile 4in x 4in	SG055	item	2			
86	tape, surgical paper 1in (Micropore)	SG079	in	6			
87	Conray Inj (iothalamate 43%)	SH026	ml	25		25	
88	drape, sterile, c-arm, fluoro	SB008	item	1			
89	x-ray ID card (flashcard)	SK093	item	1			
90	x-ray envelope	SK091	item	1			
91	film, x-ray 14inx17in	SK034	item	2		1	
92	x-ray developer solution	SK089	oz	1			
93	x-ray fixer solution	SK092	oz	1			
94	disinfectant, surface (Envirocide, Sanzide)	SM013	oz	1			
95	computer media, dvd	SK013	item	1			
96							
97							
98							
99							
100	exam lamp	EQ168		X			
101	stretcher chair	EF019		X			
102	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		X		X	
103	infusion pump	EQ032		X		X	
104	pulse oximeter	EL211		X		X	
105	Angiographic room	EL011		X		X	
106	film alternator	ER029		X		X	
107	Oxygen tank			X		X	
108	film processor	ED024		X		X	
109							

	A	B	C	H	I	J	K	L	M
1									
2				CPT Code: 37186		CPT Code: 37187		CPT Code: 37188	
3	Meeting Date: April 2005			Code Descriptor: Secondary percutaneous transluminal thrombectomy (eg, non-primary mechanical, snare basket, suction technique) non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure).  (Do not report 37XX3 in conjunction with 76000)		Code Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance  (Do not report 37XX4 in conjunction with 76000, 76001, 90784)		Code Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy  (Do not report 37XX5 in conjunction with 76000, 76001, 90784)	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			zzz	zzz	0	0	0	0
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	30.0	26.0	30.0	26.0
7	TOTAL CLINICAL LABOR TIME	L041B	RT	48.0	0.0	75.0	0.0	53.4	0.0
8	TOTAL CLINICAL LABOR TIME	L051A	RN	60.0	0.0	105.0	3.0	78.0	3.0
9	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	9.0	23.0	9.0	23.0
10	TOTAL PRE-SERV CLINICAL LABOR TIME	L041B	RT	0.0	0.0	0.0	0.0	0.0	0.0
11	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN	0.0	0.0	0.0	0.0	0.0	0.0
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	18.0	0.0	18.0	0.0
13	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L041B	RT	48.0	0.0	75.0	0.0	53.4	0.0
14	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	60.0	0.0	102.0	0.0	75.0	0.0
15	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	3.0	3.0	3.0	3.0
16	TOTAL POST-SERV CLINICAL LABOR TIME	L041B	RT	0.0	0.0	0.0	0.0	0.0	0.0
17	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN	0.0	0.0	3.0	3.0	3.0	3.0
18									
19	Start: Following visit when decision for surgery or procedure made								
20	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA			3	5	3	5
21	Coordinate pre-surgery services	L037D	RN/LPN/MTA			3	10	3	10
22	Schedule space and equipment in facility	L037D	RN/LPN/MTA				5		5
23	Provide pre-service education/obtain consent								
24	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA			3	3	3	3
25	Other Clinical Activity (please specify)								
26	End: When patient enters office/facility for surgery/procedure								
27									
28	Start: When patient enters office/facility for surgery/procedure								
29	Pre-service services								
30	Review charts	L037D	RN/LPN/MTA			2		2	
31	Greet patient and provide gowning	L037D	RN/LPN/MTA			3		3	
32	Obtain vital signs	L037D	RN/LPN/MTA			5		5	
33	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			5		5	
34	Prepare room, equipment, supplies	L041B	RT			2		2	
35	Setup scope (non facility setting only)								
36	Prepare and position patient/ monitor patient/ set up IV	L041B	RT			2		2	
37	Sedate/apply anesthesia	L051A	RN			2		2	
38	Intra-service								
39	Assist physician in performing procedure at 80 percent	L041B	RT	48		68		46	
40	Assist physician in performing procedure (CS)	L051A	RN	60		85		58	
41	Post-procedure								
42	Monitor pt following service/check tubes, monitors, drains	L051A	RN			15		15	

	A	B	C	H	I	J	K	L	M
2	Meeting Date: April 2005			CPT Code: 37186		CPT Code: 37187		CPT Code: 37188	
3				Code Descriptor: Secondary percutaneous transluminal thrombectomy (eg, non-primary mechanical, snare basket, suction technique) non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)		Code Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance  (Do not report 37XX4 in conjunction with 76000, 76001, 90784)		Code Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy  (Do not report 37XX5 in conjunction with 76000, 76001, 90784)	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
43	Clean room/equipment by physician staff	L041B	RT			3		3	
44	Clean Scope								
45	Clean Surgical Instrument Package								
46	Complete diagnostic forms, lab & X-ray requisitions								
47	Review/read X-ray, lab, and pathology reports								
48	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA			3		3	
49	Discharge day management 99238 –12 minutes								
49	99239 –15 minutes								
50	Other Clinical Activity (please specify)								
51	End: Patient leaves office								
52									
53	Start: Patient leaves office/facility								
54	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA			3	3	3	
55	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								
56	List Number and Level of Office Visits								
57	99211 16 minutes		16						
58	99212 27 minutes		27						
59	99213 36 minutes		36						
60	99214 53 minutes		53						
61	99215 63 minutes		63						
62	Other								
63									
64	Total Office Visit Time			0	0	0	0	0	0
65	Other Activity (please specify)								
66	End: with last office visit before end of global period								

	A	B	C	H	I	J	K	L	M
2	Meeting Date: April 2005			CPT Code: 37186 Code Descriptor: Secondary percutaneous transluminal thrombectomy (eg, non-primary mechanical, snare basket, suction technique) non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)  (Do not report 37XX3 in conjunction with 76000)		CPT Code: 37187 Code Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance  (Do not report 37XX4 in conjunction with 76000, 76001, 90784)		CPT Code: 37188 Code Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy  (Do not report 37XX5 in conjunction with 76000, 76001, 90784)	
3									
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
67									
68	pack, minimum multi-specialty visit	SA048	pack			1		1	
69	pack, conscious sedation	SA044	pack			1		1	
70	gown, surgical, sterile [one included with CS pack]	SB028	item			2		2	
71	gloves, sterile [one pair included with CS pack]	SB024	pair			2		2	
72	mask, surgical, with face shield	SB034	item			3		3	
73	cap, surgical	SB002	item			3		3	
74	shoe covers, surgical	SB039	pair			3		3	
75	drape-towel, sterile 18inx26in	SB019	item			2		2	
76	drape, sterile, three-quarter sheet	SB014	item			1		1	
77	drape, sterile, fenestrated 16in x 29in	SB011	item			1		1	
78	povidone soln (Betadine)	SJ041	ml			10		10	
79	guidewire, hydrophilic (GlideWire)	SD089	item	1		1		1	
80	guidewire, steerable (Hi-Torque)	SD174	item	1		1		1	
81	guidewire (Magic Torque)	SD176	item	1		1		1	
82	Arrow (Trerotola) thrombectomy device	SA015	item	1		1		1	
83	guidewire, low profile (SpartaCore)	SD173	item	1		1		1	
84	suture device for vessel closure (Perclose A-T)	SD207	item			1		1	
85	gauze, sterile 4in x 4in	SG055	item			2		2	
86	tape, surgical paper 1in (Micropore)	SG079	in			6		6	
87	Conray Inj (iothalamate 43%)	SH026	ml	25		25		25	
88	drape, sterile, c-arm, fluoro	SB008	item			1		1	
89	x-ray ID card (flashcard)	SK093	item			1		1	
90	x-ray envelope	SK091	item			1		1	
91	film, x-ray 14inx17in	SK034	item	1		2		2	
92	x-ray developer solution	SK089	oz			1		1	
93	x-ray fixer solution	SK092	oz			1		1	
94	disinfectant, surface (Envirocide, Sanizide)	SM013	oz			1		1	
95	computer media, dvd	SK013	item			1		1	
96									
97									
98									
99									
100	exam lamp	EQ168				X		X	
101	stretcher chair	EF019				X		X	
102	EKG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		X		X		X	
103	infusion pump	EQ032		X		X		X	
104	pulse oximeter	EL211		X		X		X	
105	Angiographic room	EL011		X		X		X	
106	film alternator	ER029		X		X		X	
107	Oxygen tank			X		X		X	
108	film processor	ED024		X		X		X	
109									

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

**CPT Long Descriptor: Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel  
(Do not report 37184 in conjunction with 76000, 76001, 90783, 99141, 99142)**

Sample Size: Consensus      Response Rate: (%): N/A      Global Period: 000

Physicians from the Society of Interventional Radiology (SIR) developed the direct practice expense recommendations. The SIR panel of physicians included those in hospital and freestanding (office) practices. These initial recommendations were then reviewed by a consensus panel consisting of members from the American College of Radiology (ACR), the Society for Vascular Surgery and SIR, representing a broad mix of categories of type of practice and geographic areas.

**The recommendations are based on a crosswalk to practice expenses for CPT codes 35470-35476 and 37203 from the “Endocath family” that was approved by the PEAC in January 2004.**

Please describe the clinical activities of your staff:

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescription
- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information

Intra-Service Clinical Labor Activities:

- Greeting of the patient, escorting patient to room, gowning of patient, and obtain vital signs.
- Pre-service education of the patient and family (e.g., expectations, options)/obtain consent notifying physician when patient is ready.
- Prepare room and set up equipment/supplies including the thrombectomy device and other supplies.
- Assist physician in performing procedure with conscious sedation, instrument and imaging.
- Time spent monitoring patient following service.
- Time spent cleaning room, surgical instruments, and equipment (e.g., disposing of sharps and other used materials, cleaning and sanitizing).
- Additional time for dressing & wound check /home care instructions provided. Arrange follow-up office visit.
- Assemble imaging studies, lab and pathology reports from the procedure for the physician’s consideration.

Post-Service Clinical Labor Activities:

- Provide follow-up phone calls

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

**CPT Long Descriptor: Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel  
(Do not report 37184 in conjunction with 76000, 76001, 90783, 99141, 99142)**

Sample Size: Consensus      Response Rate: (%): N/A      Global Period: 000

Physicians from the Society of Interventional Radiology (SIR) developed the direct practice expense recommendations. The SIR panel of physicians included those in hospital and freestanding (office) practices. These initial recommendations were then reviewed by a consensus panel consisting of members from the American College of Radiology (ACR), the Society for Vascular Surgery and SIR, representing a broad mix of categories of type of practice and geographic areas.

**The recommendations are based on a crosswalk to practice expenses for CPT codes 35470-35476 and 37203 from the “Endocath family” that was approved by the PEAC in January 2004.**

Please describe the clinical activities of your staff:

-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Follow-up phone calls and prescription

Intra-Service Clinical Labor Activities:

- Assist with post-procedure discharge education

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

CPT Long Descriptor: Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure) (Use 37185 in conjunction with 37184)

(Do not report 37185 in conjunction with 76000, 76001, 90783)

Sample Size: Consensus      Response Rate: (%): N/A      Global Period: ZZZ

Physicians from the Society of Interventional Radiology (SIR) developed the direct practice expense recommendations. The SIR panel of physicians included those in hospital and freestanding (office) practices. These initial recommendations were then reviewed by a consensus panel consisting of members from the American College of Radiology (ACR), the Society for Vascular Surgery (SVS) and SIR, representing a broad mix of categories of type of practice and geographic areas.

**The recommendations are based on a crosswalk to practice expenses for CPT codes 35470-35476 and 37203 from the “Endocath family” that was approved by the PEAC in January 2004.**

• Please describe the clinical activities of your staff:

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities:

- Assist physician in performing procedure with conscious sedation, instrument and imaging over and above that associated with code 37XX1.

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

CPT Long Descriptor: Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure) (Use 37185 in conjunction with 37184)

(Do not report 37185 in conjunction with 76000, 76001, 90783)

Sample Size: Consensus      Response Rate: (%): N/A      Global Period: ZZZ

Physicians from the Society of Interventional Radiology (SIR) developed the direct practice expense recommendations. The SIR panel of physicians included those in hospital and freestanding (office) practices. These initial recommendations were then reviewed by a consensus panel consisting of members from the American College of Radiology (ACR), the Society for Vascular Surgery (SVS), and SIR representing a broad mix of categories of type of practice and geographic areas.

**ACR, SVS, and SIR recommend that no direct practice expense inputs be assigned to 37185. These expenses would be provided by the facility.**

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

CPT Long Descriptor: Secondary percutaneous transluminal thrombectomy (eg, non-primary mechanical, snare basket, suction technique) non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)

(Do not report 37186 in conjunction with 76000, 76001, 90783)

Sample Size: Consensus      Response Rate: (%): N/A      Global Period: ZZZ

Physicians from the Society of Interventional Radiology (SIR) developed the direct practice expense recommendations. The SIR panel of physicians included those in hospital and freestanding (office) practices. These initial recommendations were then reviewed by a consensus panel consisting of members from the American College of Radiology (ACR), the Society for Vascular Surgery (SVS) and SIR, representing a broad mix of categories of type of practice and geographic areas.

**The recommendations are based on a crosswalk to practice expenses for CPT codes 35470-35476 and 37203 from the “Endocath family” that was approved by the PEAC in January 2004.**

Please describe the clinical activities of your staff:

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities:

- Assist physician in performing procedure with conscious sedation, instrument and imaging over and above that associated with the other therapeutic interventions.

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

CPT Long Descriptor: Secondary percutaneous transluminal thrombectomy (eg, non-primary mechanical, snare basket, suction technique) non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)

(Do not report 37186 in conjunction with 76000, 76001, 90783)

Sample Size: Consensus      Response Rate: (%): N/A      Global Period: ZZZ

Physicians from the Society of Interventional Radiology (SIR) developed the direct practice expense recommendations. The SIR panel of physicians included those in hospital and freestanding (office) practices. These initial recommendations were then reviewed by a consensus panel consisting of members from the American College of Radiology (ACR), the Society for Vascular Surgery (SVS), and SIR representing a broad mix of categories of type of practice and geographic areas.

**ACR, SVS, and SIR recommend that no direct practice expense inputs be assigned to 37185. These penses would be provided by the facility.**

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

CPT Long Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance

(Do not report 37187 in conjunction with 76000, 76001, 90784)

Sample Size: Consensus      Response Rate: (%): N/A      Global Period: 000

Physicians from the Society of Interventional Radiology (SIR) developed the direct practice expense recommendations. The SIR panel of physicians included those in hospital and freestanding (office) practices. These initial recommendations were then reviewed by a consensus panel consisting of members from the American College of Radiology (ACR), the Society for Vascular Surgery and SIR, representing a broad mix of categories of type of practice and geographic areas.

**The recommendations are based on a crosswalk to practice expenses for CPT codes 35470-35476 and 37203 from the “Endocath family” that was approved by the PEAC in January 2004.**

Please describe the clinical activities of your staff:

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescription
- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information

Intra-Service Clinical Labor Activities:

- Greeting of the patient, escorting patient to room, gowning of patient, and obtain vital signs.
- Pre-service education of the patient and family (e.g., expectations, options)/obtain consent notifying physician when patient is ready.
- Prepare room and set up equipment/supplies including the thrombectomy device and other supplies.
- Assist physician in performing procedure with conscious sedation, instrument and imaging.
- Time spent monitoring patient following service.
- Time spent cleaning room, surgical instruments, and equipment (e.g., disposing of sharps and other used materials, cleaning and sanitizing).
- Additional time for dressing & wound check /home care instructions provided. Arrange follow-up office visit.
- Assemble imaging studies, lab and pathology reports from the procedure for the physician’s consideration.

Post-Service Clinical Labor Activities:

- Provide follow-up phone calls

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

CPT Long Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance

(Do not report 37187 in conjunction with 76000, 76001, 90784)

Sample Size: Consensus      Response Rate: (%): N/A      Global Period: 000

Physicians from the Society of Interventional Radiology (SIR) developed the direct practice expense recommendations. The SIR panel of physicians included those in hospital and freestanding (office) practices. These initial recommendations were then reviewed by a consensus panel consisting of members from the American College of Radiology (ACR), the Society for Vascular Surgery and SIR, representing a broad mix of categories of type of practice and geographic areas.

**The recommendations are based on a crosswalk to practice expenses for CPT codes 35470-35476 and 37203 from the “Endocath family” that was approved by the PEAC in January 2004.**

Please describe the clinical activities of your staff:

-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Follow-up phone calls and prescription

Intra-Service Clinical Labor Activities:

- Assist with post-procedure discharge education

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

CPT Long Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy

(Do not report 37XX5 in conjunction with 76000, 76001, 90784)

Sample Size: Consensus Response Rate: (%): N/A Global Period: 000

Physicians from the Society of Interventional Radiology (SIR) developed the direct practice expense recommendations. The SIR panel of physicians included those in hospital and freestanding (office) practices. These initial recommendations were then reviewed by a consensus panel consisting of members from the American College of Radiology (ACR), the Society for Vascular Surgery and SIR, representing a broad mix of categories of type of practice and geographic areas.

**The recommendations are based on a crosswalk to practice expenses for CPT codes 35470-35476 and 37203 from the “Endocath family” that was approved by the PEAC in January 2004.**

Please describe the clinical activities of your staff:

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescription
- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information

Intra-Service Clinical Labor Activities:

- Greeting of the patient, escorting patient to room, gowning of patient, and obtain vital signs.
- Pre-service education of the patient and family (e.g., expectations, options)/obtain consent notifying physician when patient is ready.
- Prepare room and set up equipment/supplies including the thrombectomy device and other supplies.
- Assist physician in performing procedure with conscious sedation, instrument and imaging.
- Time spent monitoring patient following service.
- Time spent cleaning room, surgical instruments, and equipment (e.g., disposing of sharps and other used materials, cleaning and sanitizing).
- Additional time for dressing & wound check /home care instructions provided. Arrange follow-up office visit.
- Assemble imaging studies, lab and pathology reports from the procedure for the physician’s consideration.

Post-Service Clinical Labor Activities:

- Provide follow-up phone calls

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

CPT Long Descriptor: Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy

(Do not report 37XX5 in conjunction with 76000, 76001, 90784)

Sample Size: Consensus      Response Rate: (%): N/A      Global Period: 000

Physicians from the Society of Interventional Radiology (SIR) developed the direct practice expense recommendations. The SIR panel of physicians included those in hospital and freestanding (office) practices. These initial recommendations were then reviewed by a consensus panel consisting of members from the American College of Radiology (ACR), the Society for Vascular Surgery and SIR, representing a broad mix of categories of type of practice and geographic areas.

**The recommendations are based on a crosswalk to practice expenses for CPT codes 35470-35476 and 37203 from the “Endocath family” that was approved by the PEAC in January 2004.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Follow-up phone calls and prescription

Intra-Service Clinical Labor Activities:

- Assist with post-procedure discharge education

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Saphenous Vein Removal**

CPT created two new codes and deleted two codes so that the codes describing saphenous vein removal describe current practice. Deleted codes 37720 *Ligation and division and complete stripping of long or short saphenous veins* (work RVU = 5.65) and code 37730 *Ligation and division and complete stripping of long and short saphenous veins* (work RVU = 7.32) describe “complete stripping,” which implied stripping the vein from the calf as opposed to stripping the greater saphenous vein from the saphenofemoral junction to the knee, as is the current practice. A new code was needed because the existing code described a stripping operation that extended all the way to the ankle. Also, code 37720 described two different operations, one for the long saphenous vein and another for the short saphenous vein. CPT created two new codes to describe these different procedures.

The presenters stated that the multispecialty consensus panel reviewed the survey results and determined that the median survey RVW of 9.30 with an IWP/UT of 0.134 is too high for 37718. The consensus panel determined that a value of 6.76 RVW, a value significantly below the 25th percentile was more appropriate based on a comparison with other members of the vein excision family, specifically the most commonly chosen reference services 37765 *Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions* (work RVU = 7.34) and code 37766 *Stab phlebectomy of varicose veins, one extremity; more than 20 incisions* (work RVU = 9.29). Both codes were evaluated by the RUC in April 2003. In addition, the presenters stated that it is important that the value of 37718 maintain proper relativity with 37722, since 37722 is by far the more common service of this pair. Code 37718 and the reference codes have very similar pre and post service time elements, and the exact office visit pattern:

	37765	37766	37718
Pre-eval time	33	33	35
Pre-position tim	10	10	10
Scrub	15	15	15
Intra-time	60	90	45
Immed Post	25	25	20
99238	0.5	0.5	0.5
99213	1	1	1
99212	1	1	1

The major difference between the 37718 and 37765 is that 37718 has 45 minutes of intra-service time while the reference code 37765 has 60 minutes and 37766 has 90 minutes of intra-service time. Every survey respondent who chose 37765 and 37766 as references cited the intra-service intensity of the new service to be higher than the reference. Making the mathematical downward adjustment for removing intra-time from the reference service, then adjusting the intensity of the remaining minutes upwards by 15% results in a reduction of 2.53 RVUs that must be removed from reference 37766 to account for the intra-service adjustment:

Start with total RVW for 37766:	9.29
Subtract 45 min intra-time	-2.97
15% intensity increment	+0.44
Total RVW base on 37766	6.76

The RUC agreed that the presenters rationale accurately described the physician work involved with code 37766. The presenters also clarified that either code 37765 *Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions* or code 37766 *Stab phlebectomy of varicose veins, one extremity; more than 20 incisions* is typically performed on the same day. **The RUC recommends a work RVU of 6.76 for code 37718.**

### 37722

The presenters stated that the multispecialty consensus Panel that reviewed the survey results and determined that the median survey RVW of 10.00, with an IWP/UT of 0.11 is too high for 37722. The panel calculated a value of 7.79 work RVUs, significantly below the 25th percentile based on a comparison with two recently RUC evaluated venous excision reference services.

The first comparison is to a recently evaluated new procedure that accomplishes the exact clinical endpoint, code 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* (work RVU = 6.72). This code and 3772X2 are exactly the same in terms of what they accomplish, which is elimination of the greater saphenous vein. 36475 electro-coagulates the vein with radiofrequency and heat, while 37722 is used to report physical excision of the vein.

36475 was not chosen to serve on the reference service list for this RUC survey because it is a 000-day global service, and the presenters stated that since the new codes were 90 day procedures, survey respondents would not be able to make an accurate comparison. However, the consensus panel compared code 36475 data to 37722 because the work involved is very similar. Both services have 40 minutes of pre-service evaluation time and 10 minutes of pre-service positioning time. Code 36475 has 5 minutes more scrub, dress, wait time than 37722 (15 vs 10 min), but 37722 has 5 minutes more immediate post time, so it balances. The two services have identical intra-service times of 60 minutes, and the intra-service intensity of the two services is judged equal by the consensus panel. Both CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

services have one-half of a discharge day. Since 36475 is a 0-day global there are no further elements. 37722 has one 99213 and one 99212 during the 90-day global.

The consensus panel constructed the relative value of 37722 from 36475. The 2005 work RVW of 36475 is 6.72 with pre, intra and immediate post work, which is the same as 37722. Thus, to build a value for 37722 from 36475 the following was calculated:

36475 RVW:	6.72
Add one 99213	0.65
Add one 99212	0.42
Total RVW for 37722 based on 36475:	7.79

The RUC agreed that the presenters rationale accurately described the physician work involved with code 37722 and a work RVU of 7.79 would place the code in proper rank order, especially in comparison to code 37718. The RUC agreed that the presenters rationale accurately described the physician work involved with code 37766. The presenters also clarified that either code 37765 *Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions* or code 37766 *Stab phlebectomy of varicose veins, one extremity; more than 20 incisions* is typically performed on the same day. **The RUC recommends a work RVU of 7.79 for code 37722.**

#### Practice Expense

The RUC recommends that standard inputs for 90 day global procedures performed in the facility setting.

#### Work Neutrality

The RUC recommends that work neutrality not be applied because the presenters provided compelling evidence that the deleted codes were undervalued. Specifically, the deleted codes were to be included in the five-year review because it was felt that the codes were never properly valued based on the original Hsiao study. However, the codes needed to be changed to specify the removal of the short and the long saphenous veins before the codes could be properly valued. Therefore, instead of reviewing the codes in the Five-Year Review, the codes are being reviewed now because of the deletion and creation of new codes through the CPT process.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
37700		<i>Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruption</i> <u>(Do not report 37700 in conjunction with 37720)</u> <i>(For bilateral procedure, report 37700 with modifier 50)</i>	090	3.72  (No Change)
•37718	JJ1	Ligation, division and stripping, short saphenous vein <u>(For bilateral procedures, use modifier 50)</u> <u>(Do not report 37718 in conjunction with 37735, 37780)</u>	090	6.76
D 37720		<del>Ligation and division and complete stripping of long or short saphenous veins</del>	090	N/A
•37722	JJ2	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below <u>(For ligation and stripping of the short saphenous vein, use 37718)</u> <u>(For bilateral procedure, report 37722 with modifier 50)</u> <u>(Do not report 37722 in conjunction with 37700, 37735)</u>	090	7.79

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 37730		<p><del>Ligation and division and complete stripping of long and short saphenous veins</del></p> <p><u>(37730 has been deleted. For ligation, division and stripping of the greater saphenous vein, use 37722. For ligation, division and stripping of the short saphenous vein, use 37718)</u></p> <p><del>(For bilateral procedure, report 37730 with modifier 50)</del></p>	090	N/A
37735		<p><i>Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia</i></p> <p><u>(Do not report 37735 in conjunction with 37700, 37718, 37722, 37780)</u></p> <p><i>(For bilateral procedure, report 37735 with modifier 50)</i></p>	090	10.51  (No Change)

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

CPT Code:37718 Tracking Number: JJ1 Global Period: 090

**Recommended Work Relative Value**

Specialty Society RVU: 6.76

RUC RVU: 6.76

CPT Descriptor: Ligation, division and stripping, short saphenous vein

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 66-year old man suffered spontaneous development of a large skin ulcer on the posterior aspect of his calf, just above the ankle. He has normal arterial pulses. Venous duplex exam revealed incompetence of his short saphenous vein with extensive reflux. Valve function in his deep veins, and the greater saphenous vein, was normal. The patient's ulcer healed after 6 weeks of therapy including medicated compression dressings and leg elevation. An open surgical procedure, ligation, division and stripping of the short saphenous vein is performed to prevent recurrence.

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? 0

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Review all relevant office notes, H&P, noninvasive vascular lab studies
- Update H&P (required by JCAHO)
- Review operative plan and informed consent with patient and family
- Discuss patient comorbidities and surgical approach with Anesthesiologist
- Change into OR scrubs
- Supervise patient positioning prone position, skin prep, and draping
- Wait for anesthetic to become effective

**Description of Intra-Service Work:**

- Skin incision adjacent to popliteal skin crease, over saphenopopliteal junction
- Dissect through soft tissue to find short saphenous vein
- Make positive identification of saphenopopliteal junction to ensure correct vein
- Identify, dissect, and divide venous branches in region between silk sutures
- Clear several cm of short saphenous, find and ligate branches
- Skin incision over short saphenous vein on posterior aspect of calf, near ankle
- Dissect through soft tissue to find short saphenous vein
- Clear several cm of short saphenous & ligate branches
- Divide saphenous between clamps and tie lower end
- Open clamp on transected saphenous and insert stripper
- Carefully manipulate stripper upwards within the vein, to popliteal region
- Identify end of stripper in saphenous at saphenopopliteal junction
- Divide short saphenous between clamps adjacent to saphenopopliteal junction
- Suture upper end of saphenous vein & test for hemostasis
- Pass stripper out through transected end of short saphenous
- Attach stripper head and tie end of vein to stripper
- With extreme care, pull stripper downwards through calf and strip vein
- Hold pressure on calf to control bleeding
- When bleeding stops, irrigate all wounds with saline

- Check again for hemostasis
- Close both wounds in multiple layers

## Description of Post-Service Work:

- Apply sterile dressings and Ace wrap
- Check foot for pulses and perfusion
- Roll patient back to supine position
- Transfer patient to stretcher, accompany to recovery area
- Write orders
- Dictate operative note
- Communicate with family
- Communicate with referring and consulting physicians
- Participate with the anesthesiologist to ensure smooth anesthesia emergence
- Discuss results of procedure with patient once he/she is fully awake
- When stable, transfer back to same-day area
- Examine patient again prior to discharge, check pulses & look for hematomas
- Check dressings for evidence of hemorrhage
- Provide activity and wound care advice to patient and family
- Arrange office follow up for wound checks, suture/staple removal, etc.
- Service also includes all outpatient office visits for duration of global period

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	Gary Seabrook, MD Charles Shoemaker, MD				
Specialty(s):	SVS ASGS				
CPT Code:	37718				
Sample Size:	100	Resp n:	65	Response:	65.00 %
Sample Type:	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:	4.79	7.50	9.30	11.00	19.00
Pre-Service Evaluation Time:			35.0		
Pre-Service Positioning Time:			10.0		
Pre-Service Scrub, Dress, Wait Time:			10.0		
Intra-Service Time:	20.00	40.00	45.00	60.00	160.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
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>18.0</u>	99238x 0.50	99239x 0.00		
Office time/visit(s):	<u>38.0</u>	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>
37766	090	9.29

CPT Descriptor Stab phlebectomy of varicose veins, one extremity; more than 20 incisions

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
37765	090	7.34

CPT Descriptor Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 15.3 %

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 37718</b>	<b>Key Reference CPT Code: 37766</b>
Median Pre-Service Time	55.00	58.00
Median Intra-Service Time	45.00	90.00
Median Immediate Post-service Time	20.00	25.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	18.00
Median Office Visit Time	38.0	38.00
Median Total Time	176.00	229.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	2.67	2.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.78	2.56
Urgency of medical decision making	1.56	1.56

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

Technical skill required	2.78	2.44
Physical effort required	2.60	2.67
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	2.11	1.78
Outcome depends on the skill and judgment of physician	3.00	2.56
Estimated risk of malpractice suit with poor outcome	2.56	2.33

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

Pre-Service intensity/complexity	2.89	2.67
Intra-Service intensity/complexity	2.78	2.22
Post-Service intensity/complexity	1.89	1.78

**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.*

**OMPELLING EVIDENCE DISCUSSION**

This code is presented to the RUC as part of the upcoming 5-year review process. SVS submitted CPT 37720 (Ligation and division and complete stripping of long or short saphenous veins) to CMS as an undervalued service. The procedure cannot be evaluated objectively with the current descriptor, however, because the work of excising the long saphenous differs from that of the short saphenous. SVS therefore applied to CPT for creation of two new codes, one to represent

the more common excision of the long saphenous vein (now JJ2) and the other to represent the less common excision of the short saphenous (now JJ1).

The RUC structure and function document indicates that the new codes should be evaluated at the April 2005 meet despite that fact that this is a 5-year review issue. Evaluation in April 2005 implies that the RUC will send the result, RVW recommendations to CMS, potentially for inclusion in the 2006 MFS. SVS and the American Society for General Surgery (ASGS) indicated interest in developing primary evidence, and we collected 65 survey respondents, and the summary recommendations are presented herein. SVS and ASGS want to make it absolutely clear that the decision of whether the new RVWs for these services are incorporated in the fee schedule in 2006, or if they are held until 2007 (to coincide with the other 5-year review codes), is entirely a decision of the RUC and CMS. To be entirely honest, our societies had made the assumption that the new values would not appear until 2007.

In terms of compelling evidence, we refer the RUC to the SVS Comment Letters for the 1st, 2nd and 3rd five-year reviews. Here is a brief excerpt from the Jan 2005 letter to CMS: "As outlined in detail by Hertzner and Noether, the Hsiao/Harvard team that developed the RBRVS failed to recognize peripheral vascular surgery as a distinct discipline. The physician work RVWs for more than 200 vascular surgery codes were extrapolated from surveys of only two peripheral vascular operations in Harvard Phase 1 (infrarenal aortic aneurysm repair and carotid endarterectomy). Little is known about the actual vascular experience of the surgeons who participated in these work surveys, but, in fact, there was no stipulation that survey respondents need have any personal experience with the procedures they were asked to evaluate." The remainder of the compelling evidence discussion from each of the three 5-year reviews is readily available to any RUC member who is interested. The accumulated experience, however, has led to the conclusion expressed by RUC Chair Dr. William Rich in July 2004 testimony to a Congressional Subcommittee that "Vascular Surgery and General Surgery had been historically undervalued."

CPT 37720 has not been examined since the original Hsiao studies. We feel compelling evidence exists that it should be reconsidered in the 5-year review process. We have taken this code through the CPT process to obtain two offspring codes with descriptors suitable for the RUC survey process. The parent code 37720 will be deleted in 2006.

## WORK EVALUATION OVERVIEW

The multispecialty Consensus Panel that reviewed the survey results determined that the median survey RVW of 9.30 with an IWP/UT of 0.134 is too high for JJ1. We recommend a value of, 6.76 significantly below the 25th percentile based on a comparison with other members of the vein excision family, specifically the most commonly chosen reference services 37765 and 37766. In addition, it is important that JJ1 maintain relativity with JJ2, since JJ2 is by far the more common service of this pair. Based on relationship to JJ2, JJ1 should be 6.85. Additionally, JJ1 can be built from a similar 0-day service valued by the RUC last year, CPT 37465. Based on that, JJ1 should have an RVW of 6.66. These three methods generate very similar values. We recommend 6.76 as the middle and best choice.

## WORK EVALUATION DETAILS

The RVW of JJ1 can be constructed from the most frequently chosen reference services, 37765 and 37766. These two codes are used to report Stab phlebectomy of varicose veins, one extremity, with 37765 representing 10-20 incisions, while 37766 is used to report more than 20 incisions. 37765 and 37766 were evaluated by the RUC in April 2003. They have 2005 RVWs of 7.34 and 9.29 respectively. JJ1 and 37765/37766 have very similar pre and post service time elements, and the exact office visit pattern:

	37765	37766	JJ1
Pre-eval time	33	33	35
Pre-position tim	10	10	10
Scrub	15	15	15
Intra-time	60	90	45
Immed Post	25	25	20
99238	0.5	0.5	0.5
99213	1	1	1
99212	1	1	1

The major difference between the two is that JJ1 has 45 minutes of intra-service time while the reference 37765 has 60 minutes and 37766 has 90 minutes of intra-service time. Every survey respondent who chose 37765 and 37766 as references cited the intra-service intensity of the new service to be higher than the reference. Making the mathematical downward adjustment for removing intra-time from the reference service, then adjusting the intensity of the remaining minutes upwards by 15% results in a reduction of 2.53 RVUs that must be removed from reference 37766 to account for the intra-service adjustment:

Start with total RVW for 37766:	9.29
Subtract 45 min intra-time	-2.97
15% intensity increment	+0.44
Method 1: Total RVW base on 37766	6.76

JJ1 can also be valued in relation to its sister code JJ2. JJ2 will be the much more common service, so this seems reasonable. Based on a multi-code comparison provided under Additional Rationale for JJ2, our recommended value for JJ2 is 7.79. JJ1 has 15 minutes less intra-time than JJ2 (45 min vs. 60 min), but otherwise the same pre and post service times and visits. Our recommended RVW for JJ2 is 7.79, and of that, 4.42 RVUs account for intra-service work. The multispecialty consensus panel agreed that intra-service intensity for JJ1 is very slightly (i.e. 5%) more complex than JJ2. Thus, one can build JJ1 from JJ2 by the following:

Start with total RVW for JJ2:	7.79
Subtract 15 min intra-time	-1.11
Add 5% intensity increment	+0.17
Method 2: Total RVW for JJ1 based on JJ2:	6.85

As noted for JJ2, JJ1 can also be built from 36475. 36475 was not chosen for our reference service list on the RUC survey because it is a 0-day global service, and we are convinced that survey respondents cannot do the mental gymnastics necessary to translate the work of 0-day reference to the work of a 90-day global new service. Nevertheless, the survey data elements can be compared without difficulty.

Comparison of 36475 data to JJ1 demonstrates remarkable coincidence. The services have nearly identical pre and post times. JJ1 has 45 min intra-time, while 36475 has 60 minutes. The intra-service intensity of the two services is judged equal by the Consensus Panel. Both services have one-half of a discharge day. Since 36475 is a 0-day global there are no further elements. JJ1 has one 99213 and one 99212 during the 90-day global.

It is therefore very easy and logical to construct the relative value of JJ1 from 36475. The 2005 work RVW of 36475 is 6.72. The only major adjustments represent intra-time and office visits. Thus, to build JJ1 from 36475:

36475 RVW:	6.72
Subtract 15 min intra-time at same intensity	-1.13
Add one 99212	0.42
Add one 99213	0.65
Method 3: Total Proposed JJ1 RVW:	6.66

The three methods for developing a recommendation for JJ1 shown above yielded 6.66, 6.76, and 6.85 RVWs. We are recommending an RVW of 6.76 for JJ1, as shown in Method 1, as the best choice.

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) Either code 37765 Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions or code 37766 Stab phlebectomy of varicose veins, one extremity; more than 20 incisions is typically performed on the same day.

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) 37720 (Ligation and division and complete stripping of long or short saphenous veins)

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

Specialty GS                      How often? Commonly

Specialty VS                      How often? Commonly

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 GS                      Frequency 500                      Percentage 50.00 %

Specialty VS                      Frequency 500                      Percentage 50.00 %

Specialty                              Frequency 0                              Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500

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

Specialty GS                      Frequency 250                      Percentage 50.00 %

Specialty VS                      Frequency 250                      Percentage 50.00 %

Specialty                              Frequency 0                              Percentage 0.00 %

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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. code 37765 should be used since it has a more similar work RVU at 7.34 rather than the reference service at 9.29 RVUs

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

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

CPT Code:37722 Tracking Number: JJ2 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: 7.79  
RUC RVU: 7.79

CPT Descriptor: Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 66-year old man suffered spontaneous development of a large skin ulcer on the medial aspect of his calf, just above the ankle. He has normal arterial pulses. Venous duplex exam revealed incompetence of his greater saphenous vein with extensive reflux. Valve function in his deep veins was normal. The patient's ulcer healed after 6 weeks of therapy including medicated compression dressings and leg elevation. Ligation, division and stripping of his greater saphenous vein is performed to prevent recurrence.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

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

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Review all relevant office notes, H&P, noninvasive vascular lab studies
- Update H&P (required by JCAHO)
- Review operative plan and informed consent with patient and family
- Discuss patient comorbidities and surgical approach with Anesthesiologist
- Change into OR scrubs
- Supervise patient positioning (supine), skin prep, and draping
- Wait for anesthetic to become effective

**Description of Intra-Service Work:**

- Skin incision adjacent to groin crease, over saphenofemoral junction
- Dissect through soft tissue to find greater saphenous vein
- Make positive identification of saphenofemoral junction to ensure correct vein
- Identify, dissect, and divide venous branches between silk sutures
- Clear several cm of greater saphenous, find and ligate branches
- 2nd skin incision over saphenous vein at or just below knee
- Dissect through soft tissue to find greater saphenous vein
- Clear several cm of greater saphenous & ligate branches
- Divide saphenous between clamps and tie lower end
- Open clamp on transected saphenous and insert stripper
- Carefully manipulate stripper upwards within saphenous vein, through the thigh
- Identify end of stripper in saphenous vein at saphenofemoral junction
- Divide greater saphenous between clamps adjacent to saphenofemoral junction
- Suture upper end of transected saphenous vein at saphenofemoral junction
- Test for hemostasis, more sutures as needed
- Pass stripper through open end of saphenous vein
- Attach stripper head and tie end of vein to stripper
- With extreme care, pull stripper downwards through thigh and strip vein

- Hold pressure on thigh to control bleeding
- When bleeding stops, irrigate all wounds with saline
- Check again for hemostasis
- Close both wounds in multiple layers

## Description of Post-Service Work:

- Apply sterile dressings and Ace wrap
- Check foot for pulses and perfusion
- Transfer patient to stretcher, accompany to recovery area
- Write orders
- Dictate operative note
- Communicate with family
- Communicate with referring and consulting physicians
- Participate with the anesthesiologist to ensure smooth anesthesia emergence
- Discuss results of procedure with patient once he/she is fully awake
- When stable, transfer back to same-day area
- Examine patient again prior to discharge, check pulses & perfusion
- Check dressings for evidence of hemorrhage
- Provide activity and wound care advice to patient and family
- Arrange office follow up for wound checks, suture/staple removal, etc.
- Service also includes all outpatient office visits for duration of global period

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Gary Seabrook, MD Charles Shoemaker, MD					
<b>Specialty(s):</b>	SVS ASGS					
<b>CPT Code:</b>	37722					
<b>Sample Size:</b>	100	<b>Resp n:</b>	65	<b>Response:</b> 65.00 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		5.00	8.25	10.00	11.60	20.00
<b>Pre-Service Evaluation Time:</b>				40.0		
<b>Pre-Service Positioning Time:</b>				10.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0		
<b>Intra-Service Time:</b>		20.00	45.00	60.00	60.00	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>20.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>18.0</u>	99238x 0.50	99239x 0.00			
<b>Office time/visit(s):</b>	<u>38.0</u>	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>
37766	090	9.29

CPT Descriptor Stab phlebectomy of varicose veins, one extremity; more than 20 incisions

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
36475	000	6.72

CPT Descriptor Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and imaging, percutaneous, radiofrequency, first vein treated

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 20.0 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 37722</u>	<u>Key Reference CPT Code: 37766</u>
Median Pre-Service Time	60.00	58.00
Median Intra-Service Time	60.00	90.00
Median Immediate Post-service Time	20.00	25.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	18.00
Median Office Visit Time	38.0	38.00
Median Total Time	196.00	229.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	2.43	2.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.79	2.64
Urgency of medical decision making	1.64	1.64

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

Technical skill required	2.57	2.57
Physical effort required	2.43	2.43

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.14	2.07
Outcome depends on the skill and judgment of physician	2.79	2.64
Estimated risk of malpractice suit with poor outcome	2.79	2.57

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

Pre-Service intensity/complexity	2.57	2.57
Intra-Service intensity/complexity	2.57	2.43
Post-Service intensity/complexity	2.00	1.93

**ADDITIONAL RATIONALE**

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

**COMPELLING EVIDENCE DISCUSSION**

This code is presented to the RUC as part of the upcoming 5-year review process. SVS submitted CPT 37720 (Ligation and division and complete stripping of long or short saphenous veins) to CMS as an undervalued service. The procedure cannot be evaluated objectively with the current descriptor, however, because the work of excising the long saphenous

differs from that of the short saphenous. SVS therefore applied to CPT for creation of two new codes, one to represent the more common excision of the long saphenous vein (now JJ2) and the other to represent the less common excision of the short saphenous (now JJ1).

The RUC structure and function document indicates that the new codes should be evaluated at the April 2005 meet. despite that fact that this is a 5-year review issue. Evaluation in April 2005 implies that the RUC will send the resultant RVW recommendations to CMS, potentially for inclusion in the 2006 MFS. SVS and the American Society for General Surgery (ASGS) indicated interest in developing primary evidence, and we collected 65 survey respondents, and the summary recommendations are presented herein. SVS and ASGS want to make it absolutely clear that the decision of whether the new RVWs for these services are incorporated in the fee schedule in 2006, or if they are held until 2007 (to coincide with the other 5-year review codes), is entirely a decision of the RUC and CMS. To be entirely honest, our societies had made the assumption that the new values would not appear until 2007.

In terms of compelling evidence, we refer the RUC to the SVS Comment Letters for the 1st, 2nd and 3rd five-year reviews. Here is a brief excerpt from the Jan 2005 letter to CMS: "As outlined in detail by Hertzner and Noether, the Hsiao/Harvard team that developed the RBRVS failed to recognize peripheral vascular surgery as a distinct discipline. The physician work RVWs for more than 200 vascular surgery codes were extrapolated from surveys of only two peripheral vascular operations in Harvard Phase 1 (infrarenal aortic aneurysm repair and carotid endarterectomy). Little is known about the actual vascular experience of the surgeons who participated in these work surveys, but, in fact, there was no stipulation that survey respondents need have any personal experience with the procedures they were asked to evaluate." The remainder of the compelling evidence discussion from each of the three 5-year reviews is readily available to any RUC member who is interested. The accumulated experience, however, has led to the conclusion expressed by RUC Chair Dr. William Rich in July 2004 testimony to a Congressional Subcommittee that "Vascular Surgery and General Surgery had been historically undervalued."

CPT 37720 has not been examined since the original Hsiao studies. We feel compelling evidence exists that it should be reconsidered in the 5-year review process. We have taken this code through the CPT process to obtain two offspring codes with descriptors suitable for the RUC survey process. The parent code 37720 will be deleted in 2006.

## WORK EVALUATION

The multispecialty Consensus Panel that reviewed the survey results determined that the median survey RVW of 10.00, with an IWPUT of 0.111 is too high for JJ2. We recommend a value of 7.79, significantly below the 25th percentile based on a comparison with two recently RUC-evaluated venous excision reference services.

The first comparison is to a recently evaluated new procedure that accomplishes the exact clinical endpoint, CPT 36475. In April 2004, the RUC evaluated new service 36475, Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and imaging, percutaneous, radiofrequency, first vein treated. 36475 and JJ2 are exactly the same in terms of what they accomplish, which is elimination of the greater saphenous vein. 36475 electrocoagulates the vein with radiofrequency and heat, while JJ2 is used to report physical excision of the vein.

36475 was not chosen to serve on the reference service list for this RUC survey because it is a 0-day global service, and we are convinced that survey respondents cannot do the mental gymnastics necessary to translate the work of 0-day reference to the work of a 90-day global new service. Nevertheless, once the survey is completed, the data elements can be compared without difficulty.

Comparison of 36475 data to JJ2 demonstrates remarkable coincidence. Both services have 40 minutes of pre-service evaluation time. Both have 10 minutes of pre-service positioning time. 36475 has 5 minutes more scrub, dress, wait time than JJ2 (15 vs 10 min), but then JJ2 has 5 minutes more immediate post time, so that balances out. The two services have identical intra-service times of 60 minutes, and the intra-service intensity of the two services is judged equal by our Consensus Panel. Both services have one-half of a discharge day. Since 36475 is a 0-day global there are no further elements. JJ2 has one 99213 and one 99212 during the 90-day global.

It is therefore very easy and logical to construct the relative value of JJ2 from 36475. The 2005 work RVW of 36475 is 6.72. No adjustments need be made for pre, intra or immediate post work. Thus, to build JJ2 from 36475:

36475 RVW:	6.72
Add one 99213	0.65
Add one 99212	0.42
Total RVW for JJ2 based on 36475:	7.79

The RVW of JJ2 can also be constructed from the most frequently chosen reference service, 37766, Stab phlebectomy of varicose veins, one extremity, more than 20 incisions. 37766 was evaluated by the RUC in April 2003. It has a 2005 RVU of 9.29. JJ2 and 37766 have very similar pre and post service elements, and the exact office visit pattern, one 99213 and one 99212. The major difference between the two is that JJ2 has 60 minutes of intra-service time while the reference 37766 has 90 minutes of intra-service time. Every survey respondent who chose 37766 as a reference cited the intra-service intensity of the new service to be higher than the reference, and this is logical because the dissection is deeper and care must be taken to avoid the saphenous nerve. Making the mathematical downward adjustment for removing 30 minutes of intra-time from the reference service, then adjusting the intensity of the remaining minutes upwards by 15%, results in a reduction of 1.56 RVUs that must be removed from reference 37766 to account for the intra-service adjustment. Based on building block analysis, the intraservice work of 37766 is 5.93 RVUs. One-third of that must be deducted for 30 minutes less intra-time ( $5.93 \times 30 / 90 = 1.98$ ). The remaining work RVU is 15% more intense than 37766 based on intra-service intensity comparison, so  $5.93 - 1.98 = 3.95 \times 0.015 = 0.59$

Start with the RVW for 37766:	9.29
Subtract 30 min intra-time	-1.98
15% intra intensity increment	+0.59
Total RVW for JJ2 based on 37766	7.90

The two comparison analyses result in extremely close conclusions. We recommend an RVW of 7.79 based on the first analysis because the services are very similar. Our recommended value is far below the survey median of 10.00, and ven substantially BELOW THE 25th PERCENTILE of the survey data, which is 8.25. We feel it is fully justified.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) Either code 37765 Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions or code 37766 Stab phlebectomy of varicose veins, one extremity; more than 20 incisions is typically performed on the same day.

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 Update Process  
PEAC Summary of Recommendation  
090 Day Global Period  
Facility-ONLY Direct Inputs**

CPT	DESCRIPTION	GLOBAL
37718 JJ1	Ligation, division and stripping, short saphenous vein	090
37722 JJ2	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	090

**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 OFFICE visit times for clinical staff have been applied as appropriate.

**SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:**

Standard PEAC minimum multispecialty office visit supplies and incision care have been applied.

	A	B	C	D	E	F	G
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		37718		37722	
2				JJ1		JJ2	
3				Ligation, division and stripping, short saphenous vein		Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	
4				090		090	
5		Code	StaffType	NF	FAC	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	129	N/A	129
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60		60
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		6		6
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		63		63
10	<b>PRE-SERVICE</b>						
11	<i>Start: After visit for procedure/service</i>						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7
18	<i>End: Pt. enters site for procedure/service</i>						
19	<b>SERVICE PERIOD</b>						
40	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		6		6
42	<i>End: Patient leaves site of procedure/service</i>						
43	<b>POST-SERVICE Period</b>						
44	<i>End: Patient leaves site of procedure/service</i>						
46	<i>List Number and Level of Office Visits</i>						
47	99211 16 minutes	L037D	RN/LPN/MTA				
48	99212 27 minutes	L037D	RN/LPN/MTA		1		1
49	99213 36 minutes	L037D	RN/LPN/MTA		1		1
50	99214 53 minutes	L037D	RN/LPN/MTA				
51	99215 63 minutes	L037D	RN/LPN/MTA				
52	<b>Total Office Visit Time</b>			0	63	0	63
53	Other:						
54	<i>End: Last office visit in global period</i>						
55	<b>MEDICAL SUPPLIES</b>	Code	Unit				
56	pack, minimum multi-specialty visit	SA048	pack		2		2
57	pack, post-op incision care (suture & staple)	SA053	pack		1		1
58							
59	<b>Equipment</b>	Code					
60	table, power	EF031			63		63
61	light, exam	EQ168			63		63

## Partial Gastrectomy (Tab 15)

Charles D. Mabry, MD, American College of Surgeons (ACS) The CPT Editorial Panel deleted CPT codes 43638 Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrotomy, with vagotomy; and 43639 Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrotomy, with vagotomy; with pyloroplasty or pyloromyotomy which are outmoded procedures. The Panel originally created a cross-reference that these deleted codes should now be reported with CPT codes 43122 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrotomy, with or without pyloroplasty and 43123 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es) 43122 and 43123 have work relative values greater than the deleted codes 43638 and 43639 which would lead to a work neutrality issue. At the February 2005 meeting, the Editorial Panel removed the cross-reference as obsolete services should not be referred to other CPT codes when the codes are deleted. Staff Note: the CPT Editorial Panel did remove these cross references.

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Laparoscopic Gastric Restrictive Procedure, with Gastric Band**

The CPT Editorial Panel created eight new codes, 43770 – 43774 and 43886-43888, to describe laparoscopic and open gastric restrictive procedures, with gastric bands.

43770

The RUC reviewed the survey data of approximately 100 bariatric and gastrointestinal endoscopic surgeons. The specialty societies indicated that although code 43843 *Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty* (work RVU=18.62, IWPUT=0.132) was chosen most often as a reference code representing a similar typical patient, the specialty societies felt that the survey respondents did not adequately consider the post-operative work. The specialty societies then used a building block approach, using the intensity from another reference code that was cited by the survey respondents. Using the 25<sup>th</sup> percentile survey time data for code 43770 and an IWPUT of 0.108 from code 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)* (work RVU=27.83, IWPUT=0.108) the specialty societies developed a work RVU of 16.71, which includes the necessary band adjustments. **The RUC accepts the specialty societies' building block approach and recommends a work RVU of 16.71 for code 43770.**

43771

The RUC reviewed the survey data for code 43771 *Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric band component only*. The specialty societies indicated that 43771 involved more pre-service time, as well as a higher intensity of mental effort, technical skill and psychological stress than the reference code 38120 *Laparoscopy, surgical, splenectomy* (work RVU=16.97). The proposed work RVU of 19.50 for 43771 results in an IWPUT of 0.106 which is similar to the IWPUT for the primary procedure for placement of the entire gastric band system (43770 IWPUT=0.108), which includes the necessary band adjustments. **The RUC recommends a work RVU of 19.50 for code 43771.**

#### 43772

The RUC reviewed the survey data for code 43772 *Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band component only*. The specialty societies indicated that 43772 involved similar pre-, intra- and post-service times, and a higher intensity of mental effort, technical skill and psychological stress than the reference code 44200 *Laparoscopy, surgical; enterolysis* (work RVU=14.42). The specialty societies recommended the survey median work RUV of 15.00, which results in an IWPUT of 0.103 which is slightly lower than the IWPUT for the primary procedure for the placement of the entire gastric band system (43770 IWPUT=0.108). **The RUC recommends a work RVU of 15.00 for code 43772.**

#### 43773

The RUC reviewed the survey data for code 43773 *Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric band component only*. The specialty societies indicated that 43773 involved similar pre-, intra- and post-service times, and a higher intensity of mental effort, technical skill and psychological stress than the reference code 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)* (work RVU=17.22). The specialty societies recommended the survey median work RUV of 19.50, which results in an IWPUT of 0.107 which is slightly lower than the IWPUT for the primary procedure for the placement of the entire gastric band system (43770 IWPUT=0.108), which includes the necessary band adjustments. **The RUC recommends a work RVU of 19.50 for code 43773.**

#### 43774

The RUC reviewed the survey data for code 43774 *Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band and subcutaneous port components*. The specialty societies indicated that 43774 involved more pre-service time, as well as a higher intensity of mental effort, technical skill and psychological stress than the reference code 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)* (work RVU=11.27). The specialty societies recommended the survey median work RUV of 15.00, which results in an IWPUT of 0.106 which is consistent with the IWPUT for the primary procedure for the placement of the entire gastric band system (43770 IWPUT=0.108). **The RUC recommends a work RVU of 15.00 for code 43774.**

#### 43886

The RUC reviewed the survey data for code 43886 *Surgical, gastric restrictive procedure, open; revision of subcutaneous port component only*. The specialty societies indicated that 43886 involved more pre-service time, as well as a higher intensity of mental effort, technical skill and psychological stress than the reference code 36576 *Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site* (work RVU=3.19). The specialty societies recommended the survey median work RUV of 4.00, which results in an IWPUT of 0.029, which is similar to the IWPUT of the reference code (36576 IWPUT=0.031). The higher RVU for 43886 accounts for additional post-discharge office work within the 090-day global period compared to the data for the reference code, which has a 010-day global period. **The RUC recommends a work RVU of 4.00 for code 43886.**

#### 43887

The RUC reviewed the survey data for code 43887 *Surgical, gastric restrictive procedure, open; removal of subcutaneous port component only*. The specialty societies indicated that 43887 involved more pre-service time, as well as a higher intensity of mental effort than the reference code 36590 *Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion* (work RVU=3.30). The specialty societies indicated that the work for 43887 is similar to 36590, with the exception of one additional office visit for 4XXX9 during the 090-day global period. **The RUC recommends a work RVU of 3.95 for code 43887.**

#### 43888

The RUC reviewed the survey data for code 43888 *Surgical, gastric restrictive procedure, open; removal and replacement of subcutaneous port component only*. The specialty societies indicated that 43888 involved less pre-, intra- and post-service time than the reference code 49419 *Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (ie, totally implantable)* (work RVU=6.64). The specialty societies recommended the survey median RVU of 5.80 for 43888, which results in an IWPUT of 0.054, which is comparable to the IWPUT of a second reference code 36578 *Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site* (IWPUT=0.050). **The RUC recommends a work RVU of 5.80 for code 43888.**

#### Practice Expense

The RUC assessed and approved the standard 090-day global practice expense inputs with added supplies for band adjustments.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b><u>Bariatric Surgery</u></b>				
<u>Bariatric surgical procedures may involve the stomach, duodenum, jejunum and/or the ileum.</u>				
<b><u>Laparoscopy</u></b>				
<u>Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (separate procedure), use 49320.</u>				
<u>Typical postoperative follow-up care (see Surgery Guidelines, CPT Surgical Package Definition) after gastric restriction using the adjustable gastric band technique includes subsequent band adjustment(s) through the postoperative period for the typical patient. Band adjustment refers to changing the gastric band component diameter by injection or aspiration of fluid through the subcutaneous port component.</u>				
●43770	R1	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)  (For individual component placement, report 43770 with modifier 52)	090	16.71
●43771	R2	revision of adjustable gastric band component only	090	19.50
●43772	R3	removal of adjustable gastric band component only	090	15.00
●43773	R4	removal and replacement of adjustable gastric band component only  (Do not report 43773 in conjunction with 43772)	090	19.50
●43774	R5	removal of adjustable gastric band and subcutaneous port components  (For replacement of both gastric band and subcutaneous port components, use 43659)	090	15.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 43886	R6	Surgical, gastric restrictive procedure, open; revision of subcutaneous port component only	090	4.00
● 43887	R7	removal of subcutaneous port component only	090	3.95
● 43888	R8	removal and replacement of subcutaneous port component only  (Do not report 43888 in conjunction with 43887)  (For laparoscopic removal of both gastric band and subcutaneous port, use 43774)  (For removal and replacement of both gastric band and subcutaneous port components, use 43659)	090	5.80
▲ 43848		Revision, <u>open</u> , of gastric restrictive procedure for morbid obesity, <u>other than adjustable gastric band</u> (separate procedure)  (For adjustable gastric band procedures, see 43770-43774)	090	29.35  (No Change)

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

CPT Code:43770 Tracking Number: R1 Global Period: 090

**Recommended Work Relative Value**

Specialty Society RVU: **16.71**

RUC RVU: **16.71**

CPT Descriptor: Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 44-year-old woman presents with a BMI of 48, hypertension, and poorly controlled diabetes. She has failed nonoperative obesity interventions and has elected gastric banding instead of gastric bypass surgery. She undergoes laparoscopic placement of an adjustable gastric band and subcutaneous port.

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:**

Review history and physical. Review pre-operative work-up; labs, x-rays, cardiac evaluation, and sleep study report. Write orders for peri-operative medications; vitamin/mineral supplements, antibiotics, heparin, and bowel prep. Review planned incisions and procedure. Change into scrub clothes. Review surgical procedure, post-operative recovery in and out of the hospital, and expected outcome(s) with patient and family. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, surgical laparoscopy is performed. Pneumoperitoneum is established to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation or venous return. Four to six trocar ports are sited through the anterior abdominal wall above the umbilicus. The viscera are inspected. An orogastric tube may be placed to decompress the stomach. The liver is retracted to expose the gastroesophageal junction. A path is made behind the upper stomach, 2 cm below the gastroesophageal junction. The dissection plane may be guided by use of a per-oral gastric balloon catheter, which defines the location of the gastroesophageal junction, or by anatomical landmarks from the right crus of the diaphragm to the Angle of His. Excess visceral fat covering the upper stomach may need to be excised to prevent incorporation within the band, which would cause external compression and subsequent obstruction. The adjustable gastric band is introduced into the abdomen and pulled through the prepared retro-gastric path and around the upper stomach, just below the gastroesophageal junction. The band is locked. The band position is secured with strategically-placed gastro-gastric sutures to prevent band slippage or gastric prolapse. The tubing attached to the band is tunneled through the abdominal wall. It is then connected to an access port which is secured in or on the abdominal rectus muscle or other secure subcutaneous location. Hemostasis is obtained. The trocars are removed and all fascial and skin openings are closed as appropriate.

**Description of Post-Service Work:**

Post-operative work, in hospital:

Sterile dressings are placed. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Examine patient and check wounds and patient progress.

Review nursing/staff chart notes. Answer patient and family questions. Answer nursing/staff questions. Write and summarize orders for floor nurse. Check fluid and electrolyte status. Write orders for following labs, films, medications, diet, and patient activity. A confirmatory contrast upper gastrointestinal radiograph is ordered and reviewed to exclude gastric prolapse, perforation, or obstruction. When the contrast study and patient's status are acceptable, a clear liquid diet is instituted and the patient is discharged. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient, nutritionist and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

#### Post-operative work, in office:

The patient is examined and the wounds assessed. All patient and family questions are answered. Sutures are removed when appropriate. At each visit, check blood pressure, heart sounds, breath sounds, lower extremities, and weight. 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. Inflate the band, as needed, based on hunger, weight loss, and restriction. This is performed in the office under sterile technique, by percutaneously accessing the subcutaneous port with a non-coring needle connected to a syringe filled with saline. Saline is injected into the port, aspirated back to ensure successful puncture, and a pre-determined amount of saline is injected into the port. The needle is then removed. (It is estimated by survey that band adjustments would typically be performed twice during the postoperative period.) Discuss any additional or adjuvant treatment that may be required and other specialist referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

#### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>		Michael Edye MD FACS, SAGES Christine Ren, MD FACS, ASBS			
<b>Specialty(s):</b>		Society American Gastrointestinal Endoscopic Surgeons American Society of Bariatric Surgery			
<b>CPT Code:</b>		43770			
<b>Sample Size:</b>	400	<b>Resp n:</b>	99	<b>Response:</b> 24.75 %	
<b>Sample Type:</b>		Random			
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		15.00	18.00	18.62	20.00
<b>Pre-Service Evaluation Time:</b>				60.0	
<b>Pre-Service Positioning Time:</b>				25.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15.0	
<b>Intra-Service Time:</b>		50.00	60.00	90.00	90.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>		
<b>Immed. Post-time:</b>		<u>30.00</u>			
<b>Critical Care time/visit(s):</b>		<u>0.0</u>	99291x 0.0	99292x 0.0	
<b>Other Hospital time/visit(s):</b>		<u>30.0</u>	99231x 0.0	99232x 1.0	99233x 0.0
<b>Discharge Day Mgmt:</b>		<u>36.0</u>	99238x 1.00	99239x 0.00	
<b>Office time/visit(s):</b>		<u>69.0</u>	99211x 0.0	12x 0.0	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>
43843	090	18.62

CPT Descriptor Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
43644	090	27.83

CPT Descriptor Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 38.3 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u> 43770	<u>Key Reference CPT Code:</u> 43843
Median Pre-Service Time	100.00	60.00
Median Intra-Service Time	90.00	150.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	60.00
Median Other Hospital Visit Time	30.0	139.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	69.0	61.00
Median Total Time	355.00	536.00
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	3.97	3.89
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.45	4.29
--	------	------

Urgency of medical decision making	2.63	2.66
------------------------------------	------	------

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

Technical skill required	4.50	4.21
--------------------------	------	------

Physical effort required	3.82	3.68
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.13	4.00
---	------	------

Outcome depends on the skill and judgment of physician	4.71	4.55
--	------	------

Estimated risk of malpractice suit with poor outcome	4.71	4.47
--	------	------

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

Pre-Service intensity/complexity	4.26	4.18
----------------------------------	------	------

Intra-Service intensity/complexity	4.21	4.08
------------------------------------	------	------

Post-Service intensity/complexity	3.79	3.47
-----------------------------------	------	------

**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.*

please see ATTACHMENT: 43770 ADDITIONAL RATIONALE.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**



	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

## ATTACHMENT: 43770 ADDITIONAL RATIONALE

Although code 43843 (RVW = 18.62) was chosen most often as a reference code representing a similar typical patient, we do not believe that the survey respondents took into consideration the differences in post-operative work. The consensus committee reviewing the survey results considered an IWPUT of 0.132 (as calculated using the survey median RVW of 18.62 and the survey median time and visit information) as inconsistent with other codes.

To develop our recommendation, we used the intensity for another reference code that was cited by respondents. This reference code, which has an IWPUT of 0.108, is a similar laparoscopic gastric restrictive procedure: 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)*.

Using the time and visit survey data for 43770 and an IWPUT of 0.108, an RVW of 16.71 is calculated. **We are recommending an RVW of 16.71** which is less than the survey 25<sup>th</sup> percentile, but takes into consideration the relationship between new code 43770 and 43644.

Additionally, we would like to note that band adjustments are included in the total work for this service. These adjustments would be made during the post-op visits, and not separately billable. We asked an additional question on the survey regarding the number of typical band adjustments that would be performed during the 90-day global period. The median response was two adjustments.

			RVW				RVW
			<b>18.62</b>				<b>16.71</b>
	Svy Data	RUC Std.	RVW		Svy Data	RUC Std.	RVW
<i>Pre-service:</i>	Time	Intensity	(=time x intensity)		Time	Intensity	(=time x intensity)
Pre-service eval & positioning	85	0.0224	1.90		85	0.0224	1.90
Pre-service scrub, dress, wait	15	0.0081	0.12		15	0.0081	0.12
<b>Pre-service total</b>			<b>2.03</b>				<b>2.03</b>
<i>Post-service:</i>	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)
99233		1.51	0.00			1.51	0.00
99232	1	1.06	1.06		1	1.06	1.06
99231		0.64	0.00			0.64	0.00
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		1.08	0.00			1.08	0.00
99213	2	0.65	1.30		3	0.65	1.30
99212	1	0.43	0.43			0.43	0.43
99211		0.17	0.00			0.17	0.00
<b>Post-service total</b>			<b>4.74</b>				<b>4.96</b>
	Time	IWPUT	INTRA-RVW		Time	IWPUT	INTRA-RVW
<i>Intra-service:</i>	90	<b>0.132</b>	11.85		90	<b>0.108</b>	9.72

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

CPT Code:43771 Tracking Number: R2 Global Period: 090

**Recommended Work Relative Value  
Specialty Society RVU: 19.50  
RUC RVU: 19.50**

CPT Descriptor: Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric band component only

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45-year-old woman presents 15 months after surgical placement of adjustable gastric banding for a BMI of 45. She has lost 85 pounds since surgery, but has developed recent new onset symptoms of night-time gastroesophageal reflux that wake her from sleep. She also complains of decreased restriction and a capacity to eat more food. A contrast esophagram has confirmed band slippage or gastric prolapse. She undergoes laparoscopic revision of the adjustable gastric band.

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

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 history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Review pre-operative work-up; labs, x-rays, cardiac evaluation, and sleep study report. Write orders for peri-operative medications; vitamin/mineral supplement, antibiotics, heparin, and bowel prep. Review previous surgery report and planned incisions and procedure. Change into scrub clothes. Review surgical procedure, post-operative recovery in and out of the hospital, and expected outcome(s) with patient and family. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown

**Description of Intra-Service Work:**

Under general anesthesia, surgical laparoscopy is performed. A supraumbilical incision is made, and peritoneum is grasped with sutures on the fascia. Insertion of the first trocar proceeds with caution in view of the prior surgery. Gas flow is initiated to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation or venous return. Four to six trocar ports are sited through the anterior abdominal wall above the umbilicus. The viscera are inspected. Pneumoperitoneum is maintained at 15 mm Hg throughout the procedure. An orogastric tube may be placed to decompress the stomach. The liver is retracted anteriorly to expose the upper stomach. Adhesions (which can be extensive) of the stomach to the undersurface of the liver are lysed with an ultrasonic scalpel. The band and its tubing are identified. The band is freed from the fibrin seal created by adhesions. The gastro-gastric sutures are cut and the securing gastric plication is released. The enlarged pouch is reduced by gentle retraction of the stomach tissue below the band in a caudad direction. This slides the stomach that has prolapsed upwards through the band, back down through the band to its appropriate original position below. The band is re-positioned 1-2 cm below the gastroesophageal junction to create an appropriately small pouch. The gastric wall integrity is inspected. A leak test using methylene blue or air is performed to test for inadvertent gastrotomy. Any gastric wall injury is repaired with intra-corporeal sutures. A new gastro-gastric imbrication of the band is completed. Additional posterior-lateral sutures are added as necessary to secure the stomach/band position. Hemostasis is obtained. The trocars are removed, and all fascial and skin openings are closed as appropriate.

**Description of Post-Service Work:**

Post-operative work, in hospital:

Sterile dressings are placed. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Examine patient and check wounds and patient progress. Review nursing/staff chart notes. Answer patient and family questions. Answer nursing/staff questions. Write and summarize orders for floor nurse. Check fluid and electrolyte status. Write orders for following labs, films, medications, diet, and patient activity. A confirmatory contrast upper gastrointestinal radiograph is ordered and reviewed to exclude gastric prolapse, perforation, or obstruction. When the contrast study and patient's status are acceptable, a clear liquid diet is instituted and the patient is discharged. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient, nutritionist and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

#### Post-operative work, in office:

The patient is examined and the wounds assessed. All patient and family questions are answered. Sutures are removed when appropriate. At each visit, check blood pressure, heart sounds, breath sounds, lower extremities, and patient weight. 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. Inflate the band, as needed, based on hunger, weight loss, and restriction. This is performed in the office under sterile technique, by percutaneously accessing the subcutaneous port with a non-coring needle connected to a syringe filled with saline. Saline is injected into the port, aspirated back to ensure successful puncture, and a pre-determined amount of saline is injected into the port. The needle is then removed. (It is estimated by survey that band adjustments would typically be performed twice during the postoperative period.) Discuss any additional or adjuvant treatment that may be required and specialist referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

#### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Michael Edey MD FACS, SAGES Christine Ren, MD FACS, ASBS					
<b>Specialty(s):</b>	Society American Gastrointestinal Endoscopic Surgeons American Society of Bariatric Surgery					
<b>CPT Code:</b>	43771					
<b>Sample Size:</b>	400	<b>Resp n:</b>	31	<b>Response:</b> 7.75 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>		15.00	16.50	19.50	25.00	28.00
<b>Pre-Service Evaluation Time:</b>				45.0		
<b>Pre-Service Positioning Time:</b>				25.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0		
<b>Intra-Service Time:</b>		50.00	90.00	120.00	120.00	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b>30.00</b>					
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b>30.0</b>	99231x 0.0	99232x 1.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b>36.0</b>	99238x 1.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b>69.0</b>	99211x 0.0	12x 0.0	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>
38120	090	16.97

CPT Descriptor Laparoscopy, surgical, splenectomy**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
43644	090	27.83

CPT Descriptor Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

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

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

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 43771</u>	<u>Key Reference CPT Code: 38120</u>
Median Pre-Service Time	80.00	60.00
Median Intra-Service Time	120.00	180.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	57.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	69.0	46.00
Median Total Time	365.00	409.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.88	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.38
Urgency of medical decision making	3.75	2.50

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

Technical skill required	4.00	3.63
Physical effort required	3.63	3.63

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.13	3.25
Outcome depends on the skill and judgment of physician	4.38	3.63
Estimated risk of malpractice suit with poor outcome	4.50	3.50

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

Pre-Service intensity/complexity	3.63	3.50
Intra-Service intensity/complexity	3.88	3.50
Post-Service intensity/complexity	3.00	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.*

The survey median RVW of 19.50 is recommended for 43771. This RVW for 43771 (revision of band component) results in an IWP/UT of 0.106 which is similar to the IWP/UT for the primary procedure for placement of the entire band system (43770; IWP/UT = 0.108).

Additionally, we would like to note that band adjustments are included in the total work for this service. These adjustments would be made during the post-op visits, and not separately billable. We asked an additional question on the



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

Specialty general surgery  
 Approximately 5-7% of the national frequency would be Medicare age.  

Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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**Specialty Society RVU: **15.00**RUC RVU: **15.00**

CPT Code:43772 Tracking Number: R3 Global Period: 090

CPT Descriptor: Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band component only

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45-year-old woman presents 15 months after surgical placement of adjustable gastric banding for a BMI of 45. She has lost 85 pounds since surgery, but has developed recent new onset symptoms of severe abdominal (epigastric) pain with dysphagia and vomiting. A contrast esophagram has confirmed a large band slippage or gastric prolapse. She undergoes laparoscopic removal of the adjustable gastric band.

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

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

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Review history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Review pre-operative work-up; labs, x-rays, cardiac evaluation, and sleep study report. Write orders for peri-operative medications; vitamin/mineral supplement, antibiotics, heparin, and bowel prep. Review previous surgery report and planned incisions and procedure. Change into scrub clothes. Review surgical procedure, post-operative recovery in and out of the hospital, and expected outcome(s) with patient and family. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown

**Description of Intra-Service Work:**

Under general anesthesia, surgical laparoscopy is performed. Insertion of the first trocar proceeds with caution in view of prior surgery. Gas flow is initiated to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation or venous return. Four to six trocar ports are placed in through the anterior abdominal wall above the umbilicus. The viscera are inspected. Pneumoperitoneum is maintained at 15 mm Hg throughout the procedure. An orogastric tube may be placed to decompress the stomach. The liver is retracted anteriorly to expose the upper stomach. Adhesions (which can be extensive) of the stomach to the undersurface of the liver are lysed with an ultrasonic scalpel. The band and its tubing are identified. The band is freed from the fibrin seal created by adhesions. Some of the gastro-gastric suturing may be divided, taking care not to create a gastrotomy. The band is removed by cutting the buckle or the band next to the buckle. Gastric wall defects are identified and repaired in layers with sutures. Testing for leaks is performed with methylene blue, air insufflated through a nasogastric tube, or by intraoperative endoscopy. The tube connecting the band to the port is cut and the band with part of the tubing is removed from the abdomen. Hemostasis is obtained. The trocars are removed, and all fascial and skin openings closed as appropriate.

**Description of Post-Service Work:**

Post-operative work, in hospital:

Sterile dressings are placed. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Examine patient and check wounds and patient progress.

Review nursing/staff chart notes. Answer patient and family questions. Answer nursing/staff questions. Write and summarize orders for floor nurse. Check fluid and electrolyte status. Write orders for following labs, films, medications, diet, and patient activity. When the patient is stable, a clear liquid diet is instituted and the patient is discharged. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:

The patient is examined and the wounds assessed. All patient and family questions are answered. Sutures are removed when appropriate. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>		Michael Edey MD FACS, SAGES Christine Ren, MD FACS, ASBS			
<b>Specialty(s):</b>		Society American Gastrointestinal Endoscopic Surgeons American Society of Bariatric Surgery			
<b>CPT Code:</b>		43772			
<b>Sample Size:</b>	400	<b>Resp n:</b>	31	<b>Response:</b> 7.75 %	
<b>Sample Type:</b>		Random			
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		10.00	13.25	15.00	17.50
<b>Pre-Service Evaluation Time:</b>				45.0	
<b>Pre-Service Positioning Time:</b>				25.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		30.00	60.00	90.00	90.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>		
<b>Immed. Post-time:</b>		<u>30.00</u>			
<b>Critical Care time/visit(s):</b>		<u>0.0</u>	99291x 0.0	99292x 0.0	
<b>Other Hospital time/visit(s):</b>		<u>30.0</u>	99231x 0.0	99232x 1.0	99233x 0.0
<b>Discharge Day Mgmt:</b>		<u>36.0</u>	99238x 1.00	99239x 0.00	
<b>Office time/visit(s):</b>		<u>38.0</u>	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>
44200	090	14.42

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

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
58660	090	11.27

CPT Descriptor 1 Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

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

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 15      % of respondents: 46.8 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 43772	Key Reference CPT Code: 44200
Median Pre-Service Time	80.00	100.00
Median Intra-Service Time	90.00	120.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	76.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	38.0	38.00
Median Total Time	304.00	400.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.87	3.13
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.27
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Urgency of medical decision making	3.47	2.87
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.73	3.47
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Physical effort required	3.47	3.40
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.87	3.33
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Outcome depends on the skill and judgment of physician	3.80	3.67
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Estimated risk of malpractice suit with poor outcome	3.93	3.47
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.80	3.27
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Intra-Service intensity/complexity	3.33	3.13
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Post-Service intensity/complexity	2.47	2.40
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**ADDITIONAL RATIONALE**

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

The survey median RVW of 15.00 is recommended for 43772. This RVW for 43772 (removal of band component) results in an IWPUT of 0.103 which is slightly lower than the IWPUT for the primary procedure for placement of the entire band system (43770; IWPUT = 0.108), taking into consideration a lower complexity of intra-operative work.



Specialty general surgery

Approximately 5-7% of the national frequency would be Medicare age.

Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

**Recommended Work Relative Value**

CPT Code:43773 Tracking Number: R4 Global Period: 090

Specialty Society RVU: **19.50**RUC RVU: **19.50**

CPT Descriptor: Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric band component only

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45-year-old woman presents 15 months after surgical placement of adjustable gastric banding for a BMI of 45. She has lost 85 pounds since surgery. She has had a known chronic slippage diagnosed by contrast esophagram and has now developed worsening symptoms of dysphagia and/or vomiting. She undergoes laparoscopic removal of the old adjustable gastric band and placement of a new adjustable gastric band.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

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

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Review history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Review pre-operative work-up; labs, x-rays, cardiac evaluation, and sleep study report. Write orders for peri-operative medications; vitamin/mineral supplement, antibiotics, heparin, and bowel prep. Review previous surgery port and planned incisions and procedure. Change into scrub clothes. Review surgical procedure, post-operative recovery in and out of the hospital, and expected outcome(s) with patient and family. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, surgical laparoscopy is performed. Initial trocar insertion proceeds cautiously in view of prior surgery. Gas flow is initiated to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation or venous return. Four to six trocar ports are placed in through the anterior abdominal wall above the umbilicus. The viscera are inspected. Pneumoperitoneum is maintained at 15 mm Hg throughout the procedure. An orogastric tube may be placed to decompress the stomach. The liver is retracted anteriorly to expose the upper stomach. Adhesions (which can be extensive) of the stomach to the undersurface of the liver are lysed with an ultrasonic scalpel. The band and its tubing are identified. The band is freed from the fibrin seal created by adhesions.

The gastro-gastric sutures are cut and the securing gastric plication is released. The enlarged pouch is identified and attempts are made to reduce it by gentle retraction of the stomach tissue below the band in a caudad direction. The adhesions of the prolapsed stomach prevents adequate reduction of stomach into the correct position. Removal of the band to release the gastric prolapse is necessary. The band is cut along the side of the buckle to release the locking mechanism, or the band may be cut through the ring/shell section next to the buckle. The band portion is then completely removed and a new band is placed in the correct position. This requires a new retrogastric dissection typically in a location above the original band placement and is time consuming due to scarring from the previous band. The gastric wall integrity is inspected. A leak test using methylene blue or air may be performed to test for inadvertent gastrotomy. Any gastric wall injury is repaired with intra-corporeal sutures. A new gastro-gastric imbrication of the band is completed. Additional posterior-lateral sutures may be added as necessary to secure the stomach/band position. The old band is removed from the abdomen, the tubing leading to the access port is cut and reconnected to the tubing of

the newly placed band. Hemostasis is obtained. The trocars are removed, and all fascial and skin openings closed as appropriate.

#### Description of Post-Service Work:

##### Post-operative work, in hospital:

Sterile dressings are placed. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Examine patient and check wounds and patient progress. Review nursing/staff chart notes. Answer patient and family questions. Answer nursing/staff questions. Write and summarize orders for floor nurse. Check fluid and electrolyte status. Write orders for following labs, films, medications, diet, and patient activity. A confirmatory contrast upper gastrointestinal radiograph is ordered and reviewed to exclude gastric prolapse, perforation, or obstruction. When the contrast study and patient's status are acceptable, a clear liquid diet is instituted and the patient is discharged. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient, nutritionist and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

##### Post-operative work, in office:

The patient is examined and the wounds assessed. All patient and family questions are answered. Sutures are removed when appropriate. At each visit, check blood pressure, heart sounds, breath sounds, lower extremities, and weight. 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. Inflate the band, as needed, based on hunger, weight loss, and restriction. This is performed in the office under sterile technique, by percutaneously accessing the subcutaneous port with a non-coring needle connected to a syringe filled with saline. Saline is injected into the port, aspirated back to ensure successful puncture, and a pre-determined amount of saline is injected into the port. The needle is then removed. (It is estimated by survey that band adjustments would typically be performed twice during postoperative period.) Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Michael Edye MD FACS, SAGES Christine Ren, MD FACS, ASBS				
<b>Specialty(s):</b>	Society American Gastrointestinal Endoscopic Surgeons American Society of Bariatric Surgery				
<b>CPT Code:</b>	43773				
<b>Sample Size:</b>	400	<b>Resp n:</b>	31	<b>Response:</b>	7.75 %
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		16.00	18.00	19.50	25.00
<b>Pre-Service Evaluation Time:</b>				45.0	
<b>Pre-Service Positioning Time:</b>				25.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		50.00	98.00	120.00	153.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>30.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>30.0</u>	99231x 0.0	99232x 1.0	99233x 0.0	

<b>Discharge Day Mgmt:</b>	<b>36.0</b>	99238x 1.00 99239x 0.00
<b>Office time/visit(s):</b>	<b>69.0</b>	99211x 0.0 12x 0.0 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>
43280	090	17.22

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

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
43644	090	27.83

CPT Descriptor Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 34.3 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 43773</u>	<u>Key Reference CPT Code: 43280</u>
Median Pre-Service Time	80.00	100.00
Median Intra-Service Time	120.00	150.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	38.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	69.0	46.00
Median Total Time	365.00	400.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.91	3.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.27	4.00
Urgency of medical decision making	4.18	2.91

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

Technical skill required	4.73	4.64
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Physical effort required	4.27	4.09
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.55	4.45
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Outcome depends on the skill and judgment of physician	4.82	4.55
--	------	------

Estimated risk of malpractice suit with poor outcome	4.82	4.45
--	------	------

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

Pre-Service intensity/complexity	4.36	4.45
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Intra-Service intensity/complexity	4.55	4.45
------------------------------------	------	------

Post-Service intensity/complexity	3.91	3.91
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**ADDITIONAL RATIONALE**

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

The survey median RVW of 19.50 is recommended for 43773. This RVW for 43773 (remove and replace band component) results in an IWPUR of 0.107 which is similar to the IWPUR for the primary procedure for placement of the entire band system (43770; IWPUR = 0.108).

Additionally, we would like to note that band adjustments are included in the total work for this service. These adjustments would be made during the post-op visits, and not separately billable. We asked an additional question on the



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 general surgery  
Approximately 5-7% of the national frequency would be Medicare age.

	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

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

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

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

CPT Code:43774 Tracking Number: R5 Global Period: 090

**Recommended Work Relative Value**

Specialty Society RVU: **15.00**

RUC RVU: **15.00**

CPT Descriptor: Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band and subcutaneous port components

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 40-year-old woman presents 18 months after surgical placement of adjustable gastric banding for a BMI of 45. She has had inadequate weight loss. The band system is determined to be functioning appropriately. She undergoes laparoscopic removal of the adjustable gastric band and the subcutaneous port.

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:**

Review history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Review pre-operative work-up; labs, x-rays, cardiac evaluation, and sleep study report. Write orders for peri-operative medications; vitamin/mineral supplement, antibiotics, heparin, and bowel prep. Review previous surgery report and planned incisions and procedure. Change into scrub clothes. Review surgical procedure, post-operative recovery in and out of the hospital, and expected outcome(s) with patient and family. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, surgical laparoscopy is performed. Insertion of the first trocar proceeds with caution in view of prior surgery. Gas flow is initiated to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation or venous return. Four to six trocar ports are sited through the anterior abdominal wall above the umbilicus. The viscera are inspected. Pneumoperitoneum is maintained at 15 mm Hg throughout the procedure. An orogastric tube may be placed to decompress the stomach. The liver is retracted anteriorly to expose the upper stomach. Adhesions (which can be extensive) of the stomach to the undersurface of the liver are lysed. The band and its tubing are identified. The band is freed from the fibrin seal created by adhesions. Some of the gastro-gastric suturing may be divided, taking care not to open into the stomach lumen. The band is removed by cutting the buckle or the band next to it. Gastric wall defects are identified and repaired. A methylene blue test or air leak test through a nasogastric tube or intraoperative endoscopy is performed. The tube connecting the band to the port is cut and the band is removed from the abdomen. An incision is made over the access port. The port sutures are released and the access port is removed. Hemostasis is obtained. The trocars are removed, and all fascial and skin openings are closed as appropriate

**Description of Post-Service Work:**

Post-operative work, in hospital:

Sterile dressings are placed. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Examine patient and check wounds and patient progress. Review nursing/staff chart notes. Answer patient and family questions. Answer nursing/staff questions. Write and

summarize orders for floor nurse. Check fluid and electrolyte status. Write orders for following labs, films, medications, diet, and patient activity. When the patient is stable, a clear liquid diet is instituted and the patient is discharged. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient, nutritionist and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:

The patient is examined and the wounds assessed. All patient and family questions are answered. Sutures are removed when appropriate. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>		Michael Edye MD FACS, SAGES Christine Ren, MD FACS, ASBS			
<b>Specialty(s):</b>		Society American Gastrointestinal Endoscopic Surgeons American Society of Bariatric Surgery			
<b>CPT Code:</b>		43774			
<b>Sample Size:</b>	400	<b>Resp n:</b>	99	<b>Response:</b> 24.75 %	
<b>Sample Type:</b>		Random			
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		9.00	12.00	15.00	18.00
<b>Pre-Service Evaluation Time:</b>				45.0	
<b>Pre-Service Positioning Time:</b>				25.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15.0	
<b>Intra-Service Time:</b>		45.00	60.00	90.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>25.00</b>				
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b>19.0</b>	99231x 1.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b>36.0</b>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b>46.0</b>	99211x 0.0	12x 0.0	13x 2.0	14x 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>
58660	090	11.27

CPT Descriptor aparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
	000	

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
43644	090	27.83

CPT Descriptor Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 26.2 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 43774</u>	<u>Key Reference CPT Code: 58660</u>
Median Pre-Service Time	85.00	48.00
Median Intra-Service Time	90.00	90.00
Median Immediate Post-service Time	25.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	19.0	0.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	46.0	23.00
<b>Median Total Time</b>	<b>301.00</b>	<b>227.00</b>
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.04	3.73
Urgency of medical decision making	3.00	3.08

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

Technical skill required	4.31	4.04
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Physical effort required	3.46	3.38
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.65	3.54
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Outcome depends on the skill and judgment of physician	4.15	4.19
--	------	------

Estimated risk of malpractice suit with poor outcome	4.54	3.92
--	------	------

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

Pre-Service intensity/complexity	4.04	3.65
----------------------------------	------	------

Intra-Service intensity/complexity	3.85	3.65
------------------------------------	------	------

Post-Service intensity/complexity	2.58	2.58
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**ADDITIONAL RATIONALE**

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

The survey median RVW of 15.00 is recommended for 43774. This RVW for 43774 (removal of band and port) is slightly lower than our recommendation for 43770 (placement of band and port), and takes into consideration the lower pre- and post-service work. An RVW of 15.00, along with the survey median time and visit data, yields an IWPUT of 0.106 which is consistent with the IWPUT of 0.108 for 43770.

We note that no band adjustments would be included during the post-op visits for this this service.

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**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.

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**FREQUENCY INFORMATION**

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

43659: Unlisted laparoscopy procedure, stomach

49999: Unlisted procedure, abdomen, peritoneum, and omentum

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

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

Specialty general surgery subspecialties:

minimally invasive surgery and bariatric surgery

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

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

Specialty general surgery

We estimate 24,000 primary laparoscopic gastric band procedures were performed nationally in 2003. We cannot estimate the number of complete removal of band and port components that would occur annually because many patients have these systems in place for more than one year.

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 general surgery

The Medicare frequency would be 5-7% of the national frequency.

Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

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

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**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. 43843

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:43886 Tracking Number: R6 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **4.00**  
RUC RVU: **4.00**

CPT Descriptor: Surgical, gastric restrictive procedure, open; revision of subcutaneous port component only

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45-year-old woman presents 3.5 months after surgical placement of adjustable gastric banding for a BMI of 45. Attempts to access the subcutaneous port component are unsuccessful. An abdominal radiograph reveals that the subcutaneous port component has flipped. She undergoes revision of the subcutaneous port.

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? Yes

**Description of Pre-Service Work:**

Review history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Review pre-operative work-up; labs, x-rays, cardiac evaluation, and sleep study report. Write orders for peri-operative medications; vitamin/mineral supplement, antibiotics, heparin, and bowel prep. Review previous surgery report and planned incisions and procedure. Change into scrub clothes. Review surgical procedure, post-operative recovery in and out of the hospital, and expected outcome(s) with patient and family. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Verify that necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, an incision is made over the access port. The subcutaneous fat and capsule around the port are divided. The port is found to be flipped over, with the access portion facing the fascia. The securing suture is found to have been disrupted. The port is replaced into its original position, with the silicone access portion facing up. The access port is secured to the anterior abdominal wall fascia with non-absorbable sutures. Saline may be injected into the band for tightening via the access port during surgery. Hemostasis is obtained and the wound is closed.

**Description of Post-Service Work:**

**Post-operative work, in hospital:**

Sterile dressings are placed. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Examine patient and check wounds and patient progress. Review nursing/staff chart notes. Answer patient and family questions. Answer nursing/staff questions. Write and summarize orders for floor nurse. Check fluid and electrolyte status. Write orders for following labs, films, medications, diet, and patient activity. When the patient is stable, a clear liquid diet is instituted and the patient is discharged. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient, nutritionist and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

**Post-operative work, in office:**

The patient is examined and the wound assessed. All patient and family questions are answered. Sutures are removed when appropriate. At each visit, check blood pressure, heart sounds, breath sounds, lower extremities, and patient

weight. 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. Inflate the band, as needed, based on hunger, weight loss, and restriction. This is performed in the office under sterile technique, by percutaneously accessing the subcutaneous port with a non-coring needle connected to a syringe filled with saline. Saline is injected into the port, aspirated back to ensure successful puncture, and a pre-determined amount of saline is injected into the port. The needle is then removed. (It is estimated by survey that band adjustments would typically be performed twice during the postoperative period.) Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>		Michael Edge MD FACS, SAGES Christine Ren, MD FACS, ASBS			
<b>Specialty(s):</b>		Society American Gastrointestinal Endoscopic Surgeons American Society of Bariatric Surgery			
<b>CPT Code:</b>		43886			
<b>Sample Size:</b>	400	<b>Resp n:</b>	31	<b>Response:</b>	%
<b>Sample Type:</b> Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		3.19	3.20	4.00	6.00
<b>Pre-Service Evaluation Time:</b>				20.0	
<b>Pre-Service Positioning Time:</b>				15.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		20.00	3.00	30.00	45.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>15.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>18.0</u>	99238x 0.50	99239x 0.00		
<b>Office time/visit(s):</b>	<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:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
36576	010	3.19

CPT Descriptor Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
49419	090	6.64

CPT Descriptor Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (ie, total implantable)

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

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

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 43886</u>	<u>Key Reference CPT Code: 36576</u>
Median Pre-Service Time	45.00	41.00
Median Intra-Service Time	30.00	33.00
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	18.0	18.00
Median Office Visit Time	46.0	15.00
<b>Median Total Time</b>	<b>154.00</b>	<b>122.00</b>
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	2.75	2.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	2.45
Urgency of medical decision making	2.20	2.25

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

Technical skill required	2.25	2.15
Physical effort required	2.05	2.45

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.15	2.40
Outcome depends on the skill and judgment of physician	2.85	2.45
Estimated risk of malpractice suit with poor outcome	2.70	2.15

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

Pre-Service intensity/complexity	3.10	2.70
Intra-Service intensity/complexity	2.35	2.20
Post-Service intensity/complexity	2.45	1.95

**ADDITIONAL RATIONALE**

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

The survey median RVW of 4.00 is recommended for 43886. This RVW for 43886 (revise port component) results in an IWP/UT of 0.029 which is similar to the IWP/UT for the reference code 36576 (IWP/UT = 0.031). The slightly higher RVW of 4.00 accounts for additional post-discharge office work within the 90-day global period compared with data for the reference code 36576 which has a 10-day global period.

Additionally, we would like to note that band adjustments are included in the total work for this service. These adjustments would be made during the post-op visits, and not separately billable. We asked an additional question on the survey regarding the number of typical band adjustments that would be performed during the 90-day global period. The median response was two adjustments.

**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)

49999: Unlisted procedure, abdomen, peritoneum, and omentum

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

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

Specialty general surgery subspecialties:

minimally invasive surgery and bariatric surgery

How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

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

Specialty general surgery

We estimate 24,000 primary laparoscopic gastric band procedures were performed nationally in 2003. We cannot estimate the number of port revisions that would occur annually, but it would be an extremely small percentage.

Frequency 0 Percentage %

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
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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 general surgery  
 Approximately 5-7% of the national frequency would be Medicare age.

Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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. 49419

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:43887 Tracking Number: R7 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **3.95**  
RUC RVU: **3.95**

CPT Descriptor: Surgical, gastric restrictive procedure, open; removal of subcutaneous port component only

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45-year-old woman presents 3 weeks after surgical placement of adjustable gastric banding for a BMI of 45. She has developed a wound infection at the subcutaneous port component site which has failed to respond to antibiotic treatment. She undergoes removal of the subcutaneous port.

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? Yes

**Description of Pre-Service Work:**

Review history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Review pre-operative work-up; labs, x-rays, cardiac evaluation, and sleep study report. Write orders for peri-operative medications; vitamin/mineral supplement, antibiotics, heparin, and bowel prep. Review previous surgery report and planned incisions and procedure. Change into scrub clothes. Review surgical procedure, post-operative recovery in and out of the hospital, and expected outcome(s) with patient and family. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Verify that necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, an incision is made over the access port. The subcutaneous fat and capsule around the port are divided. The port sutures are released, the tubing connecting the access port to the band is divided, and the port is removed. The band is left intact, with the remaining tubing tied off and placed inside the peritoneal cavity. The wound is irrigated copiously and packed with gauze dressings. The dressings will need to be changed daily until the infection has cleared and the wound can be closed secondarily or heal by secondary intention.

**Description of Post-Service Work:****Post-operative work, in hospital:**

Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Examine patient and check wounds and patient progress. Review nursing/staff chart notes. Answer patient and family questions. Answer nursing/staff questions. Write and summarize orders for floor nurse including dressing changes. Check fluid and electrolyte status. Write orders for following labs, films, medications, diet, and patient activity. When the patient is stable, a clear liquid diet is instituted and the patient is discharged. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient, nutritionist, home nurse and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions including the schedule for dressing changes, prescriptions, and insurance forms.

**Post-operative work, in office:**

The patient is examined and the wounds assessed. All patient and family questions are answered. Sutures are removed when appropriate. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Michael Edge MD FACS, SAGES Christine Ren, MD FACS, ASBS				
<b>Specialty(s):</b>	Society American Gastrointestinal Endoscopic Surgeons American Society of Bariatric Surgery				
<b>CPT Code:</b>	43887				
<b>Sample Size:</b>	400	<b>Resp n:</b>	31	<b>Response:</b>	%
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		2.50	3.30	3.30	4.50
<b>Pre-Service Evaluation Time:</b>				20.0	
<b>Pre-Service Positioning Time:</b>				15.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		10.00	20.00	30.00	30.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>15.00</b>				
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b>18.0</b>	99238x 0.50	99239x 0.00		
<b>Office time/visit(s):</b>	<b>38.0</b>	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>
36590	010	3.30

CPT Descriptor Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
49422	090	6.24

CPT Descriptor Removal of permanent intraperitoneal cannula or catheter

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 43887	Key Reference CPT Code: 36590
Median Pre-Service Time	45.00	29.00
Median Intra-Service Time	30.00	30.00
Median Immediate Post-service Time	15.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	18.00
Median Office Visit Time	38.0	15.00
Median Total Time	146.00	107.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	2.75	2.25
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.60	2.25
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Urgency of medical decision making	2.95	2.60
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.05	2.20
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Physical effort required	1.90	2.20
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.25	2.50
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Outcome depends on the skill and judgment of physician	2.65	2.15
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Estimated risk of malpractice suit with poor outcome	3.15	1.95
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.05	2.65
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Intra-Service intensity/complexity	2.20	2.15
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Post-Service intensity/complexity	2.45	2.00
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**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 an RVW of 3.95 for 43887. The work for 43887 is the same as reference code 36590 with the exception of one additional office visit for 43887 (during the 90-day global period). We do not believe that for this new code, the survey respondents correctly accounted for the difference in global periods.

The RVW of 3.95 was calculated by adding the RVW for one 99213 office visit (0.65) to the RVW for 36590 (3.30). The IWPUT for 43887 with an RVW of 3.30 is 0.013. The IWPUT for 43887 with an RVW of 3.95 is 0.034 which is less than the IWPUT for 36590 (0.046), but more accurately accounts for the work involved in caring for this patient.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

49999: Unlisted procedure, abdomen, peritoneum, and omentum

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

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

Specialty general surgery subspecialties:

minimally invasive surgery and bariatric surgery

How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

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

Specialty general surgery

We estimate 24,000 primary laparoscopic gastric band procedures were performed nationally in 2003. We cannot estimate the number of band only removals that would occur annually, but it would be an extremely small percentage.

Frequency 0 Percentage %

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
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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 general surgery  
 Approximately 5-7% of the national frequency would be Medicare age.  

Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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. 49419

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**Specialty Society RVU: **5.80**RUC RVU: **5.80**

CPT Code:43888 Tracking Number: R8 Global Period: 090

CPT Descriptor: Surgical, gastric restrictive procedure, open; removal and replacement of subcutaneous port component only

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45-year-old woman presents 9 months after surgical placement of adjustable gastric banding for a BMI of 45. Band adjustments are ineffective at maintaining band diameter. A determination is made that there is a leak from the subcutaneous port component or tubing. She undergoes removal of the old subcutaneous port and placement of a new subcutaneous port

Percentage of Survey Respondents who found Vignette to be Typical: 90%

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

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Review history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Review pre-operative work-up; labs, x-rays, cardiac evaluation, and sleep study report. Write orders for peri-operative medications; vitamin/mineral supplement, antibiotics, heparin, and bowel prep. Review previous surgery report and planned incisions and procedure. Change into scrub clothes. Review surgical procedure, post-operative recovery in and out of the hospital, and expected outcome(s) with patient and family. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, an incision is made over the access port. The subcutaneous fat and capsule around the port are divided. The port sutures are released, the tubing connecting the access port to the band is divided, and the port is removed. The band is left intact, with the remaining tubing. A new access port is connected to the existing tubing leading to the gastric band using a tubing connector. The tubing is replaced into the peritoneal cavity. The access port is secured to the anterior abdominal wall fascia with non-absorbable sutures. Saline may be injected into the band for tightening via the access port during the time of surgery. Hemostasis is obtained and the wound is closed.

**Description of Post-Service Work:****Post-operative work, in hospital:**

Sterile dressings are placed. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Examine patient and check wounds and patient progress. Review nursing/staff chart notes. Answer patient and family questions. Answer nursing/staff questions. Write and summarize orders for floor nurse. Check fluid and electrolyte status. Write orders for following labs, film medications, diet, and patient activity. When the patient is stable, a clear liquid diet is instituted and the patient discharged. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:

The patient is examined and the wound assessed. All patient and family questions are answered. Sutures are removed when appropriate. At each visit, check blood pressure, heart sounds, breath sounds, lower extremities, and patient weight. 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. Inflate the band, as needed, based on hunger, weight loss, and restriction. This is performed in the office under sterile technique, by percutaneously accessing the subcutaneous port with a non-coring needle connected to a syringe filled with saline. Saline is injected into the port, aspirated back to ensure successful puncture, and a pre-determined amount of saline is injected into the port. The needle is then removed. (It is estimated by survey that band adjustments would typically be performed twice during the postoperative period.) Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>		Michael Edye MD FACS, SAGES Christine Ren, MD FACS, ASBS			
<b>Specialty(s):</b>		Society American Gastrointestinal Endoscopic Surgeons American Society of Bariatric Surgery			
<b>CPT Code:</b>		43888			
<b>Sample Size:</b>	400	<b>Resp n:</b>	31	<b>Response:</b>	%
<b>Sample Type:</b>		Random			
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		3.00	4.00	5.80	7.00
<b>Pre-Service Evaluation Time:</b>				30.0	
<b>Pre-Service Positioning Time:</b>				15.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		20.00	40.00	45.00	60.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>		
<b>Immed. Post-time:</b>		<u>15.00</u>			
<b>Critical Care time/visit(s):</b>		<u>0.0</u>	99291x 0.0	99292x 0.0	
<b>Other Hospital time/visit(s):</b>		<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0
<b>Discharge Day Mgmt:</b>		<u>18.0</u>	99238x 0.50	99239x 0.00	
<b>Office time/visit(s):</b>		<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:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
49419	090	6.64

CPT Descriptor Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (ie, totally implantable)

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
36578	010	3.49

CPT Descriptor Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site

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

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

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 43888</u>	<u>Key Reference CPT Code: 49419</u>
Median Pre-Service Time	55.00	60.00
Median Intra-Service Time	45.00	60.00
Median Immediate Post-service Time	15.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	19.00
Median Discharge Day Management Time	18.0	36.00
Median Office Visit Time	46.0	23.00
Median Total Time	179.00	228.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Intellectual Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.08	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.08	2.50
Urgency of medical decision making	2.17	2.17

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

Technical skill required	2.92	2.42
Physical effort required	2.67	2.58

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.50	2.75
Outcome depends on the skill and judgment of physician	2.92	2.67
Estimated risk of malpractice suit with poor outcome	3.50	2.67

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.33	2.83
Intra-Service intensity/complexity	3.08	2.75
Post-Service intensity/complexity	2.75	2.00

**ADDITIONAL RATIONALE**

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

The survey median RVW of 5.80 is recommended for 43888. This RVW takes into account the difference in total work compared with the reference code 49419. This RVW results in an IWPUT of 0.054 which is comparable to the IWPUT for a second reference code 36578 which has an IWPUT of 0.050. The RVW of 5.80 places 43888 appropriately between 36578 and 49419.

Additionally, we would like to note that band adjustments are included in the total work for this service. These adjustments would be made during the post-op visits, and not separately billable. We asked an additional question on the survey regarding the number of typical band adjustments that would be performed during the 90-day global period. The median response was two adjustments.

**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)

49999: Unlisted procedure, abdomen, peritoneum, and omentum

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

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

Specialty general surgery subspecialties:

minimally invasive surgery and bariatric surgery

How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

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

Specialty general surgery

We estimate 24,000 primary laparoscopic gastric band procedures were performed nationally in 2003. We cannot estimate the number of port replacements that would occur annually, but it would be an extremely small percentage.

Frequency 0 Percentage ~ %

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

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

Specialty general surgery  
Approximately 5-7% of the national frequency would be Medicare age.

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  
Facility-ONLY Direct Inputs**

R1-43770	Lap: Band & Port - place	90
R5-43774	Lap: Band & Port - remove	90
R2-43771	Lap: Band - revise	90
R3-43772	Lap: Band - remove	90
R4-43773	Lap: Band - remove and replace	90
R6-43886	Port - revise	90
R7-43887	Port - remove	90
R8-43888	Port - remove and replace	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 for codes with 90-day global period. This time has been applied.

**Service period clinical staff time:** The assignment of 12 minutes (as supported by the PEAC) relative to coding of 99238 for discharge management for inpatient services has been applied to codes R1-R5. No time is added for R6-R8, which are outpatient procedures, because followup phone calls are included in the office E/Ms.

**Post-service period clinical staff time:**

Standard EM postop OFFICE visit times for clinical staff have been applied.

**SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:**

Standard PEAC minimum multispecialty office visit supplies and incision care have been applied to all codes. Additionally, band adjustment supplies for 2 band adjustments within the global period have been added to codes R1, R2, R4, R6, and R8.

	A	B	C	D	E	F	G
1	Meeting Date: April 2005 Specialty: SAGES, ASBS	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		R1-43770		R5-43774	
2				Lap: Band & Port - place		Lap: Band & Port - remove	
3				090		090	
4		Code	StaffType	NF	FAC	NF	FAC
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	180	N/A	144
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60		60
7	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12		12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		108		72
9	PRE-SERVICE						
10	Start: After visit for procedure/service						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7
17	End: Pt. enters site for procedure/service						
18	SERVICE PERIOD						
39	Discharge day management 99238 -12 minutes	L037D	RN/LPN/MTA		12		12
40	Other Clinical Activity (please specify)						
41	End: Patient leaves site of procedure/service						
42	POST-SERVICE Period						
43	End: Patient leaves site of procedure/service						
44	Conduct phone calls/call in prescriptions						
45	List Number and Level of Office Visits						
46	99211 16 minutes	L037D	RN/LPN/MTA				
47	99212 27 minutes	L037D	RN/LPN/MTA				
48	99213 36 minutes	L037D	RN/LPN/MTA		3		2
49	99214 53 minutes	L037D	RN/LPN/MTA				
50	99215 63 minutes	L037D	RN/LPN/MTA				
51	Total Office Visit Time				108		72
52	Other:						
53	End: Last office visit in global period						
54	MEDICAL SUPPLIES	Code	Unit				
55	pack, minimum multi-specialty visit	SA048	pack		3		2
56	pack, post-op incision care (suture)	SA054	pack		1		1
57	Items below are for 2 band adjustments thru global:						
58	swab-pad, alcohol	SJ053	item		4		
59	needle, Huber point	SC039	item		2		
60	syringe 5-6ml	SC057	item		2		
61	sodium chloride 0.9% inj (10ml uou)	SH066	item		2		
62	bandage, stnp 0.75in x 3in (Bandaid)	SG021	item		2		
63							
64	Equipment	Code					
65	table, power	EF031			108		72
66	light, exam	EQ168			108		72

	A	B	C	H	I	J	K	L	M	
1	Meeting Date: April 2005 Specialty: SAGES, ASBS	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		R2-43771		R3-43772		R4-43773		
2					Lap: Band - revise	Lap: Band - remove	Lap: Band - remove and replace			
3					090		090		090	
4				Code	StaffType	NF	FAC	NF	FAC	NF
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	180	N/A	135	N/A	180	
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60		60		60	
7	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12		12		12	
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		108		63		108	
9	PRE-SERVICE									
10	<i>Start: After visit for procedure/service</i>									
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5	
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20	
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8	
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20	
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7	
17	<i>End: Pt. enters site for procedure/service</i>									
18	SERVICE PERIOD									
39	Discharge day management 99238 -12 minutes	L037D	RN/LPN/MTA		12		12		12	
40	Other Clinical Activity (please specify)									
41	<i>End: Patient leaves site of procedure/service</i>									
42	POST-SERVICE Period									
43	<i>End: Patient leaves site of procedure/service</i>									
44	Conduct phone calls/call in prescriptions									
45	List Number and Level of Office Visits									
46	99211 16 minutes	L037D	RN/LPN/MTA							
47	99212 27 minutes	L037D	RN/LPN/MTA				1			
48	99213 36 minutes	L037D	RN/LPN/MTA		3		1		3	
49	99214 53 minutes	L037D	RN/LPN/MTA							
50	99215 63 minutes	L037D	RN/LPN/MTA							
51	Total Office Visit Time				108		63		108	
52	Other:									
53	<i>End: Last office visit in global period</i>									
54	MEDICAL SUPPLIES	Code	Unit							
55	pack, minimum multi-specialty visit	SA048	pack		3		2		3	
56	pack, post-op incision care (suture)	SA054	pack		1		1		1	
57	<i>Items below are for 2 band adjustments thru global:</i>									
58	swab-pad, alcohol	SJ053	item		4				4	
59	needle, Huber point	SC039	item		2				2	
60	syringe 5-6ml	SC057	item		2				2	
61	sodium chlonde 0.9% inj (10ml uou)	SH066	item		2				2	
62	bandage, strip 0.75in x 3in (Bandaid)	SG021	item		2				2	
63										
64	Equipment	Code								
65	table, power	EF031			108		63		108	
66	light, exam	EQ168			108		63		108	

	A	B	C	N	O	P	Q	R	S
1	Meeting Date: April 2005 Specialty: SAGES, ASBS	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		R6-43886		R7-43887		R8-43888	
2				Port - revise		Port - remove		Port - remove and replace	
3				090		090		090	
4		Code	StaffType	NF	FAC	NF	FAC	NF	FAC
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	132	N/A	123	N/A	132
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60		60		60
7	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0		0		0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		72		63		72
9	PRE-SERVICE								
10	<i>Start: After visit for procedure/service</i>								
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7
17	<i>End: Pt. enters site for procedure/service</i>								
18	SERVICE PERIOD								
39	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		0		0		0
40	Other Clinical Activity (please specify)								
41	<i>End: Patient leaves site of procedure/service</i>								
42	POST-SERVICE Period								
43	<i>End: Patient leaves site of procedure/service</i>								
44	Conduct phone calls/call in prescriptions								
45	List Number and Level of Office Visits								
46	99211 16 minutes	L037D	RN/LPN/MTA						
47	99212 27 minutes	L037D	RN/LPN/MTA				1		
48	99213 36 minutes	L037D	RN/LPN/MTA		2		1		2
49	99214 53 minutes	L037D	RN/LPN/MTA						
50	99215 63 minutes	L037D	RN/LPN/MTA						
51	Total Office Visit Time				72		63		72
52	Other:								
53	<i>End: Last office visit in global period</i>								
54	MEDICAL SUPPLIES	Code	Unit						
55	pack, minimum multi-specialty visit	SA048	pack		2		2		2
56	pack, post-op incision care (suture)	SA054	pack		1		1		1
57	<i>Items below are for 2 band adjustments thru global:</i>								
58	swab-pad, alcohol	SJ053	item		4				4
59	needle, Huber point	SC039	item		2				2
60	syringe 5-6ml	SC057	item		2				2
61	sodium chlonde 0.9% inj (10ml uou)	SH066	item		2				2
62	bandage, strip 0.75in x 3in (Bandaid)	SG021	item		2				2
63									
64	Equipment	Code							
65	table, power	EF031			72		63		72
66	light, exam	EQ168			72		63		72

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Gastric Restrictive Procedure**

The CPT Editorial Panel created code 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)* to detail currently undescribed open bariatric surgical procedures.

The RUC reviewed the survey data of approximately 44 bariatric and gastrointestinal endoscopic surgeons. The RUC observed that although the specialty societies' reference service code, CPT code 43847 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption* (work RVU=26.88) has a greater total time than the new code (673 minutes versus 597 minutes) 43847 requires less pre-service time, technical skill and intra-operative intensity/complexity when compared to the new code. Therefore, the specialty societies recommended the survey median RVU of 31.00. In addition, the RUC compared CPT code 35081 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta* (work RVU=27.97) from the Multi-Specialty Points of Comparison (MPC) list to the new code, which has similar pre- and intra-service time and intra-operative intensity. **The RUC agreed with the specialty society's recommendation and rationale and recommends a work RVU of 31.00 for code 43845.**

Practice Expense

The RUC assessed and approved the standard inputs for this 090-day global period code performed only in the facility setting.

Bariatric surgical procedures may involve the stomach, duodenum, jejunum and/or ileum.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●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)  (Do not report 43845 in conjunction with 43633, 43847, 44130, 49000)	090	31.00
●43644	L2	Laparoscopy, surgical; gastric restrictive procedure, with gastric bypass and Roux-en Y gastroenterostomy (roux limb 150 cm or less)  (Do not report 43644 in conjunction with 43846, 49320)  (EGD performed for a separate condition should be reported with the modifier '59')	090	27.83  (Value approved at February 2004 RUC Meeting)
●43645	L3	gastric restrictive procedure, with gastric bypass and small intestine reconstruction to limit absorption  (Do not report 43645 in conjunction with 49320, 43847)	090	29.96  (Value approved at February 2004 RUC Meeting)

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

CPT Code:43845 Tracking Number: L1 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **31.00**  
RUC RVU: **31.00**

CPT Descriptor: 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)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 44-year-old man with BMI 55 kg/m<sup>2</sup> presents with a history of Type II diabetes and hypertension. 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 H<sub>2</sub>-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. At operation, he undergoes a gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption

Percentage of Survey Respondents who found Vignette to be Typical: 93%

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

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- 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.

**Description of Intra-Service Work:**

Under general anesthesia, a midline incision is made with lysis of adhesions as needed. Starting from the lateral mid antrum, the stomach is divided longitudinally with a staple division technique to the top of the gastric fundus lateral to the gastroesophageal junction at the angle of His. The gastric pouch is sized with a bougie placed in the stomach, to make a longitudinal 150-200 cc pouch. The lateral gastric specimen is discarded. The first portion of the duodenum is mobilized and transected with a stapler approximately 3 to 5 cm distal to the pylorus. The small bowel is transected with a stapler approximately 250cm from the ileocecal valve. The distal end (alimentary limb) is anastomosed to the proximally divided duodenal limb. The proximal transected small bowel (biliopancreatic limb) is anastomosed 50 to 100 cm proximal to the ileocecal valve on the distal previously divided small bowel. The fascia and skin are closed and drain(s) placed, as indicated.

**Description of Post-Service 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.
- Monitor patient for signs of complications (perforation, chest pain, nausea and/or vomiting).
- 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).
- 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.
- Office visits as necessary for management and training for 90 days after the day of operation are considered part of the postoperative work for this procedure, including evaluation of lab reports and adjusting medications, and techniques for advancing from liquids to solid foods, and assuring protein intake of greater than or equal to 30 grams a day.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Michael Edye MD FACS, SAGES Christine Ren, MD FACS, ASBS					
<b>Specialty(s):</b>	Society American Gastrointestinal Endoscopic Surgeons American Society of Bariatric Surgery					
<b>CPT Code:</b>	43845					
<b>Sample Size:</b>	200	<b>Resp n:</b>	44	<b>Response:</b>	22.00 %	
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>		23.00	27.75	31.00	38.25	50.00
<b>Pre-Service Evaluation Time:</b>				60.0		
<b>Pre-Service Positioning Time:</b>				20.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15.0		
<b>Intra-Service Time:</b>		110.00	150.00	210.00	240.00	420.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>30.00</u>					
<b>Critical Care time/visit(s):</b>	<u>63.0</u>	99291x 1.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>79.0</u>	99231x 1.0	99232x 2.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>84.0</u>	99211x 0.0	12x 1.0	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>
43847	090	26.88

CPT Descriptor Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
45110	090	27.96

CPT Descriptor 1 Proctectomy; complete, combined abdominoperineal, with colostomy

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
35646	090	30.95

CPT Descriptor 2 Bypass graft, with other than vein; aortobifemoral

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
33405	090	34.95

CPT Descriptor Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 52.2 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u> 43845	<u>Key Reference CPT Code:</u> 43847
Median Pre-Service Time	95.00	60.00
Median Intra-Service Time	210.00	220.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	63.0	63.00
Median Other Hospital Visit Time	79.0	180.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	84.0	84.00
<u>Median Total Time</u>	<u>597.00</u>	<u>673.00</u>
<u>Other time if appropriate</u>		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.17	4.13
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.61	4.61
--	------	------

Urgency of medical decision making	3.52	3.57
------------------------------------	------	------

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

Technical skill required	4.83	4.48
--------------------------	------	------

Physical effort required	4.30	4.17
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.65	4.61
---	------	------

Outcome depends on the skill and judgment of physician	4.83	4.70
--	------	------

Estimated risk of malpractice suit with poor outcome	4.70	4.70
--	------	------

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

Pre-Service intensity/complexity	4.22	4.35
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Intra-Service intensity/complexity	4.52	4.43
------------------------------------	------	------

Post-Service intensity/complexity	4.00	3.87
-----------------------------------	------	------

**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 results began by considering the reference code chosen most often by the survey respondents (code 43847). This code was originally reviewed by the RUC in 1994 with a RUC recommendation of 14.32 and rationale as follows:

"There was some initial confusion regarding the status of the codes describing gastroplasty for morbid obesity, since the specialty society had the impression that there was a process outside the RUC process to address the relative values for this family of codes. The RUC recommendations are therefore, provided as interim recommendations and address the rank ordering of the procedures, relative to one another. At a future meeting, the RUC will revisit these codes and evaluate whether they are appropriately valued relative to other families of procedures."

This recommendation was rejected by CMS which determined a new value using an intra-operative intensity similar to AAA repair (CPT 35018) (Fed Reg Dec 8, 1994). We note that this code (IWPUT=0.076) is not on the MPC and that the code is on the 2005 five year review as undervalued.

Also, in 2000 during the second five year review, the American College of Surgeons brought 43847 to the RUC, 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 (RVW recommendation = 29.51). This "percentage increase" methodology to value codes resulted in an IWPUT that was still low relative to the time and visit information obtained by survey.

Even though the patient and physician work for 43847 is very similar to survey code 43845, the discussion presented above supports our perception that 43847 is undervalued at RVW=26.88 (IWPUT = 0.049) and is not the best reference for valuing 43845.

We are recommending the survey median RVW of 31.00 which has an IWPUT of 0.087. As support for this value, we looked to other codes on the MPC with similar total time and similar intra-operative intensity compared with code 34802 (the code CMS used as a cross-reference for intra-intensity). We chose four MPC codes: 34802, 33405, 35646, and 45110. Please refer to the attachment for the time, visit and IWPUT details for these four codes and survey code 43845.

## 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)

43999: Unlisted procedure, stomach

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

Specialty general surgery (bariatric 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? 3000  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty general surgery (bariatric surgery) Frequency 3000 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? 300  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty general surgery (bariatric surgery) Frequency 300 Percentage %

Specialty Frequency 0 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

**Attachment: CPT 43845 RVW Recommendation Additional Rationale**

Source	CPT	Descriptor	IWPUT	RVW	Total Time	minutes			Hosp Visits (992-)					Office Visits (992-)					
						Pre	Intra	Imm-Post	91	33	32	31	38	15	14	13	12	11	
Survey	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)	0.086	31.00	594	95	210	30	1		2	1	1				3	1	
Ref 1	43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	0.049	26.88	670	60	220	30	1	2	2	2	1				3	1	
Ref 2	43848	Revision of gastric restrictive procedure for morbid obesity (separate procedure)	0.072	29.35	645	75	180	30	1	2	2	2	1				3	1	
CMS 1994 Ref	35081*	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta	0.076	27.97	635	108	203	60			1	8	1				2		
MPC Ref	34802	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)	0.100	22.97	448	135	150	40			1	1	1				1	1	
MPC Ref	45110	Proctectomy; complete, combined abdominoperineal, with colostomy	0.080	27.96	624	80	180	30		1	3	4	1			1	1	2	
MPC Ref	35646	Bypass graft, with other than vein; aortobifemoral	0.092	30.95	602	100	210	30		1	2	3	1			1		2	
MPC Ref	33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	0.101	34.95	603	40	240	60			1	6	1			1	1	1	1

\* 35081 is on the 2005 five year review by SVS as undervalued. Additionally, 35081 is not an MPC code.

**AMA/Specialty Society Update Process**  
**PEAC Summary of Recommendation**  
**Facility-ONLY Direct Inputs**

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)	90
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**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 for codes with 90-day global period. This time has been applied.

**Service period clinical staff time:** The assignment of 12 minutes (as supported by the PEAC) relative to coding of 99238 for discharge management for inpatient services has been applied.

**Post-service period clinical staff time:**

Standard EM postop OFFICE visit times for clinical staff have been applied.

**SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:**

Standard PEAC minimum multispecialty office visit supplies and incision care have been applied.

	A	B	C	D	E
1	Meeting Date: April 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		43845	
2				Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	
3				090	
4				Code	StaffType
5	<b>TOTAL CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	N/A	207
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60
7	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		135
9	<b>PRE-SERVICE</b>				
10	<i>Start: After visit for procedure/service</i>				
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	<i>End: Pt enters site for procedure/service</i>				
18	<b>SERVICE PERIOD</b>				
39	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		12
40	Other Clinical Activity (please specify)				
41	<i>End: Patient leaves site of procedure/service</i>				
42	<b>POST-SERVICE Period</b>				
43	<i>End: Patient leaves site of procedure/service</i>				
44	Conduct phone calls/call in prescriptions				
45	<i>List Number and Level of Office Visits</i>				
46	99211 16 minutes	L037D	RN/LPN/MTA		
47	99212 27 minutes	L037D	RN/LPN/MTA		1
48	99213 36 minutes	L037D	RN/LPN/MTA		3
49	99214 53 minutes	L037D	RN/LPN/MTA		
50	99215 63 minutes	L037D	RN/LPN/MTA		
51	<b>Total Office Visit Time</b>			0	135
52	Other				
53	<i>End: Last office visit in global period</i>				
54	<b>MEDICAL SUPPLIES</b>	Code	Unit		
55	pack, minimum multi-specialty visit	SA048	pack		4
56	pack, post-op incision care (suture & staple)	SA053	pack		1
57					
58	<b>Equipment</b>	Code			
59	table, power	EF031			135
60	light, exam	EQ168			135

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Laparoscopic Stomas**

The CPT Editorial Panel created two new codes 44187 *Laparoscopy, surgical; ileostomy or jejunostomy, non-tube* and 44188 *Laparoscopy, surgical; colostomy or skin level cecostomy* to report the laparoscopic approach of an ileostomy or jejunostomy and the laparoscopic approach of a colostomy or skin level cecostomy.

**44187**

The RUC reviewed the survey data of almost 90 colon/rectal surgeons and gastrointestinal endoscopic surgeons. The RUC observed that the reference code describing the open procedure, 44310 *Ileostomy or jejunostomy, non-tube* (Work RVU=15.93) has a similar total time as the surveyed code, 367 minutes and 361 minutes, respectively. It was also noted by the RUC that the reference code and the surveyed code had similar intensity and complexity. Therefore, the RUC agreed with the specialty societies' recommendation of the survey median RVU of 15.93. **The RUC recommends a work RVU of 15.93 for CPT code 44187.**

**44188**

The RUC reviewed the survey results of almost 80 colon/rectal surgeons and gastrointestinal endoscopic surgeons. Upon reviewing the specialty societies' recommendations, the RUC determined that a 99214 office visit should be removed and a 99213 office visit should be added as this allocation of office visits more accurately reflected the treatment of a typical patient. With this modification, the RUC observed that although the reference code describing the open procedure 44320 *Colostomy or skin level cecostomy*; (Work RVU=17.61) has a greater total time than the surveyed code, 465 minutes and 384 minutes, respectively, there is additional skill and intra-operative intensity required to perform this procedure as compared to the reference code. Therefore, the RUC recommended that the work RVU for the new code be cross-walked to the work RVU of the existing code. A work RVU of 17.61 for 44188 will appropriately identify the additional intra-operative work associated with 44188 as compared to 44187, 90 and 75 minutes respectively. **The RUC recommends a work RVU of 17.61 for CPT code 44188.**

**Practice Expense**

The RUC recommends the standard inputs for these 090 day global period codes that is performed only in the facility setting with a modification to reflect the change of an office visit from a 99214 to a 99213 in the 44188 code. In addition, the RUC recommends that 7 minutes be included for both 44187 and 44188 on the first post-operative office visit for the extra time required to educate patients on the care for stomas.

**Professional Liability Insurance Crosswalk**

The RUC’s recommendation for the Professional Liability Insurance (PLI) crosswalk for 44187 and 44188 is 44205 *Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy* (Work RVU=22.20). The PLI for 44205 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work for 44205 is very similar to 44187 and 44188.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 44187	U1	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube (For open procedure, use 44310)	090	15.93
● 44188	U2	Laparoscopy, surgical; colostomy or skin level cecostomy (For open procedure, use 44320) (Do not report 44188 in conjunction with 44970)	090	17.61
▲ 44310		Ileostomy or jejunostomy, non-tube ( <del>separate procedure</del> ) (For laparoscopic procedure, use 44187) (Do not report 44310 in conjunction with 44144, 44150, 44151-44153, 44155, 44156, 45113, 45119, 45136)	090	15.93  (No Change)
▲ 44320		Colostomy or skin level cecostomy ( <del>separate procedure</del> ) (For laparoscopic procedure, use 44188) (Do not report 44320 in conjunction with 44141, 44144, 44146, 44605, 45110, 45119, 45126, 45563, 45805, 45825, 50810, 51597, 57307, or 58240)	090	17.61  (No Change)

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

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**Recommended Work Relative Value**Specialty Society RVU: **15.93**RUC RVU: **15.93**

CPT Code:44187 Tracking Number: U1 Global Period: 090

CPT Descriptor: Laparoscopy, surgical; ileostomy or jejunostomy, non-tube

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58-year-old man, who recently underwent a supra-pubic prostatectomy, presents with rectal discharge of urine. His urinalysis is positive for fecal flora and sediment. He has a CT-confirmed abscess in the prostate bed and communication between the rectum and the neck of the bladder at the urethral anastomosis and a contrast-confirmed recto-urethral fistula. At laparoscopy, to achieve fecal diversion, the terminal ileum is identified and brought out as an ileostomy through the skin in a preoperatively selected site.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

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

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Review history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Write pre-operative orders for peri-operative medications. Review pre-operative work-up, with particular attention to pathology reports and films. Review planned incisions and procedure - a potential site for the ostomy is marked. Verify blood and/or x-match is available. Change into scrub clothes. The procedure and the differential diagnosis are reviewed with the patient and family as well as the different possible outcomes of surgery and potential complications depending on the findings at the time of surgery. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, surgical laparoscopy is performed. A supraumbilical incision is made and a 12mm port is placed. Gas flow is initiated to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation or venous return. Two additional 5 mm ports are placed, one in the right paraumbilical region in the pre-operative marked stoma site and one in the left iliac fossa, lateral to the rectus muscle. The abdomen is explored with the patient in steep Trendelenburg and left-side-down position. Through the right-sided port site, the bowel at the terminal ileum is gently grasped to ensure adequate mobilization of the terminal ileum to reach the anterior abdominal wall. The proximal and distal end is marked with 1 and 2 clips respectively. The stoma site is then created with the use of the Bovie and splitting the rectus muscle, working around the trocar in the stoma site. The bowel is delivered through the abdominal wall after releasing the pneumoperitoneum, which is then reestablished to inspect the abdomen to ensure hemostasis, bowel viability, and a tension free ileostomy, without unwanted twists. The trocars are removed and the fascial openings closed as appropriate, and the individual wounds of the port sites closed.

**Description of Post-Service Work:**

Post-operative work, in hospital:

Sterile dressings and an ostomy appliance are placed. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome

and expected recovery letter for primary care physician and / or insurance company. Discharge patient from the PACU. The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia, initially post-operatively, then on a daily basis - documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor. Examine patient, check wounds and patient progress daily as necessary. Check fluid and electrolyte status : urine output. Review nursing/other staff patient chart notes. Answer patient family questions. Answer nursing/other staff questions. Write orders for following labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound and stoma are examined. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

#### Post-operative work, in office:

At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound and Ostomy are assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. All patient and family questions are answered, including multiple questions about the stoma. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

#### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005			
<b>Presenter(s):</b>	David Margolin, MD Guy Orangio, MD				
<b>Specialty(s):</b>	ASCRS				
<b>CPT Code:</b>	44187				
<b>Sample Size:</b>	500	<b>Resp n:</b>	89	<b>Response:</b> 17.80 %	
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		13.00	15.93	15.93	18.00
<b>Pre-Service Evaluation Time:</b>				45.0	
<b>Pre-Service Positioning Time:</b>				25.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		30.00	60.00	75.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>30.00</b>				
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b>79.0</b>	99231x 1.0	99232x 2.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b>36.0</b>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b>61.0</b>	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>
4310	090	15.93

CPT Descriptor Ileostomy or jejunostomy, non-tube**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 69      % of respondents: 77.5 %

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 44187</b>	<b>Key Reference CPT Code: 44310</b>
Median Pre-Service Time	80.00	75.00
Median Intra-Service Time	75.00	63.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	79.0	117.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	61.0	46.00
<b>Median Total Time</b>	<b>361.00</b>	<b>367.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.39	3.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.51	3.52
Urgency of medical decision making	3.52	3.58

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.78	3.45
Physical effort required	3.30	3.15

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.49	3.55
Outcome depends on the skill and judgment of physician	3.57	3.42
Estimated risk of malpractice suit with poor outcome	3.31	3.42

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.56	3.61
Intra-Service intensity/complexity	3.50	3.42
Post-Service intensity/complexity	2.89	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.*

The survey median RVW of 15.93 is recommended for 442X3 which is the same as reference code 44310. This value is supported by the very similar intensity/complexity measures of work shown above.



Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

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### Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale.

44205 Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy

The PLI for 44205 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work for 44205 is very similar to 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**

CPT Code:44188 Tracking Number: U2 Global Period: 090

**Recommended Work Relative Value**

Specialty Society RVU: **18.00**

RUC RVU: **17.61**

CPT Descriptor: Laparoscopy, surgical; colostomy or skin level cecostomy

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A G4P4, 78-year-old woman, who is undergoing preoperative chemotherapy and radiation therapy for a distal Stage 3 rectal cancer located at 2 cm from the dentate line, presents with complaints of severe tenesmus, fecal incontinence, worsened by the diarrhea associated with the chemotherapy. Her perineum is severely excoriated and associated with severe ulcerative dermatitis. At laparoscopy, the left colon is mobilized and brought out as a colostomy through the skin in a preoperatively selected site to allow for relief from fecal incontinence and perineal irritation and completion of the neo-adjuvant treatment, prior to definitive resection.

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? 0%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Review history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Write pre-operative orders for peri-operative medications. Review pre-operative work-up, with particular attention to pathology reports and films. Review planned incisions and procedure - a potential site for the colostomy is marked. Verify blood and/or x-match is available. Change into scrub clothes. The procedure and the differential diagnosis are reviewed with the patient and family as well as the different possible outcomes of surgery and potential complications depending on the findings at the time of surgery. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:** Under general anesthesia, surgical laparoscopy is performed. A supraumbilical incision is made and carried down to the linea alba, which is grasped with Kocher clamps. Divided Vicryl stay sutures are placed in the linea alba. The peritoneum is identified and divided. The 12mm Hassan port is placed. Gas flow is initiated to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation or venous return. Three additional 5 mm ports are placed, one in the left paraumbilical region, one in the right paraumbilical region, and one in the right iliac fossa, each lateral to the rectus muscle, each placed under direct vision. The abdomen is explored with the patient in steep Trendelenburg and right-side-down position. Adhesions of the sigmoid to the anterior abdominal wall are divided. The line of Toldt is divided to achieve mobilization and the left ureter is identified and reflected posteriorly out of harm's way. A 10mm trocar is placed in the previously marked stoma site. The proximal end and the distal end of the loop is marked with 1 and 2 clips respectively and grasped with a Babcock. The stoma site is created around the trocar and enlarged to accept two fingers. After decompressing the pneumoperitoneum, the bowel is exteriorized and divided with a linear stapler cutter. The distal end is returned in the abdomen and the proximal end secured to the skin. The pneumoperitoneum is then reestablished to inspect the abdomen to ensure hemostasis, bowel viability, and a tension free colostomy, without unwanted twists. The trocars are removed and the fascial openings closed as appropriate, and the individual wounds of the port sites closed.

**Description of Post-Service Work:**

Post-operative work, in hospital:

Sterile dressings and an ostomy appliance are placed. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Discharge patient from the PAC. The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia, initially post-operative, then on a daily basis - documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor. Examine patient, check wounds and patient progress daily as necessary. Check fluid and electrolyte status and urine output. Review nursing/other staff patient chart notes. Answer patient family questions. Answer nursing/other staff questions. Write orders for following labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound and stoma are examined. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

#### Post-operative work, in office:

At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound and colostomy are assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. All patient and family questions are answered, including multiple questions about the stoma. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

#### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005			
<b>Presenter(s):</b>	David Margolin, MD Guy Orangio, MD				
<b>Specialty(s):</b>	ASCRS				
<b>CPT Code:</b>	44188				
<b>Sample Size:</b>	500	<b>Resp n:</b>	77	<b>Response:</b>	%
<b>Sample Type:</b> Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		16.96	18.00	18.00	20.00
<b>Pre-Service Evaluation Time:</b>				45.0	
<b>Pre-Service Positioning Time:</b>				25.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		45.00	60.00	90.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>30.00</b>				
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b>79.0</b>	99231x 1.0	99232x 2.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b>36.0</b>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b>69.0</b>	99211x 0.0	12x 0.0	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>
4320	090	17.61

CPT Descriptor Colostomy or skin level cecostomy;

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 65      % of respondents: 84.4 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 44188</u>	<u>Key Reference CPT Code: 44320</u>
Median Pre-Service Time	80.00	75.00
Median Intra-Service Time	90.00	90.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	79.0	158.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	69.0	76.00
Median Total Time	<b>384.00</b>	<b>465.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.48	3.42
Urgency of medical decision making	3.33	3.18

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.08	3.15
Physical effort required	3.60	3.13

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.48	3.29
Outcome depends on the skill and judgment of physician	3.73	3.26
Estimated risk of malpractice suit with poor outcome	3.40	3.18

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.56	3.38
Intra-Service intensity/complexity	3.85	3.15
Post-Service intensity/complexity	3.08	3.03

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey median RVW of 18.00 is recommended for 442X4. This value is appropriately greater than new cc 442X3 (Laparoscopy, surgical; ileostomy or jejunostomy, non-tube) (recommended RVW=15.93), taking into account the additional intra- and post-operative work. This value also takes into consideration the additional skill and intra-operative intensity compared with reference code 44320 as shown in the intensity/complexity component measures of work above. Additionally, we note that the survey median RVW of 18.00 is consistent with a previous RUC recommendation that the open procedure (44320) be ranked between codes 44120 (Enterectomy, resection of small



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 CRS                      Frequency 500                      Percentage 50.00 %

- Specialty GS                      Frequency 500                      Percentage 50.00 %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale.

44205 Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy

The PLI for 44205 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work for 44205 is very similar to the new code.

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:**

S1	44227	Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)	090
U1	44187	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube	090
U2	44188	Laparoscopy, surgical; colostomy or skin level cecostomy	090
V1	45395	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy	090
V2	45397	Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed	090
W1	45400	Laparoscopy, surgical; proctopexy (for prolapse)	090
W2	45402	Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection	090
Y1	46710	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement, transperineal approach	090
Y2	46712	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach	090

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

Representatives of the American Society of Colon and Rectal Surgeons generated these recommendations by reviewing approved practice expense details for other CRS procedures.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** The PEAC approved clinical staff for 90-day global procedures has been indicated.

**Service period clinical staff time (admission to discharge):** For these facility only codes, 12 minutes is included for discharge management activities.

**Post-service period clinical staff time (post discharge):** For all codes, the standard times per office visit level have been applied. For codes U1, U2, V1, V2, and Y2, seven minutes is indicated for stoma education during the post-op office visit period. For codes Y1 and Y2, six minutes has been added for scope equipment cleaning at the first post-op office visit. This is 2/3 the standard cleaning time, as previously approved by the PEAC.

**SUPPLIES AND EQUIPMENT:**

Supplies and equipment necessary for each post-op office visit are indicated.

	A	B	C	D	E	F	G		
1	Meeting Date: Feb 2005 RUC Recommendation	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		44187		44188			
2				U1		U2			
3				Laparoscopy, surgical; ileostomy or jejunostomy, non-tube		Laparoscopy, surgical, colostomy or skin level cecostomy			
4						090		090	
5				Code	StaffType	NF	FAC	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	178	N/A	187		
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60		60		
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12		12		
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		106		115		
10	PRE-SERVICE								
11	Start: After visit for procedure/service								
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		
18	End: Pt. enters site for procedure/service								
19	SERVICE PERIOD								
40	Discharge day management 99238 -12 minutes	L037D	RN/LPN/MTA		12		12		
42	End: Patient leaves site of procedure/service								
43	POST-SERVICE Period								
44	End: Patient leaves site of procedure/service								
46	List Number and Level of Office Visits								
47	99211 16 minutes	L037D	RN/LPN/MTA						
48	99212 27 minutes	L037D	RN/LPN/MTA		1				
49	99213 36 minutes	L037D	RN/LPN/MTA		2		3		
50	99214 53 minutes	L037D	RN/LPN/MTA						
51	99215 63 minutes	L037D	RN/LPN/MTA						
52	Total Office Visit Time			0	99	0	108		
53	Other: The PEAC voted and approved an additional 7 minutes on the first post operative office visit for the extra time required to care for stomas.				7		7		
54	Other: Scope cleaning at pot-op visit @ 2/3 standard time								
55	End: Last office visit in global period								
56	MEDICAL SUPPLIES	Code	Unit						
57	pack, minimum multi-specialty visit	SA048	pack		3		3		
58	pack, post-op incision care (suture & staple)	SA053	pack		1		1		
59	stoma adhesive	SJ049	oz		3		3		
60	stoma pouch and wafer	SJ050	item		3		3		
61	lubncating jelly (K-Y) (5gm uou)	SJ032	item						
62	swab, procto 16in	SJ052	item						
63	canister, suction	SD009	item						
64	tubing, suction, non-latex (6ft uou)	SD132	item						
65	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item						
66	endoscope anti-fog solution	SM014	ml						
67	pack, cleaning and disinfecting, endoscope	SA042	pack						
68	Equipment	Code							
69	table, power	EF031			106		115		
70	light, exam	EQ168			106		115		
71	anoscope with light source	ES002							
72	suction machine (Gomco)	EQ235							

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Laparoscopic Splenic Flexure**

The CPT Editorial Panel created a new code 44213 *Laparoscopy, surgical; mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy* to report the laparoscopic approach of a splenic flexure. The RUC reviewed the survey data of over 35 colon/rectal surgeons and gastrointestinal endoscopic surgeons. The RUC observed that reference code 44139 *Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)* (work RVU=2.23) had less intra-service time than the surveyed code, 30 minutes and 45 minutes respectively. In addition, the RUC observed that the surveyed code requires more technical skill and has a higher intra-operative intensity than the reference code. Therefore the specialty societies recommended the survey median RVU of 3.50. The RUC agreed with the specialty societies' recommendation and in addition felt that this value for the new code is appropriate as it is less than 44203 *Laparoscopy, surgical; each additional small intestine resection and anastomosis* (RVW=4.44), which has an intra-operative time of 60 minutes (15 minutes more than the surveyed code). **The RUC recommends a work RVU of 3.50 for CPT code 44213.**

**Practice Expense**

The RUC agreed with the specialty societies' recommendation of no additional practice expense inputs for this code, as all of the practice expense inputs are accounted for in the base code.

**Professional Liability Insurance Crosswalk**

The RUC's recommendation for the Professional Liability Insurance (PLI) Crosswalk for 44213 is 44203 *Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)* (Work RVU=4.44). The PLI for 44203 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work is very similar to the new code.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+ ● 44213	T1	Laparoscopy, surgical; mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)  (Use 44213 in conjunction with 44204-44208)  (For open procedure, use 44139)	ZZZ	3.50

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:44213 Tracking Number: T1 Global Period: ZZZ

**Recommended Work Relative Value**Specialty Society RVU: **3.50**RUC RVU: **3.50**

CPT Descriptor: Laparoscopy, surgical; mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: After laparoscopic colon resection for middle to low rectal cancer, an end-to-end colorectal anastomosis between the splenic flexure and the rectum is performed, requiring mobilization of the entire splenic flexure.

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: Laparoscopic mobilization of the splenic flexure involves placement of additional operative trocar ports (one or possibly two) to attain proper traction tension for the tedious dissection. With medial traction to expose the lateral line of Toldt, dissection of the colon is carried out cephalad, along the line of Toldt, lateral to the descending colon. The transverse colon is retracted toward the pelvis, while the omentum is retracted cephalad, then the omentum is dissected from the transverse colon, in order to enter the lesser sac for access to the colon mesentery. This dissection is carried to the spleen and then the ligaments are taken down from the lower pole of the spleen and the splenic hilum. Next, the colonic mesentery is divided in one of two ways; the transverse mesentery is divided through the lesser sac up to the splenic flexure and the proximal descending colon; or the transverse colon is retracted in the cephalad direction and the descending colon is retracted laterally in order to isolate the ligament of Treitz as a land mark for the retroperitoneal dissection of splenic flexure mesentery. During the procedure, the operative table will be repositioned multiple times to allow gravity to assist in the retraction of the hollow organs. For example, the Trendelenburg position is utilized while the omentum is dissected off of the transverse colon and the reverse Trendelenburg position is utilized while the mesentery of the transverse colon is divided through the lesser sac.

Description of Post-Service Work: N/A

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005			
<b>Presenter(s):</b>	David Margolin, MD Guy Orangio, MD				
<b>Specialty(s):</b>	ASCRS				
<b>CPT Code:</b>	44213				
<b>Sample Size:</b>	200	<b>Resp n:</b>	37	<b>Response:</b>	18.50 %
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.23	3.00	3.50	4.00	6.00
<b>Pre-Service Evaluation Time:</b>			0.0		

<b>Pre-Service Positioning Time:</b>				<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		15.00	30.00	<b>45.00</b>	45.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b>0.00</b>					
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b>0.0</b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b>0.0</b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
4139	ZZZ	2.23

CPT Descriptor Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
44121	ZZZ	4.44

CPT Descriptor Enterectomy, resection of small intestine; each additional resection and anastomosis

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 33      % of respondents: 89.1 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 44213</u>	<u>Key Reference CPT Code: 44139</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	45.00	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	45.00	30.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.06	3.03
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.06	3.03
Urgency of medical decision making	3.06	3.03

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.53	4.09
Physical effort required	4.19	3.81

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.19	3.88
Outcome depends on the skill and judgment of physician	4.41	4.28
Estimated risk of malpractice suit with poor outcome	3.72	3.47

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.46	2.42
Intra-Service intensity/complexity	4.19	3.47
Post-Service intensity/complexity	2.46	2.42

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey median RVW of 3.50 is recommended for 442X2. This RVW is greater than reference code 44139 taking into account the additional intra-operative time (+15 min) and additional technical skill and intra-operative intensity shown in the intensity/complexity component measures of work above. Additionally, this RVW is appropriately less than 44203 (Laparoscopy, surgical; each additional small intestine resection and anastomosis) (RVW=4.44), which has an intra-operative time of 60 minutes.



Specialty CRS	Frequency 1000	Percentage 50.00 %
Specialty GS	Frequency 1000	Percentage 50.00 %
Specialty	Frequency	Percentage %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale.

CPT 44203 Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)

The PLI for 44203 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work is very similar to the new code.

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 Periods  
Facility Direct Inputs**

CPT Long Descriptor:

T1	44213	Laparoscopy, surgical; mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy	ZZZ
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**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

Representatives of the American Society of Colon and Rectal Surgeons generated this recommendation by considering whether any additional practice expense related time, supplies, or equipment is necessary for this add-on code.

**CLINICAL STAFF TIME:**

None

**SUPPLIES AND EQUIPMENT:**

None

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Laparoscopic Enterostomy Closure**

The CPT Editorial Panel created a new code 44227 *Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)* to report the laparoscopic approach of an enterostomy closure. The RUC reviewed the survey data of over 90 colon/rectal surgeons and gastrointestinal endoscopic surgeons. During its review, the RUC made the following observation about performing laparoscopic procedures, that once the techniques for performing laparoscopic surgery have been mastered for any existing procedure, the learning curve for performing a new procedure laparoscopically is not as dramatic as the learning curve for performing the laparoscopic techniques themselves. The RUC observed that although the societies' reference service code, CPT code 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU=25.32) has a greater total time than the new code, 524 minutes and 488 minutes, respectively, the reference code requires less technical skill and less intra-operative intensity/complexity when compared to the new code. Therefore, the specialty societies recommended the survey median RVU of 26.50. The RUC agreed with the specialty societies' recommendation and agreed that this value for the new code is appropriately placed between 44204 *Laparoscopy, surgical; colectomy, partial, with anastomosis* (RVW=25.04) and 44206 *Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)* (RVW=29.96) as 44227 requires greater exposure and represents a more complex re-operation than 44204 and 44206 includes more intra-operative work and the post-operative work is more intense/complex than the surveyed code. **The RUC recommends a work RVU of 26.50 for CPT code 44227.**

**Practice Expense**

The RUC recommends the standard inputs for this 090 day global period code that is performed only in the facility setting.

**Professional Liability Insurance Crosswalk**

The RUC's recommendation for the Professional Liability Insurance Crosswalk for 44227 is 44206 *Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)*. The PLI for 44206 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work (and RVW) for 44206 is very similar to the new code.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 44227	S1	Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)  (For open procedure, use 44625 or 44626)	090	26.50
44620		<i>Closure of enterostomy, large or small intestine;</i>	090	12.18  (No Change)
44625		<i>with resection and anastomosis other than colorectal</i>	090	15.03  (No Change)
44626		<i>with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)</i>  (For laparoscopic procedure, use 44188)	090	25.32  (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:44227 Tracking Number: S1 Global Period: 090

**Recommended Work Relative Value**

Specialty Society RVU: **26.50**

RUC RVU: **26.50**

CPT Descriptor: Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 73-year-old man three months s/p Hartmann procedure for perforated diverticulitis presents for reversal of his colostomy.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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 history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Write pre-operative orders for peri-operative medications. Review pre-operative work-up, with particular attention to pathology reports and films. Review planned incisions and procedure. Verify blood and/or x-match is available. Change into scrub clothes. The procedure and the differential diagnosis are reviewed with the patient and family as well as the different possible outcomes of surgery and potential complications depending on the findings at the time of surgery. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, surgical laparoscopy is performed. A supraumbilical incision is made, and peritoneum is grasped with sutures on the fascia. The peritoneum is opened under direct vision. A Hassan blunt trocar is inserted. Gas flow is initiated to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation or venous return. Two 5mm trocars are placed in the right lower quadrant and another 5mm trocar is placed in the midepigastrium. The viscera are inspected. The previous operation typically involves pelvic sepsis and creates dense adhesions that maximally complicate the re-exploration. Therefore, laparoscopic lysis of adhesions is oftentimes the first step performed. The rectal stump is then identified after mobilizing any adherent small bowel off the top of the Hartmann pouch. The stoma is dissected free from the anterior abdominal wall fascia. The colon is mobilized from the transverse colon distally including the splenic flexure. The descending colon will serve as the segment for the anastomosis. The ureters are identified bilaterally with care to prevent injury. Once the colon is fully mobilized from inside the abdomen, the colostomy is freed up from the skin of the anterior abdominal wall utilizing an elliptical incision, and carried down into the peritoneal cavity. With the transient loss of pneumoperitoneum, the colostomy is resected and the anvil of a circular stapler is placed in the proximal colon. After securing it with a purse-string suture, the proximal bowel is reduced into the abdominal cavity and the colostomy site is closed in two layers. Once pneumoperitoneum has been reinstated, an anastomosis is performed utilizing the circular stapling device. While the pelvis is filled with irrigation solution, a rigid proctoscopy is performed with insufflation of the rectum to assure that the anastomosis does not create an air leak and remains intact. Hemostasis is obtained. The trocars are removed, the fascial openings closed as appropriate, and the individual wounds of the port sites closed.

**Description of Post-Service Work:**

Post-operative work, in hospital:

Sterile dressings are placed. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Discharge patient from the PACU. The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia, initially post-operatively, then on a daily basis documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor. Examine patient, check wounds and patient progress daily as necessary. Check fluid and electrolyte status and urine output. Review nursing/other staff patient chart notes. Answer patient family questions. Answer nursing/other staff questions. Write orders for following labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound is examined. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

#### Post-operative work, in office:

At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. All patient and family questions are answered. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

#### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005			
<b>Presenter(s):</b>	David Margolin, MD Guy Orangio, MD				
<b>Specialty(s):</b>	ASCRS				
<b>CPT Code:</b>	44227				
<b>Sample Size:</b>	500	<b>Resp n:</b>	96	<b>Response:</b>	19.20 %
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RWV:</b>		22.00	26.00	26.50	28.00
<b>Pre-Service Evaluation Time:</b>				45.0	
<b>Pre-Service Positioning Time:</b>				25.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		90.00	120.00	150.00	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>30.00</b>				
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b>131.0</b>	99231x 1.0	99232x 1.0	99233x 2.0	
<b>Discharge Day Mgmt:</b>	<b>36.0</b>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b>61.0</b>	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>
.4626	090	25.32

CPT Descriptor Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 45      % of respondents: 46.8 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 44227</u>	<u>Key Reference CPT Code: 44626</u>
Median Pre-Service Time	80.00	60.00
Median Intra-Service Time	150.00	150.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	131.0	210.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	61.0	38.00
Median Total Time	488.00	524.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.43	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.51
Urgency of medical decision making	2.58	2.56

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.70	3.91
Physical effort required	4.30	3.95

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.09	3.91
Outcome depends on the skill and judgment of physician	4.43	4.12
Estimated risk of malpractice suit with poor outcome	3.77	3.67

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.70	3.66
Intra-Service intensity/complexity	4.52	3.88
Post-Service intensity/complexity	3.18	3.07

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey median RVW of 26.50 is recommended for 442X1. This value is slightly greater than reference code 4467 and takes into account the additional technical skill and intra-operative intensity/complexity as shown in the component measures of work above.

Additionally, the recommended RVW for 442X1 (26.50) is appropriately between 44204 (Laparoscopy, surgical; colectomy, partial, with anastomosis) (RVW=25.04) and 44206 (Laparoscopy, surgical; colectomy, partial, with end



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 CRS	Frequency 1000	Percentage	%
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Specialty GS	Frequency 1000	Percentage	%
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale.

CPT 44206 Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure

The PLI for 44206 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work (and RVW) for 44206 is very similar to the new code.

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:**

S1	44227	Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)	090
U1	44187	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube	090
U2	44188	Laparoscopy, surgical; colostomy or skin level cecostomy	090
V1	45395	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy	090
V2	45397	Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed	090
W1	45400	Laparoscopy, surgical; proctopexy (for prolapse)	090
W2	45402	Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection	090
Y1	46710	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach	090
Y2	46712	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach	090

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

Representatives of the American Society of Colon and Rectal Surgeons generated these recommendations by reviewing approved practice expense details for other CRS procedures.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** The PEAC approved clinical staff for 90-day global procedures has been indicated.

**Service period clinical staff time (admission to discharge):** For these facility only codes, 12 minutes is included for discharge management activities.

**Post-service period clinical staff time (post discharge):** For all codes, the standard times per office visit level have been applied. For codes U1, U2, V1, V2, and Y2, seven minutes is indicated for stoma education during the post-op office visit period. For codes Y1 and Y2, six minutes has been added for scope equipment cleaning at the first post-op office visit. This is 2/3 the standard cleaning time, as previously approved by the PEAC.

**SUPPLIES AND EQUIPMENT:**

Supplies and equipment necessary for each post-op office visit are indicated.

	A	B	C	T	U
1	Meeting Date: Feb 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		44227	
2				S1	
3				Laparoscopy, surgical, closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)	
4				090	
5		Code	StaffType	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	171
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		99
10	PRE-SERVICE				
11	<i>Start: After visit for procedure/service</i>				
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7
18	<i>End: Pt. enters site for procedure/service</i>				
19	SERVICE PERIOD				
40	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		12
42	<i>End: Patient leaves site of procedure/service</i>				
43	POST-SERVICE Period				
44	<i>End: Patient leaves site of procedure/service</i>				
46	List Number and Level of Office Visits				
47	99211 16 minutes	L037D	RN/LPN/MTA		
48	99212 27 minutes	L037D	RN/LPN/MTA		1
49	99213 36 minutes	L037D	RN/LPN/MTA		2
50	99214 53 minutes	L037D	RN/LPN/MTA		
51	99215 63 minutes	L037D	RN/LPN/MTA		
52	Total Office Visit Time			0	99
53	Other: The PEAC voted and approved an additional 7 minutes on the first post operative office visit for the extra time required to care for stomas.				
54	Other: Scope cleaning at pot-op visit @ 2/3 standard time				
55	<i>End: Last office visit in global period</i>				
56	MEDICAL SUPPLIES	Code	Unit		
57	pack, minimum multi-specialty visit	SA048	pack		3
58	pack, post-op incision care (suture & staple)	SA053	pack		1
59	stoma adhesive	SJ049	oz		
60	stoma pouch and wafer	SJ050	item		
61	lubricating jelly (K-Y) (5gm uou)	SJ032	item		
62	swab, procto 16in	SJ052	item		
63	canister, suction	SD009	item		
64	tubing, suction, non-latex (6ft uou)	SD132	item		
65	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item		
66	endoscope anti-fog solution	SM014	ml		
67	pack, cleaning and disinfecting, endoscope	SA042	pack		
68	Equipment	Code			
69	table, power	EF031			99
70	light, exam	EQ168			99
71	anoscope with light source	ES002			
72	suction machine (Gomco)	EQ235			

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

### Laparoscopic Proctectomy

The CPT Editorial Panel created two new codes 45395 *Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy* and 45397 *Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy* to report the laparoscopic approach of a complete proctectomy and a proctectomy that is combined with an abdominoperineal pull-through procedure.

#### **45395**

The RUC reviewed the survey data of over 50 colon/rectal surgeons and gastrointestinal endoscopic surgeons. The RUC observed that the surveyed code had more intra-service time as compared to the reference service code, 210 minutes and 180 minutes respectively. In addition, the RUC noted that the surveyed code has a greater technical skill and intra-operative intensity than the reference code. Therefore the RUC agreed with the specialty societies' recommendation of the survey median RVU of 30.50. **The RUC recommends a work RVU of 30.50 for CPT code 45395.**

#### **45397**

The RUC reviewed the survey data of over 50 colon/rectal surgeons and gastrointestinal endoscopic surgeons. The RUC observed that the surveyed code had more intra-service time as compared to the reference service code, 240 minutes and 210 minutes respectively. In addition, the RUC noted that the surveyed code has a greater technical skill and intra-operative intensity than the reference code. Therefore the specialty society recommended the survey median RVU of 34.00. The RUC agreed with the specialty societies recommendation of the survey median RVU of 34.00 and felt that the survey median RVU of 34.00 is appropriately greater than 44208 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy* (work RVU=31.95) and less than 44211 *Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy* (work RVU=34.95). **The RUC recommends a work RVU of 34.00 for CPT Code 45397.**

### Practice Expense

The RUC recommends the standard inputs for these 090 day global period codes that is performed only in the facility setting. In addition, the RUC recommends that 7 minutes be included for both 45395 and 45397 on the first post-operative office visit for the extra time required to educate patients on the care for stomas.

### Professional Liability Insurance Crosswalk

The RUC's recommendation for the Professional Liability Insurance Crosswalk for 45395 is 44208 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy* (Work RVU=31.95) and for 45397 is 44211 *Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy* (Work RVU=34.95). The PLI for these existing codes incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work (and RVW) for these existing codes is very similar to the new codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
45392		<i>Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)</i>  <i>(Do not report 45392 in conjunction with 45330, 45341, 45342, 45378, 76872)</i>	000	6.54  (No Change)
● 45395	V1	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy  (For open procedure, use 45110)	090	30.50
● 45397	V2	Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed  (For open procedure, use 45119)	090	34.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
45500		<i>Proctoplasty; for stenosis</i>	090	7.28  (No Change)
45110		<i>Proctectomy; complete, combined abdominoperineal, with colostomy</i> <u>(For laparoscopic procedure, use 45395)</u>	090	27.96  (No Change)
▲45119		Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with <del>or without proximal diverting ostomy</del> <u>enterostomy when performed</u>  <u>(For laparoscopic procedure, use 45397)</u>	090	30.79  (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:45395 Tracking Number: V1 Global Period: 090

**Recommended Work Relative Value**Specialty Society RVU: **30.50**RUC RVU: **30.50**

CPT Descriptor: Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65-year-old man presents with a low rectal lesion 1 cm proximal to the dentate line that is biopsy-proven moderately differentiated adenocarcinoma. The lesion is T2 on endorectal ultrasound and negative for metastatic disease based on previous CT PET scan. He had received preoperative chemoradiation and is one month post radiotherapy. At laparoscopic operation, he undergoes a complete proctectomy with colostomy.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Review history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Write pre-operative orders for peri-operative medications. Review pre-operative work-up, with particular attention to pathology reports and films. Review planned incisions and procedure - a potential site for the ostomy is marked. Verify blood and/or x-match is available. Change into scrub clothes. The procedure and the differential diagnosis are reviewed with the patient and family as well as the different possible outcomes of surgery and potential complications depending on the findings at the time of surgery. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, surgical laparoscopy is performed. A right lower quadrant and suprapubic 12mm trocar and right upper quadrant and left lower quadrant 5mm trocars are placed. After an exploratory laparoscopy, the sigmoid colon is retracted medially and dissection along the line of Toldt is performed to the level of the splenic flexure. Next, the sigmoid colon is retracted laterally in order to isolate and transect the IMA. The left ureter is isolated in the retroperitoneal space of the sigmoid and mobilized. The mesentery of the sigmoid is opened at the level of the pelvic brim and sharp dissection is performed to isolate and divide the IMA (through the RLQ port with an endovascular stapler). The dissection is continued along the medial mesentery to the level of the IMV, which is divided with an endovascular stapler. Sharp dissection of the lateral ligaments to the pelvic floor is carried out. The rectum is mobilized posterior to Waldeyer's fascia to the level of the pelvic floor. At the level of the descending sigmoid junction, the colon is divided intracorporeally with an endogastrointestinal stapler. Perineal dissection is carried out with transperineal removal of the specimen, and the perineal skin is closed. The descending colon is then brought out through a previously marked ostomy site. Hemostasis is obtained. The trocars are removed and the fascial openings closed as appropriate, and the individual wounds of the port sites closed.

**Description of Post-Service Work:**

Post-operative work, in hospital:

Sterile dressings and a colostomy appliance are placed. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome

and expected recovery letter for primary care physician and / or insurance company. Discharge patient from the PACU. The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia, initially post-operatively, then on a daily basis - documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to doctor. Examine patient, check wounds and patient progress daily as necessary. Check fluid and electrolyte status and urine output. Review nursing/other staff patient chart notes. Answer patient family questions. Answer nursing/other staff questions. Write orders for following labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound and stoma are examined. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:

At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound and colostomy are assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. All patient and family questions are answered, including multiple questions about the stoma. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005			
<b>Presenter(s):</b>	David Margolin, MD Guy Orangio, MD				
<b>Specialty(s):</b>	ASCRS				
<b>CPT Code:</b>	45395				
<b>Sample Size:</b>	300	<b>Resp n:</b>	52	<b>Response:</b>	%
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	25.00	30.00	30.50	33.00	37.00
<b>Pre-Service Evaluation Time:</b>			45.0		
<b>Pre-Service Positioning Time:</b>			35.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.0		
<b>Intra-Service Time:</b>	140.00	180.00	210.00	240.00	330.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>30.00</b>				
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b>139.0</b>	99231x 2.0	99232x 2.0	99233x 1.0	
<b>Discharge Day Mgmt:</b>	<b>36.0</b>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b>99.0</b>	99211x 0.0	12x 1.0	13x 2.0	14x 1.0 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>
45110	090	27.96

CPT Descriptor Proctectomy; complete, combined abdominoperineal, with colostomy

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 41      % of respondents: 78.8 %

**TIME ESTIMATES (Median)**

<b><u>TIME ESTIMATES (Median)</u></b>	<b>New/Revised CPT Code: 45395</b>	<b>Key Reference CPT Code: 45110</b>
Median Pre-Service Time	90.00	80.00
Median Intra-Service Time	210.00	180.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	139.0	207.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	99.0	91.00
Median Total Time	604.00	624.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.18	4.19
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.29	4.27
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Urgency of medical decision making	3.67	3.63
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.82	4.27
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Physical effort required	4.71	4.70
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.50	4.49
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Outcome depends on the skill and judgment of physician	4.71	4.70
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Estimated risk of malpractice suit with poor outcome	3.92	3.89
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.34	4.32
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Intra-Service intensity/complexity	4.79	4.19
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Post-Service intensity/complexity	3.89	3.86
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey median RVW of 30.50 is recommended for 454X1. This value is greater than reference code 45110 and takes into account the additional intra-operative time and greater technical skill and intra-operative intensity as shown in the intensity/complexity component measures of work above. Additionally, the survey median RVW of 30.50 is comparable to code 44208 (Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy).



Specialty GS	Frequency 1000	Percentage 50.00 %	
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale.

CPT 44208 Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy

The PLI for 44208 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work (and RVW) for 44208 is very similar to 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**

CPT Code:45397 Tracking Number: V2 Global Period: 090

**Recommended Work Relative Value**Specialty Society RVU: **34.00**RUC RVU: **34.00**

CPT Descriptor: Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colonic anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72-year-old woman presents with a low rectal lesion 6 cm proximal to the dentate line that is biopsy-proven moderately differentiated adenocarcinoma. The lesion is T3 without adenopathy on endorectal ultrasound and negative for metastatic disease based on CT PET scan. She had received preoperative chemoradiation and is one month post radiotherapy. At laparoscopic operation, a total mesorectal resection with proctectomy is performed. The remaining colon is mobilized proximal to the splenic flexure. A colonic J-pouch is fashioned in the descending colon and anastomosed to the rectal stump or anus. A diverting loop ileostomy is created in the right lower quadrant to protect the anastomosis.

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:**

Review history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Write pre-operative orders for peri-operative medications. Review pre-operative work-up, with particular attention to pathology reports and films. Review planned incisions and procedure - a potential site for the ileostomy is marked. Verify blood and/or x-match is available. Change into scrub clothes. The procedure and the differential diagnosis are reviewed with the patient and family as well as the different possible outcomes of surgery and potential complications depending on the findings at the time of surgery. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, surgical laparoscopy is performed. A right lower quadrant and suprapubic 12mm trocar and right upper quadrant and left lower quadrant 5mm trocars are placed. After an exploratory laparoscopy, the sigmoid colon is retracted medially and dissection along the line of Toldt is performed to the level of the splenic flexure. The medial mobilization and dissection of the sigmoid mesentery with intracorporeal ligation of the IMA & IMV is performed utilizing an endovascular stapler. The rectum is mobilized to below the mesorectum for eventual intracorporeal transection of the rectum with an endovascular stapler for TMC resection. After transection of the rectum, the suprapubic or the LLQ trocar site is extended in order to remove the specimen. Construction of the colonic J-pouch is accomplished by transecting the proximal colon at or near the descending sigmoid junction and folding the distal end of the remaining colon onto itself, creating a 6 cm. pouch. A circular stapler is placed in the rectal stump and while the anvil of the staple is placed in the J portion of the pouch, a double stapled anastomosis is performed... If the lesion is closer to the anus, a transanal mucosectomy is performed and a hand sewn coloanal pouch anastomosis is performed. A proximal diverting loop ileostomy is created. Hemostasis is obtained. The trocars are removed and the fascial openings closed as appropriate and the individual wounds of the port sites closed.

**Description of Post-Service Work:**

Post-operative work, in hospital:

Sterile dressings and an ileostomy appliance are placed. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Discharge patient from the PACU.

The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia, initially post-operatively, then on a daily basis - documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor. Examine patient, check wounds and patient progress daily as necessary. Check fluid and electrolyte status and urine output. Review nursing/other staff patient chart notes. Answer patient family questions. Answer nursing/other staff questions. Write orders for following labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound and stoma are examined. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

#### Post-operative work, in office:

At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound and ileostomy are assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. All patient and family questions are answered, including multiple questions about the stoma. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

#### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005			
<b>Presenter(s):</b>	David Margolin, MD Guy Orangio, MD				
<b>Specialty(s):</b>	ASCRS				
<b>CPT Code:</b>	45397				
<b>Sample Size:</b>	300	<b>Resp n:</b>	51	<b>Response:</b>	%
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RWV:</b>	31.00	33.00	34.00	35.00	50.00
<b>Pre-Service Evaluation Time:</b>			45.0		
<b>Pre-Service Positioning Time:</b>			35.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.0		
<b>Intra-Service Time:</b>	160.00	208.00	240.00	300.00	450.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>30.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>139.0</u>	99231x 2.0	99232x 2.0	99233x 1.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>99.0</u>	99211x 0.0	12x 1.0	13x 2.0	14x 1.0 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>
45119	090	30.79

CPT Descriptor Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 30      % of respondents: 58.8 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 45397</u>	<u>Key Reference CPT Code: 45119</u>
Median Pre-Service Time	90.00	80.00
Median Intra-Service Time	240.00	210.00
Median Immediate Post-service Time	30.00	45.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	139.0	199.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	99.0	61.00
Median Total Time	634.00	631.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.33	4.37
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.41	4.41
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Urgency of medical decision making	3.74	3.81
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.96	4.59
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Physical effort required	4.89	4.44
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.74	4.74
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Outcome depends on the skill and judgment of physician	4.93	4.63
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Estimated risk of malpractice suit with poor outcome	4.15	3.96
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.48	4.50
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Intra-Service intensity/complexity	4.85	4.41
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Post-Service intensity/complexity	4.04	4.04
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey median RVW of 34.00 is recommended for 454X2. This value is greater than reference code 45119 and takes into account the additional intra-operative time and greater technical skill and intra-operative intensity as shown in the intensity/complexity component measures of work above. Additionally, the survey median RVW of 34.00 is appropriately greater than 44208 (Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy) (RVW=31.95) and less than 44211 (Laparoscopy, surgical; colectomy, total,



Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty CRS	Frequency 100	Percentage 50.00 %
Specialty GS	Frequency 100	Percentage 50.00 %
Specialty	Frequency	Percentage %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale.

44211 Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy

The PLI for 44211 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work (and RVW) for 44211 is very similar to the new code.

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:

S1	44227	Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)	090
U1	44187	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube	090
U2	44188	Laparoscopy, surgical; colostomy or skin level cecostomy	090
V1	45395	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy	090
V2	45397	Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed	090
W1	45400	Laparoscopy, surgical; proctopexy (for prolapse)	090
W2	45402	Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection	090
Y1	46710	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach	090
Y2	46712	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach	090

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

Representatives of the American Society of Colon and Rectal Surgeons generated these recommendations by reviewing approved practice expense details for other CRS procedures.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** The PEAC approved clinical staff for 90-day global procedures has been indicated.

**Service period clinical staff time (admission to discharge):** For these facility only codes, 12 minutes is included for discharge management activities.

**Post-service period clinical staff time (post discharge):** For all codes, the standard times per office visit level have been applied. For codes U1, U2, V1, V2, and Y2, seven minutes is indicated for stoma education during the post-op office visit period. For codes Y1 and Y2, six minutes has been added for scope equipment cleaning at the first post-op office visit. This is 2/3 the standard cleaning time, as previously approved by the PEAC.

**SUPPLIES AND EQUIPMENT:**

Supplies and equipment necessary for each post-op office visit are indicated.

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Laparoscopic Protopexy**

The CPT Editorial Panel created two new codes to describe the laparoscopic approach for proctopexy so that they are differentiated from the open procedures that can not be used to report the laparoscopic procedures. The RUC compared codes 45400 *Laparoscopy, surgical; proctopexy (for prolapse)* and code 45402 *Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection* to their open procedure counterparts, code 45540 *Proctopexy for prolapse; abdominal approach* (work RVU = 16.25) and code 45550 *Proctopexy combined with sigmoid resection, abdominal approach* (work RVU= 22.97). The RUC agreed with the presenters that the new codes had significantly higher risk and were technically more difficult than the open procedures and to establish proper rank order, the new procedures needed to be valued higher than the open procedures. Additionally, if there was not sufficient RVU difference between the new codes and the open codes there would be a rank order anomaly among the family of laparoscopic codes.

In addition to examining the survey results, the RUC also examined the IWPUT calculations as an additional rationale and felt that using the 25<sup>th</sup> percentile RVU of 18.06 for code 45400 produced an IWPUT of 0.097 and the RUC was comfortable that this value placed the code in proper rank order. Also, the 25<sup>th</sup> percentile value places 45400 appropriately greater than 44200 (*Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure)*) (work RVU, 14.42) and is less than 44205 (*Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy*) (work RVU, 22.05)

The RUC used an additional reference code 44204 *Laparoscopy, surgical; colectomy, partial with anastomosis* (work RVU=25.04 and IWPUT of 0.097) to compare to 45402. The total time for code 44204 is 439 minutes compared to 446 minutes for 45402. However, the intra service time for 44204 is 30 minutes longer. The committee felt that the intensity of code 45402 is greater than this reference code but the total RVU should be the same. At an RVU of 25.04, the IWPUT for 45402 is .110. The committee felt that this reflected the higher intensity while the total RVU of 25.04 kept the code in proper rank order especially compared to 44204. This value also is similar to the 25<sup>th</sup> percentile as determined by the RUC survey.

**The RUC recommends a work RVU of 18.06 for code 45400.**

**The RUC recommends a work RVU of 25.04 for code 45402.**

Practice Expense

The RUC recommends the standard inputs for 90 day global procedures performed only in the facility setting.

<b>CPT Code (•New)</b>	<b>Tracking Number</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
● 45400	W1	Laparoscopy, surgical; proctopexy (for prolapse)  (For open procedure, use 45540, 45541)	090	18.06
● 45402	W2	Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection  (For open procedure, use 45550)	090	25.04
▲ 45540		Proctopexy (eg, for prolapse); abdominal approach  (For laparoscopic procedure, use 45400)	090	16.25  (No Change)
▲ 45550		Proctopexy, (eg, for prolapse) with sigmoid resection, abdominal approach  (For laparoscopic procedure, use 45402)	090	22.97  (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:45400 Tracking Number: W1 Global Period: 090

**Recommended Work Relative Value**

Specialty Society RVU: **18.06**

RUC RVU: **18.06**

CPT Descriptor: Laparoscopy, surgical; proctopexy (for prolapse)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 75-year-old woman presents with full-thickness rectal prolapse. She has no history of constipation, but has moderate symptoms of fecal incontinence. Laparoscopically, the rectum is mobilized, the prolapse is reduced, and the mobilized rectum is fixated to the sacrum.

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:**

Review history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Write pre-operative orders for peri-operative medications. Review pre-operative work-up, with particular attention to pathology reports and films. Review planned incisions and procedure. Verify blood and/or x-match is available. Change into scrub clothes. The procedure and the differential diagnosis are reviewed with the patient and family as well as the different possible outcomes of surgery and potential complications depending on the findings at the time of surgery. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, surgical laparoscopy is performed and a number of ports are inserted to permit adequate instrumentation. After an exploratory laparoscopy, the sigmoid colon and rectum are mobilized off the presacral fascia, with great care to protect the presacral autonomic nerves and ureters. The presacral space is entered and the rectum mobilized adequately to reduce any prolapse. An appropriate section of the rectum is chosen for attachment to the sacrum to maintain reduction of the prolapse. The mesorectum of this section of rectum is then affixed to the sacrum or sacral promontory. Hemostasis is obtained. The trocars are removed and the fascial openings closed as appropriate and the individual wounds of the port sites closed.

**Description of Post-Service Work:**

Post-operative work, in hospital:

Sterile dressings are placed. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Discharge patient from the PACU. The patient is evaluated for sepsis, bowel function, and analgesia, initially post-operatively, then on a daily basis - documented in the medical record.

Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor. Examine patient, check wounds and patient progress daily as necessary. Check fluid and electrolyte status and urine output. Review nursing/other staff patient chart notes. Answer patient family questions. Answer nursing/other staff questions. Write orders for following labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of

bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound is examined. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:

At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. All patient and family questions are answered. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005				
<b>Presenter(s):</b>	David Margolin, MD Guy Orangio, MD					
<b>Specialty(s):</b>	ASCRS					
<b>CPT Code:</b>	45400					
<b>Sample Size:</b>	300	<b>Resp n:</b>	42	<b>Response:</b>	%	
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		16.00	18.06	20.00	22.50	32.50
<b>Pre-Service Evaluation Time:</b>				45.0		
<b>Pre-Service Positioning Time:</b>				25.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0		
<b>Intra-Service Time:</b>		75.00	90.00	100.00	120.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>30.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>87.0</u>	99231x 3.0	99232x 1.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>61.0</u>	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>
45540	090	16.25

CPT Descriptor Proctopexy (eg, for prolapse); abdominal approach

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 32      % of respondents: 76.1 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 45400</u>	<u>Key Reference CPT Code: 45540</u>
Median Pre-Service Time	80.00	90.00
Median Intra-Service Time	100.00	118.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	87.0	128.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	61.0	46.00
Median Total Time	394.00	448.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.41	3.39
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.28	3.26
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Urgency of medical decision making	2.77	2.79
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.03	3.61
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Physical effort required	3.56	3.42
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.47	3.52
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Outcome depends on the skill and judgment of physician	3.81	3.71
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Estimated risk of malpractice suit with poor outcome	3.03	3.03
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.50	3.43
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Intra-Service intensity/complexity	3.75	3.00
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Post-Service intensity/complexity	3.00	2.97
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**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 25th percentile RVW of 18.06 is recommended for 454X3 because we believe that selection of s\ reference codes with significantly greater work than 454X3 (ie, 45550, 44145, and 44207) impacted the "median" R\ for the respondents. [Note that the median time and visit data shown, however, is accurate.] The 25th percentile RVW of 18.06 places 454X3 appropriately greater than 44200 (Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion)) (RVW=14.42) and less than 44205 (Laparoscopy, surgical; colectomy, partial, with removal of terminal



Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 700  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty CRS                      Frequency 350                      Percentage 50.00 %

Specialty GS                      Frequency 350                      Percentage 50.00 %

Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale.

44204 Laparoscopy, surgical; colectomy, partial, with anastomosis

The PLI for 44204 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work for 44204 is very similar to 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**Specialty Society RVU: **25.27**RUC RVU: **25.04**

CPT Code:45402 Tracking Number: W2 Global Period: 090

CPT Descriptor: Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 75-year-old woman presents with full-thickness rectal prolapse. She has a history of severe constipation and has no significant symptoms of fecal incontinence. Laparoscopically, the rectum is mobilized and the sigmoid colon is resected. The specimen is removed through a small incision. Laparoscopically, an anastomosis is fashioned using an end-end stapling device and the distal rectum is fixed to the sacrum.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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 history and physical with emphasis on previous operations that might make the laparoscopic approach more difficult. Write pre-operative orders for peri-operative medications. Review pre-operative work-up, with particular attention to pathology reports and films. Review planned incisions and procedure. Verify blood and/or x-match is available. Change into scrub clothes. The procedure and the differential diagnosis are reviewed with the patient and family as well as the different possible outcomes of surgery and potential complications depending on the findings at the time of surgery. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, surgical laparoscopy is performed and a number of ports are inserted to permit adequate instrumentation. After an exploratory laparoscopy, the sigmoid colon and rectum are then mobilized off the presacral fascia, with great care to protect the presacral autonomic nerves and ureters. The presacral space is entered and the rectum mobilized adequately to reduce any prolapse. The sigmoid colon is then resected, with or without an accompanying portion of the upper rectum. The vascular supply to this piece of bowel is ligated, either by dividing the inferior mesenteric artery at the proximal and distal ends, or by dividing individual branches of the sigmoid arteries, and preserving the inferior mesenteric artery. The bowel is divided at the distal point of transection, below the confluence of the taeniae coli, using a laparoscopic stapling device. The proximal bowel is then extracted through a small muscle splitting incision, and the anvil of an end-end stapler inserted, before returning the proximal end of the bowel to the abdomen and closing the fascia. The anastomosis is fashioned with a transanal circular stapling device. An appropriate section of the rectum is chosen for attachment to the sacrum to maintain reduction of the prolapse. The mesorectum of this section of rectum is then affixed to the sacrum or sacral promontory. Hemostasis is obtained. The trocars are removed and the fascial openings closed as appropriate and the individual wounds of the port sites closed.

**Description of Post-Service Work:**

Post-operative work, in hospital:

Sterile dressings are placed. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for

primary care physician and / or insurance company. Discharge patient from the PACU. The patient is evaluated for sepsis, bowel function, and analgesia, initially post-operatively, then on a daily basis - documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor. Examine patient, check wounds and patient progress daily as necessary. Check fluid and electrolyte status and urine output. Review nursing/other staff patient chart notes. Answer patient family questions. Answer nursing/other staff questions. Write orders for following labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound is examined. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

#### Post-operative work, in office:

At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. All patient and family questions are answered. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

#### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005			
<b>Presenter(s):</b>	David Margolin, MD Guy Orangio, MD				
<b>Specialty(s):</b>	ASCRS				
<b>CPT Code:</b>	45402				
<b>Sample Size:</b>	300	<b>Resp n:</b>	47	<b>Response:</b> 15.66 %	
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	22.00	25.27	27.00	30.00	40.20
<b>Pre-Service Evaluation Time:</b>			45.0		
<b>Pre-Service Positioning Time:</b>			35.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.0		
<b>Intra-Service Time:</b>	80.00	120.00	150.00	180.00	270.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>30.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>79.0</u>	99231x 1.0	99232x 2.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>61.0</u>	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>
45550	090	22.97

CPT Descriptor Proctopexy (eg, for prolapse) with sigmoid resection, abdominal approach

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28      % of respondents: 59.5 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 45402</u>	<u>Key Reference CPT Code: 45550</u>
Median Pre-Service Time	90.00	70.00
Median Intra-Service Time	150.00	180.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	79.0	136.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	61.0	61.00
Median Total Time	446.00	513.00
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	3.93	3.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.29
Urgency of medical decision making	3.85	3.33

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.44	3.89
Physical effort required	4.00	3.85
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.26	3.93
Outcome depends on the skill and judgment of physician	4.30	3.85
Estimated risk of malpractice suit with poor outcome	3.96	3.64

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.04	4.00
Intra-Service intensity/complexity	4.33	3.84
Post-Service intensity/complexity	3.59	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.*

The survey 25th percentile RVW of 25.27 is recommended for 454X4 because we believe that selection of sc reference codes with significantly greater work than 454X4 (ie, 44145, 44146, and 44207) impacted the "median" RV for the respondents. [Note that the median time and visit data shown, however, is accurate.] The 25th percentile RVW of 25.27 places 454X4 appropriately similar to 44204 (Laparoscopy, surgical; colectomy, partial, with anastomosis) (RVW=25.04) and less than 44207 (Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy



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 CRS                      Frequency 150                      Percentage 50.00 %

Specialty GS                      Frequency 150                      Percentage 50.00 %

Specialty                              Frequency                              Percentage                              %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale:

44204 Laparoscopy, surgical; colectomy, partial, with anastomosis

The PLI for 44204 incorporates the risk associated with surgical laparoscopy. Additionally, the physician's work for 44204 is very similar to the new code.

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:

S1	442X1	Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)	090
U1	442X3	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube	090
U2	442X4	Laparoscopy, surgical; colostomy or skin level cecostomy	090
V1	454X1	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy	090
V2	454X2	Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed	090
W1	45400	Laparoscopy, surgical; proctopexy (for prolapse)	090
W2	45402	Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection	090
Y1	4670X1	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach	090
Y2	4670X2	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach	090

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

Representatives of the American Society of Colon and Rectal Surgeons generated these recommendations by reviewing approved practice expense details for other CRS procedures.

**LINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** The PEAC approved clinical staff for 90-day global procedures has been indicated.

**Service period clinical staff time (admission to discharge):** For these facility only codes, 12 minutes is included for discharge management activities.

**Post-service period clinical staff time (post discharge):** For all codes, the standard times per office visit level have been applied. For codes U1, U2, V1, V2, and Y2, seven minutes is indicated for stoma education during the post-op office visit period. For codes Y1 and Y2, six minutes has been added for scope equipment cleaning at the first post-op office visit. This is 2/3 the standard cleaning time, as previously approved by the PEAC.

**SUPPLIES AND EQUIPMENT:**

Supplies and equipment necessary for each post-op office visit are indicated.

	A	B	C	D	E	F	G
1	Meeting Date: Feb 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		45400		45402	
2				W1		W2	
3				Laparoscopy, surgical; proctopexy (for prolapse)		Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection	
4				090		090	
5		Code	StaffType	NF	FAC	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	171	N/A	171
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60		60
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12		12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		99		99
10	<b>PRE-SERVICE</b>						
11	<b>Start: After visit for procedure/service</b>						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7
18	<b>End: Pt. enters site for procedure/service</b>						
19	<b>SERVICE PERIOD</b>						
40	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12		12
42	<b>End: Patient leaves site of procedure/service</b>						
43	<b>POST-SERVICE Period</b>						
44	<b>End: Patient leaves site of procedure/service</b>						
46	List Number and Level of Office Visits						
47	99211 16 minutes	L037D	RN/LPN/MTA				
48	99212 27 minutes	L037D	RN/LPN/MTA		1		1
49	99213 36 minutes	L037D	RN/LPN/MTA		2		2
50	99214 53 minutes	L037D	RN/LPN/MTA				
51	99215 63 minutes	L037D	RN/LPN/MTA				
52	<b>Total Office Visit Time</b>			0	99	0	99
53	Other: The PEAC voted and approved an additional 7 minutes on the first post operative office visit for the extra time required to care for stomas.						
54	Other: Scope cleaning at pot-op visit @ 2/3 standard time						
55	<b>End: Last office visit in global period</b>						
56	<b>MEDICAL SUPPLIES</b>	Code	Unit				
57	pack, minimum multi-specialty visit	SA048	pack		3		3
58	pack, post-op incision care (suture & staple)	SA053	pack		1		1
59	stoma adhesive	SJ049	oz				
60	stoma pouch and wafer	SJ050	item				
61	lubricating jelly (K-Y) (5gm uou)	SJ032	item				
62	swab, procto 16in	SJ052	item				
63	canister, suction	SD009	item				
64	tubing, suction, non-latex (6ft uou)	SD132	item				
65	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item				
66	endoscope anti-fog solution	SM014	ml				
67	pack, cleaning and disinfecting, endoscope	SA042	pack				
68	<b>Equipment</b>	Code					
69	table, power	EF031			99		99
70	light, exam	EQ168			99		99
71	anoscope with light source	ES002					
72	suction machine (Gomco)	EQ235					

AMA/Specialty Society RVS Update Committee  
 Summary of Recommendations

April 2005

**Diagnostic Rectal Exam Under Anesthesia**

The CPT Editorial Panel created a new code to allow for correct reporting of a diagnostic anorectal exam under general, spinal or epidural anesthesia.

The RUC reviewed code 45990 *Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic* and felt that 45990 involved more pre- and intra-service time and a higher intensity than the reference service code 57410 *Pelvic examination under anesthesia* (work RVU=1.75). Additionally, the RUC observed that the half-day discharge management, 99238 *Hospital discharge day management; 30 minutes or less* should be removed because 45990 has a 000-day global period. The RUC removed the half-day discharge day management, however 18 minutes was added to the seven minutes of immediate post-service time, totaling 25 minutes. The RUC notes that code 45990 would not be reported in conjunction with with proctosigmoidoscopies, anoscopies, pelvic examinations under anesthesia and anogenital examinations with colposcopic magnification in childhood for suspected trauma. **The RUC recommends the survey median RVU of 1.80 for 45990.**

Practice Expense

The RUC assessed and approved facility only practice expense inputs for 45990, which was cross-walked from codes 46600 and 45300.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
45990	LL1	Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic  (Do not report 45990 in conjunction with 45300- 45327, 46600, 57410, 99170)	000	1.80

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

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CPT Code:45990 Tracking Number: LL1 Global Period: 000

**Recommended Work Relative Value**  
Specialty Society RVU: **1.80**  
RUC RVU: **1.80**

**CPT Descriptor:**

Surgical diagnostic anorectal exam (459X1) includes the following elements: external perineal exam, digital rectal exam, pelvic exam (when performed), diagnostic anoscopy, and diagnostic rigid proctoscopy.

Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic

(Do not report 459X1 in conjunction with 45300- 45327, 46600, 57410, 99170)

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 35-year old man with severe rectal pain is referred for evaluation. Initial office evaluation revealed no external evidence or signs of anorectal pathology. Due to severe pain, further evaluation including DRE, anoscopy, and proctoscopy cannot be performed in the office and the patient is referred to a facility. Under anesthesia (general, spinal, or epidural), a complete examination of the perianal skin, anal verge, anal canal, and rectum is performed. This includes visual inspection of the perineal skin, DRE of the anal canal and distal rectum, anoscopic examination and proctoscopic examination. No anorectal source of pain is identified.

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: Write orders for pre-operative medications and enemas. Review pre-operative work-up. Counsel the patient and obtain informed consent. Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome with patient and family. Review type of anesthesia with anesthesiologist. Monitor patient positioning and padding.

Description of Intra-Service Work: Under anesthesia (general, spinal, or epidural), a complete examination of the perianal skin, anal verge, anal canal, and rectum is performed. This includes visual inspection of the perineal skin, DRE of the anal canal and distal rectum (a sweep of the entire coccyx and at least half of the sacrum), anoscopic examination and proctoscopic examination. No anorectal source of pain is identified.

Description of Post-Service Work: In the recovery room, after monitoring the effects of anesthesia, vital signs are obtained, symptomatic treatment (including diet) and possible further diagnostic testing are discussed with the patient/family, and the patient is discharged. All appropriate medical records are completed, including the operative dictation and follow-up with referring physician.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>		David Margolin, MD (ASCRS) Guy Orangio, MD (ASCRS) Charles Shoemaker, MD (ASGS)				
<b>Specialty(s):</b>		American Society of Colon and Rectal Surgeons American Society of General Surgeons				
<b>CPT Code:</b>		45990				
<b>Sample Size:</b>	400	<b>Resp n:</b>	168	<b>Response:</b> 42.00 %		
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		0.40	1.75	1.80	2.00	5.00
<b>Pre-Service Evaluation Time:</b>				30.0		
<b>Pre-Service Positioning Time:</b>				10.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0		
<b>Intra-Service Time:</b>		15.00	20.00	20.00	26.00	45.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>		25.00				
<b>Critical Care time/visit(s):</b>		0.0	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>		0.0	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>		0.0	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>		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>
57410	000	1.75

CPT Descriptor Pelvic examination under anesthesia

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99170	000	1.75

CPT Descriptor Anogenital examination with colposcopic magnification in childhood for suspected trauma

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 105      % of respondents: 62.5 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 45990</u>	<u>Key Reference CPT Code: 57410</u>
Median Pre-Service Time	50.00	30.00
Median Intra-Service Time	20.00	15.00
Median Immediate Post-service Time	25.00	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	95.00	70.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.60
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.90	2.89
--	------	------

Urgency of medical decision making	3.49	3.29
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.22	3.17
--------------------------	------	------

Physical effort required	2.68	2.67
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.65	2.59
---	------	------

Outcome depends on the skill and judgment of physician	3.72	3.53
--	------	------

Estimated risk of malpractice suit with poor outcome	3.22	3.22
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.07	3.01
----------------------------------	------	------

Intra-Service intensity/complexity	3.17	3.06
------------------------------------	------	------

Post-Service intensity/complexity	2.79	2.72
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey median RVW of 1.80 is recommended for new code 45990. The consensus committee compared time, intensity, and complexity data for the survey code to data for the key reference code 57410 Pelvic examination under anesthesia (MPC code and RUC-surveyed). All statistics are greater for 45990 compared with 57410. This can be accounted for by the additional work elements defined for code 45990, which include a manual exam and two endoscopies (ie, external perineal exam, digital rectal exam, pelvic exam (when performed), diagnostic anoscopy, and diagnostic rigid proctoscopy).

A second reference code is 99170 Anogenital examination with colposcopic magnification in childhood for suspected trauma (RVW=1.75 RUC surveyed). The total time for 99170 (50 minutes), which is typically performed in an office setting, is less than the total time for 45990, which is performed in the OR.

A third reference code is 52000 Cystourethroscopy (RVW=2.01 Hvd data). The total time for 52000 (38 minutes), which is typically performed in an office setting, is less than the total time for 45990, which is performed in the OR.

A fourth reference code is 91122 Anorectal manometry (RVW=1.77 RUC surveyed). The total time for 91122 (65 minutes), which is typically performed in an office setting, is less than the total time for 45990, which is performed in the OR.

## 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)

45999 Unlisted procedure, rectum

46999 Unlisted procedure, anus

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty CRS                      How often? Commonly

Specialty GS                        How often? Sometimes

Specialty                            How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty

Rectal or anal pain is one of the most common presenting complaints of patients to a colorectal surgeon's, general surgeon's, primary care physician or gastroenterologist's office. Based on the response to the survey's question about previous experience, we would estimate the national annual frequency at 10-15 patients per colorectal surgeon.

	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty

Although an estimate cannot be made, the frequency of Medicare-age patients requiring this service would be significantly lower than the national average, more on the order of 1 to 2 Medicare-aged patients per colorectal surgeon per year.

	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  
000 Day Global Period  
Facility-ONLY Direct Inputs**

CPT	DESCRIPTION	GLOBAL
45990	Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic	0

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The direct practice expense details were jointly developed by physicians from ACROs and ASGS and are based on approved details for many GI endoscopy codes (including 46600 and 45300).

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time:** 19 minutes for facility preservice time has been included. This time is crosswalked from 46600 and 45300, which are elements of this new code.

**Service period clinical staff time:** N/A

**Post-service period clinical staff time:** 3 minutes for phone call to patient and/or PCP is included

**SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:** N/A

	A	B	C	D	E
1				45990	
2	Meeting Date: Apr 2005			LL1	
3	NOTE: Times are crosswalked from PEAC approved facility inputs for 45300 and 46600	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic	
4				000	
5		Code	StaffType	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	22
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		19
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		3
10	PRE-SERVICE				
11	Start: After visit for procedure/service				
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3
18	End: Pt. enters site for procedure/service				
19	SERVICE PERIOD				
20	Start: Pt. enters site for procedure/service				
42	End: Patient leaves site of procedure/service				
43	POST-SERVICE Period				
44	End: Patient leaves site of procedure/service				
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3
54	End: Last office visit in global period				
55	MEDICAL SUPPLIES	Code	Unit		
56					n/a
57	Equipment	Code			
58					n/a

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Anal Sphincter Chemodenervation**

CPT created code 46505 *Chemodenervation of internal anal sphincter* to describe a new medical modality that involves injecting Botulinum toxin for the medical management of anal fissures. The RUC reviewed the specialty society's survey data and was comfortable with the median RVU, however the RUC noted that the median value was based on the inclusion of a full discharge day management service. Since this is an outpatient procedure, the RUC concluded that the physician work associated with half of a visit would be more typical and therefore reduced the recommended value by 0.64 RVUs, which is half a discharge day management service. Therefore the RUC concluded that a work RVU of 2.86 was appropriate especially compared to reference service 64614 *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* (work RVU= 2.20), which does not include a post service office visit or any discharge day management. **The RUC recommends a work RVU of 2.86 for code 46505.**

Practice Expense

The RUC approved practice expense inputs for the facility and non-facility setting. Intra-service assist time was set equal to the physician time and in the non-facility setting a local anesthetic is typically used, which is reflected in the supplies.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•46505	X1	Chemodenervation of internal anal sphincter  (For chemodenervation of other muscles, see 64612-64614, 64640)  (Report the specific service as well as code(s) for the specific substance(s) or drug(s) provided	010	2.86

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**  
Specialty Society RVU: **3.50**  
RUC RVU: **2.86**

CPT Code:46505 Tracking Number: X1 Global Period: 010

CPT Descriptor: Chemodenervation of internal anal sphincter

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 38-year-old woman presents with a history of bright red rectal bleeding and pain with every bowel movement. She has a posterior midline fissure that has failed treatment with topical creams and nitroglycerin ointment. Treatment of the fissure by injection of chemodenervation agent (eg, botulinum toxin) is performed to temporarily relax the internal anal sphincter, allow healing of the fissure, and minimize the complication of fecal incontinence associated with a surgical sphincterotomy.

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:**

Write orders for pre-operative medications and enemas. Review pre-operative work-up. Review the planned procedure. Counsel the patient and obtain informed consent. Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome with patient and family. Verify that all necessary surgical instruments and supplies are available in the operative suite. Monitor patient positioning and padding; either lithotomy or prone jack-knife position.

**Description of Intra-Service Work:**

Under anesthesia, a digital rectal exam and anoscopic evaluation are performed. Forty units of botulinum toxin are injected in divided doses at the posterior midline and both lateral quadrants of the intersphincteric area.

**Description of Post-Service Work:**

A dry dressing is applied. The patient is taken to the recovery room. After monitoring the effects of anesthesia, vital signs are obtained and the patient is discharged from the facility. All appropriate medical records are completed, including the operative dictation. She is seen in the office in one week to assess the efficacy of treatment.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005			
<b>Presenter(s):</b>	David Margolin, MD Guy Orangio, MD				
<b>Specialty(s):</b>	ASCRS				
<b>CPT Code:</b>	46505				
<b>Sample Size:</b>	300	<b>Resp n:</b>	49	<b>Response:</b>	16.33 %
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.00	3.00	3.50	3.50	4.00
<b>Pre-Service Evaluation Time:</b>			20.0		
<b>Pre-Service Positioning Time:</b>			10.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.0		

<b>Intra-Service Time:</b>		<b>5.00</b>	<b>10.00</b>	<b>15.00</b>	<b>15.00</b>	<b>30.00</b>
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>10.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>18.0</u></b>	99238x 0.50	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>23.0</u></b>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
64614	010	2.20

CPT Descriptor Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 38.7 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 46505</u>	<u>Key Reference CPT Code: 64614</u>
Median Pre-Service Time	35.00	15.00
Median Intra-Service Time	15.00	20.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	0.00
Median Office Visit Time	23.0	0.00
Median Total Time	101.00	50.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.25	2.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.08	2.08
Urgency of medical decision making	2.00	2.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.25	2.25
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Physical effort required	2.29	2.29
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.17	2.17
---	------	------

Outcome depends on the skill and judgment of physician	2.38	2.29
--	------	------

Estimated risk of malpractice suit with poor outcome	2.42	2.42
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.21	2.17
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Intra-Service intensity/complexity	2.50	2.46
------------------------------------	------	------

Post-Service intensity/complexity	2.13	2.08
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Comparison of new code 465X1 with reference code 64614:

Site of service: 465X1 - facility, requiring discharge management 64614 - office

Post-discharge management: 465X1 - one office visit 64614 - no office visit, followup to PCP

The additional work for 465X1 compared with 64614, as described above, supports the recommendation of 3.50 work RVUs. The survey data and RVW of 3.50 results in an IWPUT of 0.042, which is conservative.

A similar comparison can be made to the other chemodervation codes 64612, 64613, and 64735 (total times = 51, 52, and 64 minutes respectively).

## 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) 46999 Unlisted procedure, anus

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty CRS                      How often? Sometimes

Specialty GS                      How often? Sometimes

Specialty                              How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty

National frequency is unknown. An anal fissure is a common problem that causes substantial morbidity in people who are otherwise healthy. Multiple fissures or lateral fissures may have other causes, such as Crohn's disease, ulcerative colitis, tuberculosis, infection with human immunodeficiency virus (HIV), or syphilis. Most fissures heal with palliative and/or topical pharmacologic treatment. Approximately 10% will require more aggressive treatment. Injection with a chemodervation agent is an available option to circumvent surgery.

Frequency	Percentage	%
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Specialty CRS	Frequency	Percentage	%
---------------	-----------	------------	---

Specialty GS	Frequency	Percentage	%
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Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 50  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty CRS	Frequency 40	Percentage 80.00 %	
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Specialty GS	Frequency 10	Percentage 20.00 %	
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale.

CPT 67345 Chemodenervation of extraocular muscle

The PLI for 67345 incorporates the total risk of a 010 day global chemodenervation procedure that is performed in a facility setting and includes a post-discharge office visit (ie, the reference code 64614 does not include follow up work). Additionally, the work-RVUs are similar for both procedures.

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 & Nonfacility Direct Inputs**

CPT Long Descriptor:


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X1 46505 Chemodenervation of internal anal sphincter

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**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

Representatives of the American Society of Colon and Rectal Surgeons generated these recommendations by reviewing approved practice expense details for other CRS 10-day global procedures.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** The maximum time for 10-day global of 18 and 30 minutes has been indicated. This procedure is performed after failed medical management and in lieu of surgery in an OR. Pre-service diagnostic, referral forms, and scheduling are all the same as for a 90-day global procedure. Patient education and counseling is necessary since the result of the procedure is relaxed (numb) sphincter tone. Phone calls to patient/family are necessary to be reconfirm prep for the procedure.

**Service period clinical staff time (admission to discharge):**

For the facility setting, 12 minutes is included for discharge management activities.

For the non-facility setting, pre-service and post-service standard times are applied for tasks as shown on the spreadsheet. The full physician intra-time (@100%) is shown for staff during the procedure time; to assist with positioning and instrument handling.

**Post-service period clinical staff time (post discharge):** For all codes, the standard times per office visit level have been applied. Additionally, six minutes has been added for scope equipment cleaning at the post-op office visit. This is 2/3 the standard cleaning time, as previously approved by the PEAC.

**SUPPLIES AND EQUIPMENT:**

Supplies and equipment necessary on the day of the procedure and for each post-op office visit are indicated.

	A	B	C	D	E				
1	Meeting Date: Feb 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		X1 Chemodeneration of internal anal sphincter					
2						010			
3				Code	StaffType			NF	FAC
4									
5									
6	<b>TOTAL CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	<b>108</b>	<b>78</b>				
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	<b>18</b>	<b>30</b>				
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA	<b>48</b>	<b>6</b>				
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	<b>42</b>	<b>42</b>				
10	<b>PRE-SERVICE</b>								
11	<b>Start: After visit for procedure/service</b>								
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	<b>5</b>	<b>5</b>				
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	<b>3</b>	<b>10</b>				
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		<b>5</b>				
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	<b>7</b>	<b>7</b>				
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	<b>3</b>	<b>3</b>				
17	Other Clinical Activity (please specify)								
18	<b>End: Pt. enters site for procedure/service</b>								
19	<b>SERVICE PERIOD</b>								
20	<b>Start: Pt. enters site for procedure/service</b>								
21	<b>Pre-service services</b>								
22	Review charts	L037D	RN/LPN/MTA	<b>2</b>					
23	Greet patient and provide gowning	L037D	RN/LPN/MTA	<b>3</b>					
24	Obtain vital signs	L037D	RN/LPN/MTA	<b>3</b>					
25	Provide pre-service education/obtain consent								
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	<b>2</b>					
27	Setup scope (non facility setting only)	L037D	RN/LPN/MTA	<b>5</b>					
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	<b>2</b>					
29	Sedate/apply anesthesia	L037D	RN/LPN/MTA	<b>2</b>					
30	<b>Intra-service</b>								
31	Assist physician in performing procedure	L037D	RN/LPN/MTA	<b>15</b>					
32	<b>Post-Service</b>								
33	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	<b>5</b>					
34	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	<b>3</b>					
35	Clean Scope	L037D	RN/LPN/MTA	<b>10</b>					
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	L037D	RN/LPN/MTA	<b>3</b>					
40	Discharge day management 99238 –12 minutes 99239 –15 minutes	L037D	RN/LPN/MTA		<b>6</b>				
41	Other Clinical Activity (please specify)								
42	<b>End: Patient leaves site of procedure/service</b>								
43	<b>POST-SERVICE Period</b>								
44	<b>End: Patient leaves site of procedure/service</b>								
45	Conduct phone calls/call in prescriptions								
46	<b>List Number and Level of Office Visits</b>								
47	99211 16 minutes	L037D	RN/LPN/MTA						
48	99212 27 minutes	L037D	RN/LPN/MTA						
49	99213 36 minutes	L037D	RN/LPN/MTA	<b>1</b>	<b>1</b>				
50	99214 53 minutes	L037D	RN/LPN/MTA						
51	99215 63 minutes	L037D	RN/LPN/MTA						
52	<b>Total Office Visit Time</b>			<b>36</b>	<b>36</b>				
53	Other: Scope cleaning at pot-op visit @ 2/3 standard time			<b>6</b>	<b>6</b>				
54	<b>End: Last office visit in global period</b>								

	A	B	C	D	E
1	Meeting Date: Feb 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		X1 Chemodeneration of internal anal sphincter	
2					
3					
4				010	
5				Code	StaffType
6	<b>TOTAL CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	108	78
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	18	30
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA	48	6
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	42	42
55	<b>MEDICAL SUPPLIES</b>	<b>Code</b>	<b>Unit</b>		
56	pack, minimum multi-specialty visit	SA048	pack	2	1
57	gloves, non-sterile	SB022	pair	2	1
58	cap, surgical	SB001	item	4	2
59	gown, staff, impervious	SB027	item	4	2
60	mask, surgical, with face shield	SB034	item	4	2
61	shoe covers, surgical	SB039	pair	4	2
62	lubricating jelly (K-Y) (5gm uou)	SJ032	item	8	4
63	swab, procto 16in	SJ052	item	6	3
64	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	10	
65	needle, 18-27g	SC029	item	2	
66	syringe 10-12ml	SC051	item	1	
67	sodium chloride 0.9% inj (10ml uou) (to dilute botox)	SH066	item	1	
68	canister, suction	SD009	item	2	1
69	tubing, suction, non-latex (6ft uou)	SD132	item	2	1
70	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	2	1
71	gauze, non-sterile 2in x 2in	SG050	item	8	4
72	endoscope anti-fog solution	SM014	ml	2	1
73	pack, cleaning and disinfecting, endoscope	SA042	pack	2	1
74	<b>Equipment</b>	<b>Code</b>			
75	light, surgical	EF014		84	36
76	table, power	EF031		84	36
77	anoscope with light source	ES002		90	42
78	suction machine (Gomco)	EQ235		84	36

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Ileoanal Pouch Fistula Repair**

CPT created two new codes to accurately describe circumferential transanal pouch advancement to repair a pouch-vaginal or pouch-perineal fistula or long exit conduit of S-pouch. The RUC reviewed code 46710 *Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach* and felt that the recommended median RVU of 18.00 resulted in an IWPUT of .119 that was too high for this procedure. Therefore, it was agreed to use a work relative value between the 25<sup>th</sup> % and the median value that would produce an IWPUT that would place the code in proper rank order such as with code 454X3 *Laparoscopy, surgical; proctopexy (for prolapse)* (recommended RVU = 18.06). Using a work relative value of 16.00 results in an IWPUT of .097 that is the same as code 454X3. The RUC determined that this intensity value and work relative value was appropriate and placed the code in proper rank order especially with code 454X3, which the RUC felt had the same intra-service intensity as 46710. **The RUC recommends a work RVU of 16.00 for code 46710**

The presenters explained that code 46712 *Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach* involved some of the most difficult cases that colon and rectal surgeons see and the procedure involves significant risk. The RUC examined the new code in comparison to the reference procedure, code 45119 *Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with or without proximal diverting ostomy* (work RVU, 30.79). Total times of these two codes were similar with code 46712 having 30 additional minutes of intra-service time. Also, the intensity measures of the surveyed code were higher in each category when compared to the reference service. Therefore, the RUC agreed that the median survey RVU of 34.00 would place the code in proper rank order and reflect the additional complexity and technical skill needed in comparison with the reference service. Also, the presenters explained that the higher RVU is warranted because the procedure is always performed in a reoperative field in a patient that already has a pouch with inherent sphincter pouch dysfunction and chronic inflammation. More than reoperative surgery, this deep pelvic operation is technically difficult because of the tenuous blood supply to the pouch and risk of ureter damage that requires slow, detailed dissections in a confined space. Failure of this operation would result in a permanent stoma. **The RUC recommends a work RVU of 34.00 for code 46712.**

Practice Expense

The RUC recommends the standard inputs for 90 day global procedures performed only in the facility setting.

<b>CPT Code (•New)</b>	<b>Tracking Number</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Source of Current Work RVU*</b>	<b>Work RVU Recommendation</b>
● 46710	Y1	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach	090	N/A	16.00
● 46712	Y2	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach	090	N/A	34.00

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:46710 Tracking Number: Y1 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **18.00**  
RUC RVU: **16.00**

CPT Descriptor: Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 35-year-old woman presents with passage of stool through the vagina. Her history includes a prior proctocolectomy and ileal pouch-anal anastomosis for ulcerative colitis. Crohn's disease has been considered. At operation, she undergoes a transperineal mobilization of the pouch with advancement and re-anastomosis.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Review pre-operative work-up, with particular attention to pathology reports and films. Write pre-operative orders for peri-operative medications. Review planned incisions and procedure. Verify blood and/or x-match is available. Change into scrub clothes. The procedure and the differential diagnosis are reviewed with the patient and family as well as the different possible outcomes of surgery and potential complications depending on the findings at the time of surgery. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

Under general anesthesia, the distal pouch is mobilized for 6-10 cm. If residual anal canal mucosa is present, a completion mucosectomy is performed. An operating anoscope is inserted, and the level of the anastomosis defined. An epinephrine containing solution is injected below the level of the previous anastomosis. The cautery is then used to circumferentially dissect the pouch immediately proximal to the dentate line. This is deepened to the internal sphincter that is defined and protected with great care. Hemostasis is meticulous with cautery. Dissection proceeds proximally. The previous anastomosis is reached and dissection continues past this point, generally for a distance of 6-10 cm until the pouch has been circumferentially mobilized. For cases with a pouch-vaginal or anastomosis-vaginal fistula, this dissection has divided the fistula tract. Attention is turned to the vaginal or perineal end of the tract, which is excised and debrided, before being closed with one or more layers of meticulously placed absorbable sutures. The distal end of the mobilized pouch is then trimmed, excising the anal transitional zone or fistula site. Great attention is made to avoid making the pouch too short, or rendering it ischemic. The new distal margin of the pouch is then sutured circumferentially to the dentate line as a new hand-sewn ileo-anal anastomosis. Hemostasis is checked for, and obtained, at each stage of the procedure.

**Description of Post-Service Work:**

Post-operative work, in hospital:

terile dressings are placed. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Discharge patient from the PACU. The patient is evaluated for

sepsis, bowel function, and analgesia, initially post-operatively, then on a daily basis - documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor. Examine patient, check wounds and patient progress daily as necessary. Check fluid and electrolyte status and urine output. Review nursing/other staff patient chart notes. Answer patient family questions. Answer nursing/other staff questions. Write orders for following labs, films medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound is examined. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

**Post-operative work, in office:**

At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. All patient and family questions are answered. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005			
<b>Presenter(s):</b>	David Margolin, MD Guy Orangio, MD				
<b>Specialty(s):</b>	ASCRS				
<b>CPT Code:</b>	46710				
<b>Sample Size:</b>	300	<b>Resp n:</b>	40	<b>Response:</b> 13.33 %	
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		12.00	14.00	18.00	20.00
<b>Pre-Service Evaluation Time:</b>				60.0	
<b>Pre-Service Positioning Time:</b>				20.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		60.00	75.00	90.00	105.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>30.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>49.0</u>	99231x 1.0	99232x 1.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>61.0</u>	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>
45820	090	18.45

CPT Descriptor Closure of rectourethral fistula;**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 31      % of respondents: 77.5 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 46710	Key Reference CPT Code: 45820
Median Pre-Service Time	90.00	90.00
Median Intra-Service Time	90.00	100.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	49.0	128.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	61.0	61.00
Median Total Time	356.00	445.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.71	3.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	3.13
Urgency of medical decision making	3.00	2.74

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.30	3.60
Physical effort required	3.68	3.16

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.13	3.45
Outcome depends on the skill and judgment of physician	4.32	3.90
Estimated risk of malpractice suit with poor outcome	3.81	3.23

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference**  
**Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.97	3.32
Intra-Service intensity/complexity	4.19	3.35
Post-Service intensity/complexity	3.55	2.87

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey median RVW of 18.00 is recommended for 4670X1. This value is slightly less than reference code 45<sup>r</sup> and takes into account the significantly greater pre-service and intra-service intensity/complexity as shown in component measures of work above. Unlike 45820, new code 4670X1 is always performed in a reoperative field in a patient that already has a pouch with inherent sphincter pouch dysfunction and chronic inflammation. New code 4670X1 is largely associated with pouch vaginal fistulae, combined with anal sphincter preservation. This is a refined dissection



Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty CRS                      Frequency 15                      Percentage 75.00 %

Specialty GS                      Frequency 5                      Percentage 25.00 %

Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:46712 Tracking Number: Y2 Global Period: 090

**Recommended Work Relative Value**Specialty Society RVU: **34.00**RUC RVU: **34.00**

CPT Descriptor: Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 35-year-old woman presents with passage of stool through the vagina. Her history includes a prior proctocolectomy and ileal pouch-anal anastomosis for ulcerative colitis. Crohn's disease has been considered. At operation, she undergoes a transperineal and transabdominal mobilization of the pouch with advancement and re-anastomosis.

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:**

Review pre-operative work-up, with particular attention to pathology reports and films. Write pre-operative orders for peri-operative medications. Review planned incisions and procedure - a potential site for the ileostomy is marked. Verify blood and/or x-match is available. Change into scrub clothes. The procedure and the differential diagnosis are reviewed with the patient and family as well as the different possible outcomes of surgery and potential complications depending on the findings at the time of surgery. Answer patient and family questions and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

**Description of Intra-Service Work:**

The patient is placed under general anesthesia in the perineolithotomy position. The abdomen is opened through a lower midline incision and dissection is performed to mobilize the pelvic reservoir from the sacrum, the lateral pelvic walls, and then from the vagina. Complete mobilization of the pelvic pouch is performed to the level of the anastomosis. After this is completed, attention is turned to the perineal area. An epinephrine containing solution is injected below the level of the previous anastomosis. The cautery is then used to circumferentially dissect the pouch immediately proximal to the dentate line. This is deepened to the internal sphincter that is defined and protected with great care. Hemostasis is meticulous with cautery. Dissection proceeds proximally. This is carried up to the level of the abdominal dissection. This divides any fistula tracts. The old pouch is brought into the abdomen and assessed for viability. If the old pouch is viable, it is returned to the pelvis, assuring it is not under too much tension, and sewn to the anal canal. If the old pouch was not salvaged, a new neo-pelvic reservoir is constructed and sewn to the anal canal. When this is completed, attention is returned to the abdominal incision and a temporary loop ileostomy is created. All wounds are closed as appropriate.

**Description of Post-Service Work:**

Post-operative work, in hospital:

terile dressings and an ileostomy appliance are placed. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. Discharge patient from the PACU.

The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia, initially post-operatively, then on a daily basis - documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor. Examine patient, check wounds and patient progress daily as necessary. Check fluid and electrolyte status and urine output. Review nursing/other staff patient chart notes. Answer patient family questions. Answer nursing/other staff questions. Write orders for following labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound and stoma are examined. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:

At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound and ileostomy are assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. All patient and family questions are answered, including repetitive questions about the stoma. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

### SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2005			
Presenter(s):	David Margolin, MD Guy Orangio, MD				
Specialty(s):	ASCRS				
CPT Code:	46712				
Sample Size:	300	Resp n:	41	Response: 13.66 %	
Sample Type:	Random				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:	25.04	32.00	34.00	34.00	45.00
Pre-Service Evaluation Time:			60.0		
Pre-Service Positioning Time:			20.0		
Pre-Service Scrub, Dress, Wait Time:			10.0		
Intra-Service Time:	190.00	220.00	240.00	270.00	360.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>30.00</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>161.0</u>	99231x 1.0	99232x 2.0	99233x 2.0	
Discharge Day Mgmt:	<u>36.0</u>	99238x 1.00	99239x 0.00		
Office time/visit(s):	<u>61.0</u>	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>
45119	090	30.79

CPT Descriptor Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with or without proximal diverting ostomy

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 60.9 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u> 46712	<u>Key Reference CPT Code:</u> 45119
Median Pre-Service Time	90.00	80.00
Median Intra-Service Time	240.00	210.00
Median Immediate Post-service Time	30.00	45.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	161.0	199.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	61.0	61.00
Median Total Time	618.00	631.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.32	4.56
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.48	4.72
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Urgency of medical decision making	3.36	3.00
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	5.00	4.84
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Physical effort required	4.60	4.44
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.96	4.88
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Outcome depends on the skill and judgment of physician	5.00	4.92
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Estimated risk of malpractice suit with poor outcome	4.36	4.28
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.88	4.72
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Intra-Service intensity/complexity	5.00	4.84
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Post-Service intensity/complexity	3.36	3.48
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey median RVW of 34.00 is recommended for 4670X2. This value is greater than reference code 45119, take into account additional intra-operative time. Similar to the discussion for new code 4670X1, 4670X2 is always performed in a reoperative field in a patient that already has a pouch with inherent sphincter pouch dysfunction and chronic inflammation. More than reoperative surgery, this deep pelvic operation is technically difficult because of the tenuous blood supply to the pouch and risk of ureter damage that requires slow, detailed dissections in a confined space. Failure of this operation would result in a permanent stoma.

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**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.

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**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 46999 Unlisted procedure, anus

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty CRS                      How often? Rarely

Specialty GS                      How often? Rarely

Specialty                              How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty

Pouch-vaginal and pouch-perineal fistulas are uncommon conditions. Similarly, dysplasia of the anal transitional zone between the dentate line and the anastomosis, and lengthening of the exit conduit of an S-configured ileal pouch are uncommon. Approximately 1000 patients undergo ileal pouch surgery annually. Perhaps 1-2% of these develop complications that require repair, either by a perineal approach or by a combined perineal/abdominal approach.

Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 20  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty CRS                      Frequency 15                      Percentage 75.00 %

Specialty GS                      Frequency 5                      Percentage 25.00 %

Specialty                                      Frequency                                      Percentage                                      %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? 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:

S1	442X1	Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (eg, closure of Hartmann type procedure)	090
U1	442X3	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube	090
U2	442X4	Laparoscopy, surgical; colostomy or skin level cecostomy	090
V1	454X1	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy	090
V2	454X2	Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed	090
W1	454X3	Laparoscopy, surgical; proctopexy (for prolapse)	090
W2	454X4	Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection	090
Y1	46710	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach	090
Y2	46712	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach	090

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

Representatives of the American Society of Colon and Rectal Surgeons generated these recommendations by reviewing approved practice expense details for other CRS procedures.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** The PEAC approved clinical staff for 90-day global procedures has been indicated.

**Service period clinical staff time (admission to discharge):** For these facility only codes, 12 minutes is included for discharge management activities.

**Post-service period clinical staff time (post discharge):** For all codes, the standard times per office visit level have been applied. For codes U1, U2, V1, V2, and Y2, seven minutes is indicated for stoma education during the post-op office visit period. For codes Y1 and Y2, six minutes has been added for scope equipment cleaning at the first post-op office visit. This is 2/3 the standard cleaning time, as previously approved by the PEAC.

**SUPPLIES AND EQUIPMENT:**

Supplies and equipment necessary for each post-op office visit are indicated.

	A	B	C	D	E	F	G
1	Meeting Date: Feb 2005	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		46710		46712	
2				Y1		Y2	
3				Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach		Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach	
4				090		090	
5				Code	StaffType	NF	FAC
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	177	N/A	184
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60		60
8	TOTAL INTRA CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12		12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		105		112
10	<b>PRE-SERVICE</b>						
11	<i>Start: After visit for procedure/service</i>						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7
18	<i>End: Pt. enters site for procedure/service</i>						
19	<b>SERVICE PERIOD</b>						
40	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12		12
42	<i>End: Patient leaves site of procedure/service</i>						
43	<b>POST-SERVICE Period</b>						
44	<i>End: Patient leaves site of procedure/service</i>						
46	<i>List Number and Level of Office Visits</i>						
47	99211 16 minutes	L037D	RN/LPN/MTA				
48	99212 27 minutes	L037D	RN/LPN/MTA		1		1
49	99213 36 minutes	L037D	RN/LPN/MTA		2		2
50	99214 53 minutes	L037D	RN/LPN/MTA				
51	99215 63 minutes	L037D	RN/LPN/MTA				
52	<b>Total Office Visit Time</b>			0	99	0	99
53	<i>Other: The PEAC voted and approved an additional 7 minutes on the first post operative office visit for the extra time required to care for stomas.</i>						7
54	<i>Other: Scope cleaning at pot-op visit @ 2/3 standard time</i>				6		6
55	<i>End: Last office visit in global period</i>						
56	<b>MEDICAL SUPPLIES</b>	Code	Unit				
57	pack, minimum multi-specialty visit	SA048	pack		3		3
58	pack, post-op incision care (suture & staple)	SA053	pack		1		1
59	stoma adhesive	SJ049	oz				3
60	stoma pouch and wafer	SJ050	item				3
61	lubricating jelly (K-Y) (5gm uou)	SJ032	item		4		4
62	swab, procto 16in	SJ052	item		3		3
63	canister, suction	SD009	item		1		1
64	tubing, suction, non-latex (6ft uou)	SD132	item		1		1
65	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item		1		1
66	endoscope anti-fog solution	SM014	ml		1		1
67	pack, cleaning and disinfecting, endoscope	SA042	pack		1		1
68	<b>Equipment</b>	Code					
69	table, power	EF031			99		106
70	light, exam	EQ168			99		106
71	anoscope with light source	ES002			36		36
72	suction machine (Gomco)	EQ235			36		36

RUC Recommendations for  
CPT 2006  
Volume II

*RUC Meetings*  
*September 2004, February 2005,*  
*April 2005*

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
RUC RECOMMENDATIONS FOR CPT 2006**

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# CPT 2006 RUC Recommendations

CPT Code	Global Coding Period	Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
01964	XXX	D	May04	13	Incomplete or Missed Abortion Anesthesia		Oct04	10						Yes	
01965	XXX	N	May04	13	Incomplete or Missed Abortion Anesthesia	A1	Oct04	10	ASA	4.00	4.00			Yes	
01966	XXX	N	May04	13	Incomplete or Missed Abortion Anesthesia	A2	Oct04	10	ASA	4.00	4.00			Yes	
15000	000	R	Feb05	24	Free Skin Grafts	FF1	Apr05	06	ASPS, ABA	3.99	3.99	Yes		Yes	
15001	ZZZ	R	Feb05	24	Free Skin Grafts	FF2	Apr05	06	ASPS, ABA	1.00	1.00	Yes		Yes	
15040	000	N	Feb05	24	Free Skin Grafts	FF3	Apr05	06	ASPS, ABA	2.00	2.00			Yes	
15100	090	R	Feb05	24	Free Skin Grafts		Apr05	06		9.04	9.04	Yes		Yes	
15101	ZZZ	R	Feb05	24	Free Skin Grafts		Apr05	06		1.72	1.72	Yes		Yes	
15110	090	N	Feb05	24	Free Skin Grafts	FF4	Apr05	06	ASPS, ABA	9.50	9.50			Yes	
15111	ZZZ	N	Feb05	24	Free Skin Grafts	FF5	Apr05	06	ASPS, ABA	1.85	1.85			Yes	
15115	090	N	Feb05	24	Free Skin Grafts	FF6	Apr05	06	ASPS, ABA	9.81	9.81			Yes	
15116	ZZZ	N	Feb05	24	Free Skin Grafts	FF7	Apr05	06	ASPS, ABA	2.50	2.50			Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
15120	090	R	Feb05	24	Free Skin Grafts		Apr05	06		9.81	9.81	Yes	Yes		
15121	ZZZ	R	Feb05	24	Free Skin Grafts		Apr05	06		2.67	2.67	Yes	Yes		
15130	090	N	Feb05	24	Free Skin Grafts	FF8	Apr05	06	ASPS, ABA	7.00	7.00			Yes	
15131	ZZZ	N	Feb05	24	Free Skin Grafts	FF9	Apr05	06	ASPS, ABA	1.50	1.50			Yes	
15135	090	N	Feb05	24	Free Skin Grafts	FF10	Apr05	06	ASPS, ABA	10.50	10.50			Yes	
15136	ZZZ	N	Feb05	24	Free Skin Grafts	FF11	Apr05	06	ASPS, ABA	1.50	1.50			Yes	
15150	090	N	Feb05	24	Free Skin Grafts	FF12	Apr05	06	ASPS, ABA	8.25	8.25			Yes	
15151	ZZZ	N	Feb05	24	Free Skin Grafts	FF13	Apr05	06	ASPS, ABA	2.00	2.00			Yes	
15152	ZZZ	N	Feb05	24	Free Skin Grafts	FF14	Apr05	06	ASPS, ABA	2.50	2.50			Yes	
15155	090	N	Feb05	24	Free Skin Grafts	FF15	Apr05	06	ASPS, ABA	9.00	9.00			Yes	
15156	ZZZ	N	Feb05	24	Free Skin Grafts	FF16	Apr05	06	ASPS, ABA	2.75	2.75			Yes	
15157	ZZZ	N	Feb05	24	Free Skin Grafts	FF17	Apr05	06	ASPS, ABA	3.00	3.00			Yes	
15170	090	N	Feb05	24	Free Skin Grafts	FF18	Apr05	06	ASPS, ABA	5.00	5.00			Yes	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Issue	Tracking Number	RUC Date	RUC S.S. Tab	Specialty	RUC Rec	Same RVU as last year?	MFS	Comments
15171	ZZZ	N	Feb05	24	Free Skin Grafts	FF19	Apr05	06 ASPS, ABA	1.55	1.55	Yes	
15175	090	N	Feb05	24	Free Skin Grafts	FF20	Apr05	06 ASPS, ABA	7.00	7.00	Yes	
15176	ZZZ	N	Feb05	24	Free Skin Grafts	FF21	Apr05	06 ASPS, ABA	2.45	2.45	Yes	
15300	090	N	Feb05	24	Free Skin Grafts	FF22	Apr05	06 ASPS, ABA	3.99	3.99	Yes	
15301	ZZZ	N	Feb05	24	Free Skin Grafts	FF23	Apr05	06 ASPS, ABA	1.00	1.00	Yes	
15320	090	N	Feb05	24	Free Skin Grafts	FF24	Apr05	06 ASPS, ABA	4.70	4.70	Yes	
15321	ZZZ	N	Feb05	24	Free Skin Grafts	FF25	Apr05	06 ASPS, ABA	1.50	1.50	Yes	
15330	090	N	Feb05	24	Free Skin Grafts	FF26	Apr05	06 ASPS, ABA	3.99	3.99	Yes	
15331	ZZZ	N	Feb05	24	Free Skin Grafts	FF27	Apr05	06 ASPS, ABA	1.00	1.00	Yes	
15335	090	N	Feb05	24	Free Skin Grafts	FF28	Apr05	06 ASPS, ABA	4.50	4.50	Yes	
15336	ZZZ	N	Feb05	24	Free Skin Grafts	FF29	Apr05	06 ASPS, ABA	1.43	1.43	Yes	
15340	010	N	Feb05	24	Free Skin Grafts	FF30	Apr05	06 ASPS, ABA, APMA	3.72	3.72	Yes	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
15341	ZZZ	N	Feb05	24	Free Skin Grafts	FF31	Apr05	06	ASPS, ABA, APMA	0.50	0.50		Yes	
15342	010	D	Feb05	24	Free Skin Grafts		Apr05	06					Yes	
15343	ZZZ	D	Feb05	24	Free Skin Grafts		Apr05	06					Yes	
15350	090	D	Feb05	24	Free Skin Grafts		Apr05	06					Yes	
15351	ZZZ	D	Feb05	24	Free Skin Grafts		Apr05	06					Yes	
15360	090	N	Feb05	24	Free Skin Grafts	FF32	Apr05	06	ASPS, ABA	3.87	3.87		Yes	
15361	ZZZ	N	Feb05	24	Free Skin Grafts	FF33	Apr05	06	ASPS, ABA	1.15	1.15		Yes	
15365	090	N	Feb05	24	Free Skin Grafts	FF34	Apr05	06	ASPS, ABA	4.15	4.15		Yes	
15366	ZZZ	N	Feb05	24	Free Skin Grafts	FF35	Apr05	06	ASPS, ABA	1.45	1.45		Yes	
15400	090	R	Feb05	24	Free Skin Grafts	FF36	Apr05	06	ASPS, ABA	3.99	3.99	Yes	Yes	
15401	ZZZ	R	Feb05	24	Free Skin Grafts	FF37	Apr05	06	ASPS, ABA	1.00	1.00	Yes	Yes	
15420	090	N	Feb05	24	Free Skin Grafts	FF38	Apr05	06	ASPS, ABA	4.50	4.50		Yes	
15421	ZZZ	N	Feb05	24	Free Skin Grafts	FF39	Apr05	06	ASPS, ABA	1.50	1.50		Yes	

CPT Code	Global Coding Period	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
15430	090	N	Feb05	24	Free Skin Grafts	FF40	Apr05	06	ASPS, ABA	5.75	5.75		Yes	
15431	ZZZ	N	Feb05	24	Free Skin Grafts	FF41	Apr05	06	ASPS, ABA				Yes	Carrier Priced
15810	090	D	Feb05	26	Salabrasion		Deleted						Yes	
15811	090	D	Feb05	26	Salabrasion		Deleted						Yes	
16010	000	D	Feb05	24	Free Skin Grafts		Apr05	06					Yes	
16015	000	D	Feb05	24	Free Skin Grafts		Apr05	06					Yes	
16020	000	R	Feb05	24	Free Skin Grafts	FF42	Apr05	06	ASPS, ABA	0.80	0.80	Yes	Yes	
16025	000	R	Feb05	24	Free Skin Grafts	FF43	Apr05	06	ASPS, ABA	1.85	1.85	Yes	Yes	
16030	000	R	Feb05	24	Free Skin Grafts	FF44	Apr05	06	ASPS, ABA	2.08	2.08	Yes	Yes	
19260	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE1	Apr05	07	STS	15.42	15.42	Yes	Yes	
19271	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE2	Apr05	07	STS	18.87	18.87	Yes	Yes	
19272	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE3	Apr05	07	STS	21.52	21.52	Yes	Yes	
21493	090	D	Aug04	12	Hyoid Larynx Fracture		Deleted						Yes	
21494	090	D	Aug04	12	Hyoid Larynx Fracture		Deleted						Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
22010	090	N	Feb05	27	Incision and Drainage Spinal Deep Abscess	HH1	Apr05	08	NASS, AANS/C NS, AAOS	11.05	11.05			Yes	
22015	090	N	Feb05	27	Incision and Drainage Spinal Deep Abscess	HH2	Apr05	08	NASS, AANS/C NS, AAOS	10.94	10.94			Yes	
22520	010	R	Feb05	110	Vertebral Augmentation - Kyphoplasty		Apr05	09	NASS, AAPM, AANS/C NS, SIR, ACR, ASA, ASNR, AAOS	8.90	8.90	Yes	Yes	Yes	Under Review-Five Year Review
22521	010	R	Feb05	110	Vertebral Augmentation - Kyphoplasty		Apr05	09	NASS, AAPM, AANS/C NS, SIR, ACR, ASA, ASNR, AAOS	8.33	8.33	Yes	Yes	Yes	Under Review-Five Year Review

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue Tab	Issue	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
22522	ZZZ	R	Feb05	110	Vertebral Augmentation - Kyphoplasty		Apr05	09	NASS, AAPM, AANS/C NS, SIR, ACR, ASA, ASNR, AAOS	4.30	4.30	Yes	Yes	Under Review-Five Year Review
22523	010	N	Feb05	110	Vertebral Augmentation - Kyphoplasty	M1	Apr05	09	NASS, AAPM, AANS/C NS, SIR, ACR, ASA, ASNR, AAOS	8.94	8.94		Yes	
22524	010	N	Feb05	110	Vertebral Augmentation - Kyphoplasty	M2	Apr05	09	NASS, AAPM, AANS/C NS, SIR, ACR, ASA, ASNR, AAOS	8.54	8.54		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
22525	ZZZ	N	Feb05	110	Vertebral Augmentation - Kyphoplasty	M3	Apr05	09	NASS, AAPM, AANS/CNS, SIR, ACR, ASA, ASNR, AAOS	4.67	4.47		Yes	
28890	090	N	Nov04	04	High Energy Extracorporeal Shock Wave Therapy	N1	Feb05	08	APMA, AOFAS, AAOS	4.50	3.30		Yes	
29866	090	R	Feb05	28	Osteochondral Procedures		Feb05		Editorial	13.88	13.88	Yes	Yes	
29867	090	R	Feb05	28	Osteochondral Procedures		Feb05		Editorial	17.00	17.00	Yes	Yes	
29868	090	R	Feb05	28	Osteochondral Procedures		Feb05		Editorial	23.59	23.59	Yes	Yes	
30130	090	R	Nov04	10	Inferior Turbinate Procedures	O1	Feb05	09	AAO-HNS	3.37	3.37	Yes	Yes	
30140	090	R	Nov04	10	Inferior Turbinate Procedures	O2	Feb05	09	AAO-HNS	3.42	3.42	Yes	Yes	
30801	010	R	Nov04	10	Inferior Turbinate Procedures	O3	Feb05	09	AAO-HNS	1.09	1.09	Yes	Yes	
30802	010	R	Nov04	10	Inferior Turbinate Procedures	O4	Feb05	09	AAO-HNS	2.03	2.03	Yes	Yes	
30930	010	R	Nov04	10	Inferior Turbinate Procedures	O5	Feb05	09	AAO-HNS	1.26	1.26	Yes	Yes	
31526	000	R	Feb05	05	Laryngeal Telescope		Feb05		Editorial	2.57	2.57	Yes	Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
31531	000	R	Feb05	05	Laryngeal Telescope					3.58	3.58	Yes	Yes	
31536	000	R	Feb05	05	Laryngeal Telescope					3.55	3.55	Yes	Yes	
31541	000	R	Feb05	05	Laryngeal Telescope					4.52	4.52	Yes	Yes	
31561	000	R	Feb05	05	Laryngeal Telescope					5.99	5.99	Yes	Yes	
31571	000	R	Feb05	05	Laryngeal Telescope					4.26	4.26	Yes	Yes	
31585	090	D	Aug04	12	Hyoid Larynx Fracture								Yes	
31586	090	D	Aug04	12	Hyoid Larynx Fracture								Yes	
32002	000	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07 STS		2.19	2.19	Yes	Yes	
32020	000	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07 STS		3.97	3.97	Yes	Yes	
32100	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07 STS		15.22	15.22	Yes	Yes	
32440	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE4	Apr05	07 STS		24.96	24.96	Yes	Yes	
32442	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE5	Apr05	07 STS		26.20	26.20	Yes	Yes	
32445	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE6	Apr05	07 STS		25.05	25.05	Yes	Yes	
32480	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE7	Apr05	07 STS		23.71	23.71	Yes	Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
32482	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE8	Apr05	07	STS	24.96	24.96	Yes	Yes		
32484	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE9	Apr05	07	STS	20.66	20.66	Yes	Yes		
32486	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE10	Apr05	07	STS	23.88	23.88	Yes	Yes		
32488	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE11	Apr05	07	STS	25.67	25.67	Yes	Yes		
32491	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE12	Apr05	07	STS	21.22	21.22	Yes	Yes		
32500	090	R	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE13	Apr05	07	STS	21.97	21.97	Yes	Yes		
32503	090	N	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE14	Apr05	07	STS	30.00	30.00			Yes	
32504	090	N	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection	EEE15	Apr05	07	STS	34.80	34.80			Yes	
32520	090	D	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07						Yes	
32522	090	D	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07						Yes	
32525	090	D	Feb05	06	Apical Lung Tumor Resection/Lung and Chest Wall Resection		Apr05	07						Yes	

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33478	090	R	Aug04	17	Cavopulmonary Shunting		Apr05	12	STS	26.70	26.70	Yes	Yes
33502	090	R	Aug04	15	Coronary Artery Anomaly Unroofing		Apr05	10		21.01	21.01	Yes	Yes
33503	090	R	Aug04	15	Coronary Artery Anomaly Unroofing		Apr05	10		21.75	21.75	Yes	Yes
33504	090	R	Aug04	15	Coronary Artery Anomaly Unroofing		Apr05	10		24.62	24.62	Yes	Yes
33505	090	R	Aug04	15	Coronary Artery Anomaly Unroofing		Apr05	10		26.80	26.80	Yes	Yes
33506	090	R	Aug04	15	Coronary Artery Anomaly Unroofing		Apr05	10		35.45	35.45	Yes	Yes
33507	090	N	Aug04	15	Coronary Artery Anomaly Unroofing	D1	Apr05	10	STS	30.00	30.00		Yes
33548	090	N	Aug04	16	Ventricular Restoration	E1	Apr05	11	STS	37.97	37.97	Yes	Interim - to be reviewed Sept05
33617	090	R	Aug04	17	Cavopulmonary Shunting		Apr05	12	STS	36.94	36.94	Yes	Yes
33767	090	R	Aug04	17	Cavopulmonary Shunting		Apr05	12	STS	24.46	24.46	Yes	Yes
33768	090	N	Aug04	17	Cavopulmonary Shunting	F1	Apr05	12	STS	8.00	8.00	Yes	Yes
33880	090	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II1	Apr05	14	SVS, SIR, ACR	33.00	33.00		Yes
33881	090	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II2	Apr05	14	SVS, SIR, ACR	28.00	28.00		Yes
33883	090	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II3	Apr05	14	SVS, SIR, ACR	20.00	20.00		Yes

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33884	ZZZ	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II4	Apr05	14	SVS, SIR, ACR	8.20	8.20			Yes	
33886	090	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II5	Apr05	14	SVS, SIR, ACR	17.00	17.00			Yes	
33889	000	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II6	Apr05	14	SVS, SIR, ACR	15.92	15.92			Yes	
33891	000	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II7	Apr05	14	SVS, SIR, ACR	20.00	20.00			Yes	
33918	090	D	Aug04	19	Repair of Pulmonary Artery Arborization Anomaly		Apr05	13						Yes	
33919	090	D	Aug04	19	Repair of Pulmonary Artery Arborization Anomaly		Apr05	13						Yes	
33925	090	N	Aug04	19	Repair of Pulmonary Artery Arborization Anomaly	G1	Apr05	13	STS	29.50	29.50			Yes	
33926	090	N	Aug04	19	Repair of Pulmonary Artery Arborization Anomaly	G2	Apr05	13	STS	42.00	42.00			Yes	
34833	000	R	Feb05	33	Descending Thoracic Aorta Endovascular Repair		Apr05	14	SVS, SIR, ACR	11.98	11.98	Yes		Yes	
34834	000	R	Feb05	33	Descending Thoracic Aorta Endovascular Repair		Apr05	14	SVS, SIR, ACR	5.34	5.34	Yes	Yes	Yes	

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35601	090	R	Feb05	33	Descending Thoracic Aorta Endovascular Repair		Apr05	14	SVS, SIR, ACR	17.47	17.47	Yes	Yes	
35691	090	R	Feb05	33	Descending Thoracic Aorta Endovascular Repair		Apr05	14	SVS, SIR, ACR	18.02	18.02	Yes	Yes	
35694	090	R	Feb05	33	Descending Thoracic Aorta Endovascular Repair		Apr05	14	SVS, SIR, ACR	19.13	19.13	Yes	Yes	
36598	000	N	Nov04	16	Radiologic Venous Catheter Evaluation	P1	Feb05	06	SIR, ACR	0.88	0.74		Yes	
37184	000	N	Feb05	07	Mechanical Thrombectomy	KK1	Apr05	15	SVS, SIR, ACR	8.66	8.66		Yes	
37185	ZZZ	N	Feb05	07	Mechanical Thrombectomy	KK2	Apr05	15	SVS, SIR, ACR	3.28	3.28		Yes	
37186	ZZZ	N	Feb05	07	Mechanical Thrombectomy	KK3	Apr05	15	SVS, SIR, ACR	4.92	4.92		Yes	
37187	000	N	Feb05	07	Mechanical Thrombectomy	KK4	Apr05	15	SVS, SIR, ACR	8.03	8.03		Yes	
37188	000	N	Feb05	07	Mechanical Thrombectomy	KK5	Apr05	15	SVS, SIR, ACR	5.71	5.71		Yes	

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37209	000	R	Feb05	07	Mechanical Thrombectomy		Apr05	15	SVS, SIR, ACR	2.27	2.27	Yes	Yes	Yes	
37700	090	R	Feb05	34	Saphenous Vein Removal		Apr05	16	SVS	3.72	3.72	Yes	Yes	Yes	
37718	090	N	Feb05	34	Saphenous Vein Removal	JJ1	Apr05	16	SVS	6.76	6.76			Yes	
37720	090	D	Feb05	34	Saphenous Vein Removal		Apr05	16						Yes	
37722	090	N	Feb05	34	Saphenous Vein Removal	JJ2	Apr05	16	SVS	7.79	7.79			Yes	
37730	090	D	Feb05	34	Saphenous Vein Removal		Apr05	16						Yes	
37735	090	R	Feb05	34	Saphenous Vein Removal		Apr05	16	SVS	10.51	10.51	Yes	Yes	Yes	
42325	090	D	Feb05	35	Oral Procedure Code		Deleted							Yes	
42326	090	D	Feb05	35	Oral Procedure Code		Deleted							Yes	
43638	090	D	Nov04	17	Partial Gastrectomy		Deleted							Yes	
43639	090	D	Nov04	17	Partial Gastrectomy		Deleted							Yes	
43770	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R1	Apr05	17	SAGES	16.71	16.71			Yes	
43771	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R2	Apr05	17	SAGES	19.50	19.50			Yes	
43772	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R3	Apr05	17	SAGES	15.00	15.00			Yes	
43773	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R4	Apr05	17	SAGES	19.50	19.50			Yes	

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43774	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R5	Apr05	17	SAGES		15.00	15.00		Yes	
43845	090	N	Nov03	R	Gastric Restrictive Procedures	L1	Apr05	5	SAGES		31.00	31.00		Yes	CPT 2005 Issue
43848	090	R	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band		Apr05	17	SAGES		29.35	29.35	Yes	Yes	
43886	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R6	Apr05	17	SAGES		4.00	4.00		Yes	
43887	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R7	Apr05	17	SAGES		3.95	3.95		Yes	
43888	090	N	Nov04	06	Laparoscopic Gastric Restrictive Procedure, with Gastric Band	R8	Apr05	17	SAGES		5.80	5.80		Yes	
44180	090	N	Nov04		Laparoscopic Enterolysis		Renumb				14.42	14.42		Yes	Renumbered from 44200
44186	090	N	Nov04		Laparoscopic Jejunostomy		Renumb				9.77	9.77		Yes	Renumbered from 44201
44187	090	N	Nov04	19	Laparoscopic Stoma	U1	Feb05	19	SAGES, ASCoRS		15.93	15.93		Yes	
44188	090	N	Nov04	19	Laparoscopic Stoma	U2	Feb05	19	SAGES, ASCoRS		18.00	17.61		Yes	
44200	090	D	Nov04		Laparoscopic Enterolysis		Deleted							Yes	
44201	090	D	Nov04		Laparoscopic Jejunostomy		Deleted							Yes	
44213	ZZZ	N	Nov04	18	Laparoscopic Splenic Flexure	T1	Feb05	18	SAGES, ASCoRS		3.50	3.50		Yes	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
44227	090	N	Nov04	18	Laparoscopic Enterostomy Closure	S1	Feb05	17	SAGES, ASCoRS	26.50	26.50			Yes	
44239	YYY	D	Nov04	23	Unlisted Laparoscopic Procedure		Deleted							Yes	
44310	090	R	Nov04	19	Laparoscopic Stoma		Feb05	19	SAGES, ASCoRS	15.93	15.93	Yes	Yes		
44320	090	R	Nov04	19	Laparoscopic Stoma		Feb05	19	SAGES, ASCoRS	17.61	17.61	Yes	Yes		
44620	090	R	Nov04	18	Laparoscopic Enterostomy Closure		Feb05	17	SAGES, ASCoRS	12.18	12.18	Yes	Yes		
44625	090	R	Nov04	18	Laparoscopic Enterostomy Closure		Feb05	17	SAGES, ASCoRS	15.03	15.03	Yes	Yes		
44626	090	R	Nov04	18	Laparoscopic Enterostomy Closure		Feb05	17	SAGES, ASCoRS	25.32	25.32	Yes	Yes		
45110	090	R	Nov04	20	Laparoscopic Proctectomy		Feb05	20	ASCoRS, SAGES	27.96	27.96	Yes	Yes		
45119	090	R	Nov04	20	Laparoscopic Proctectomy		Feb05	20	ASCoRS, SAGES	30.79	30.79	Yes	Yes		
45395	090	N	Nov04	20	Laparoscopic Proctectomy	V1	Feb05	20	ASCoRS, SAGES	30.50	30.50			Yes	
45397	090	N	Nov04	20	Laparoscopic Proctectomy	V2	Feb05	20	ASCoRS, SAGES	34.00	34.00			Yes	
45400	090	N	Nov04	21	Laparoscopic Proctopexy	W1	Feb05	21	ASCoRS, SAGES	18.06	18.06			Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
45402	090	N	Nov04	21	Laparoscopic Proctopexy	W2	Feb05	21	ASCoRS, SAGES	25.27	25.04			Yes	
45499	YYY	N	Nov04	23	Unlisted Laparoscopic Procedure				Renumb					Yes	Carrier Priced - Renumbered from 44239
45540	090	R	Nov04	21	Laparoscopic Proctopexy		Feb05	21	ASCoRS, SAGES	16.25	16.25	Yes	Yes		
45550	090	R	Nov04	21	Laparoscopic Proctopexy		Feb05	21	ASCoRS, SAGES	22.97	22.97	Yes	Yes		
45990	000	N	Feb05	36	Diagnostic Rectal Exam Under Anesthesia	LL1	Apr05	18	ASGS, ASCoRS	1.80	1.80			Yes	
46505	010	N	Nov04	25	Anal Sphincter Chemodenervation	X1	Feb05	23	ASCoRS	3.50	2.86			Yes	
46710	090	N	Nov04	26	Ileoanal Pouch Fistula Repair	Y1	Feb05	22	ASCoRS	18.00	16.00			Yes	
46712	090	N	Nov04	26	Ileoanal Pouch Fistula Repair	Y2	Feb05	22	ASCoRS	34.00	34.00			Yes	
50250	090	N	Feb05	38	Open Cryoablation of Renal Tumor	MM1	Apr05	19	AUA	19.97	19.97			Yes	
50382	000	N	Feb05	39	Ureteral Stent Exchange/Remove	NN1	Apr05	20	SIR, ACR	6.74	5.50			Yes	
50384	000	N	Feb05	39	Ureteral Stent Exchange/Remove	NN2	Apr05	20	SIR, ACR	5.30	5.00			Yes	
50387	000	N	Feb05	39	Ureteral Stent Exchange/Remove	NN3	Apr05	20	SIR, ACR	2.63	2.00			Yes	
50389	000	N	Feb05	39	Ureteral Stent Exchange/Remove	NN4	Apr05	20	SIR, ACR	1.10	1.10			Yes	

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50592	010	N	Nov04	D	Percutaneous Radiofrequency Ablation of Renal Tumors	OO1	Apr05	21	SIR, ACR	8.11	6.75			Yes	
50668	010	R	Feb05	39	Ureteral Stent Exchange/Remove		Apr05	20	SIR, ACR	1.17	1.17	Yes	Yes		
51999	YYY	N	Nov04	29	Unlisted Bladder Laproscopy				Carrier Pr					Yes	Carrier Priced
52647	090	R	Nov04	30	Laser Prostate Vaporization				Editorial	10.34	10.34	Yes	Yes		
52648	090	R	Nov04	30	Laser Prostate Vaporization				Editorial	11.19	11.19	Yes	Yes		
57295	090	N	Feb05	22	Revision-Removal of Vaginal Graft	PP1	Apr05	22	ACOG	7.45	7.45			Yes	
57421	000	R	Feb05	42	Endometrial Sampling		Apr05	23		2.20	2.20	Yes	Yes		
58100	000	R	Feb05	42	Endometrial Sampling		Apr05	23		1.53	1.53	Yes	Yes		
58110	ZZZ	N	Feb05	42	Endometrial Sampling	QQ1	Apr05	23	ACOG	0.77	0.77			Yes	
61630	090	N	Feb05	44	Intracranial Angioplasty and Stenting	RR1	Apr05	24	SIR, ACR, AANS/C NS, ASNR	21.50	21.08			Yes	
61635	090	N	Feb05	44	Intracranial Angioplasty and Stenting	RR2	Apr05	24	SIR, ACR, AANS/C NS, ASNR	23.50	23.08			Yes	

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61640	090	N	Feb05	44	Intracranial Angioplasty and Stenting	RR3	Apr05	24	SIR, ACR, AANS/CNS, ASNR	12.71	12.32			Yes	
61641	ZZZ	N	Feb05	44	Intracranial Angioplasty and Stenting	RR4	Apr05	24	SIR, ACR, AANS/CNS, ASNR	5.00	4.33			Yes	
61642	ZZZ	N	Feb05	44	Intracranial Angioplasty and Stenting	RR5	Apr05	24	SIR, ACR, AANS/CNS, ASNR	9.03	8.66			Yes	
64613	010	R	Feb05	92	Needle EMG with Chemodenervation	XX4	Apr05	31	AAN, AANEM, AAPMR, AAO-HNS	1.96	1.96	Yes	Yes		
64614	010	R	Feb05	92	Needle EMG with Chemodenervation	XX5	Apr05	31	AAN, AANEM, AAPMR	2.20	2.20	Yes	Yes		
64650	000	N	Nov04	31	Hyperhidrosis Chemodenervation	Z1	Apr05	25	AAN, AAD	0.70	0.70			Yes	
64653	000	N	Nov04	31	Hyperhidrosis Chemodenervation	Z4	Apr05	25	AAN, AAD	0.88	0.88			Yes	

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67901	090	R	Nov04	31	Blepharoptosis Repair, Harvest of Fascia	AA1	Apr05	26	AAO	7.39	7.39		Yes	
67902	090	R	Nov04	31	Blepharoptosis Repair, Harvest of Fascia	AA2	Apr05	26	AAO	9.35	9.35		Yes	
69410	000	D	Aug04	20	Middle Ear Baffle Technique		Deleted						Yes	
75900	XXX	R	Feb05	07	Mechanical Thrombectomy		Apr05	15	SVS, SIR, ACR	0.49	0.49	Yes	Yes	
75956	XXX	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II8	Apr05	14	SVS, SIR, ACR	7.00	7.00		Yes	
75957	XXX	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II9	Apr05	14	SVS, SIR, ACR	6.00	6.00		Yes	
75958	XXX	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II10	Apr05	14	SVS, SIR, ACR	4.00	4.00		Yes	
75959	XXX	N	Feb05	33	Descending Thoracic Aorta Endovascular Repair	II11	Apr05	14	SVS, SIR, ACR	3.50	3.50		Yes	
76012	XXX	R	Feb05	110	Vertebral Augmentation - Kyphoplasty		Apr05	09	NASS, AAPM, AANS/C NS, SIR, ACR, ASA, ASNR, AAOS	1.31	1.31	Yes	Yes	

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76013	XXX	R	Feb05	110	Vertebral Augmentation - Kyphoplasty		Apr05	09	NASS, AAPM, AANS/C, NS, SIR, ACR, ASA, ASNR, AAOS	1.38	1.38	Yes	Yes	Yes	
76375	XXX	D	Feb05	48	3D Image Rendering		Apr05	27						Yes	
76376	XXX	N	Feb05	48	3D Image Rendering	SS1	Apr05	27	ACR	0.20	0.20			Yes	
76377	XXX	N	Feb05	48	3D Image Rendering	SS2	Apr05	27	ACR	0.79	0.79			Yes	
77412	XXX	R	Nov04	A4	Neutron Therapy		Feb05	26		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
77413	XXX	R	Nov04	A4	Neutron Therapy		Feb05	26		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
77414	XXX	R	Nov04	A4	Neutron Therapy		Feb05	26		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
77416	XXX	R	Nov04	A4	Neutron Therapy		Feb05	26		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
77421	XXX	N	Feb05	30	Stereoscopic X-Ray Guidance	TT2	Apr05	28	ASTRO, ACR	0.39	0.39			Yes	
77422	XXX	N	Nov04	A4	Neutron Therapy	BB1	Feb05	26	ASTRO	0.00	0.00			Yes	PE Inputs Only
77423	XXX	N	Nov04	A4	Neutron Therapy	BB2	Feb05	26	ASTRO	0.00	0.00			Yes	PE Inputs Only
78160	XXX	D	Feb05	51	Radioactive Iron-Fibrinogen Studies		Deleted							Yes	
78162	XXX	D	Feb05	51	Radioactive Iron-Fibrinogen Studies		Deleted							Yes	

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78170	XXX	D	Feb05	51	Radioactive Iron-Fibrinogen Studies		Deleted						Yes	
78172	XXX	D	Feb05	51	Radioactive Iron-Fibrinogen Studies		Deleted						Yes	
78455	XXX	D	Feb05	51	Radioactive Iron-Fibrinogen Studies		Deleted						Yes	
80195	XXX	N	Feb05	55	Sirolimus Therapeutic Drug Assay		CLFS						No	
82270	XXX	N	Nov04	A6	Fecal Occult Blood Testing		CLFS						No	
82271	XXX	N	Nov04	A6	Fecal Occult Blood Testing		CLFS						No	
83036	XXX	R	Feb05	09	Glycosylated Hemoglobin Test		CLFS						No	
83037	XXX	R	Feb05	09	Glycosylated Hemoglobin Test		CLFS						No	
83630	XXX	R	Feb05	09	Quantitative Lactoferrin		CLFS						No	
83631	XXX	N	Feb05	09	Quantitative Lactoferrin		CLFS						No	
83695	XXX	N	Feb05	61	Lipoprotein(a) Quantitative Direct Measurement		CLFS						No	
83700	XXX	N	Feb05	62	Lipoprotein Procedures		CLFS						No	Renumbered from 83715
83701	XXX	N	Feb05	62	Lipoprotein Procedures		CLFS						No	Renumbered from 83716
83704	XXX	N	Feb05	62	Lipoprotein Procedures		CLFS						No	
83715	XXX	D	Feb05	62	Lipoprotein Procedures		Deleted						No	
83716	XXX	D	Feb05	62	Lipoprotein Procedures		Deleted						No	
83890	XXX	R	Feb05	11	Molecular Diagnostic Testing Component Procedures		CLFS						No	



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83898	XXX	R	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83900	XXX	N	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83901	XXX	R	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83907	XXX	N	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83908	XXX	N	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83909	XXX	N	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
83914	XXX	N	Feb05	10	Molecular Diagnostic Testing Component Procedures		CLFS						No	
84238	XXX	R	Feb05	65	Acetylcholine Receptor Antibody		CLFS						No	
86064	XXX	D	Feb05	F	Quantitative Flow Codes for T Cells		Deleted						No	
86200	XXX	N	May04	19	ELISA Detections - Cyclic Citrullinated Peptide		CLFS						No	
86355	XXX	N	Feb05	F	Quantitative Flow Codes for T Cells		CLFS						No	
86357	XXX	N	Feb05	F	Quantitative Flow Codes for T Cells		CLFS						No	
86367	XXX	N	Feb05	F	Quantitative Flow Codes for T Cells		CLFS						No	
86379	XXX	D	Feb05	F	Quantitative Flow Codes for T Cells		Deleted						No	
86480	XXX	N	Feb05	111	Tuberculin Invitro Testing		CLFS						No	

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86585	XXX	D	Nov04	A9	TB Tine Test		CLFS					No	
86587	XXX	D	Feb05	F	Quantitative Flow Codes for T Cells		Deleted					No	
86923	XXX	N	Feb05	71	Electronic Crossmatch		CLFS					No	
86960	XXX	N	Feb05	68	Platelet Volume Reduction		CLFS					No	
87209	XXX	N	Feb05	76	Trichrome Stain		CLFS					No	
87900	XXX	N	Feb05	98	Infectious Agent Genotype Analysis Nucleic Acid HIV-1		CLFS					No	
87904	XXX	R	Nov04	A9	Nucleic Acid Infections Agent Phenotype-Drug Resistance Analysis		CLFS					No	
88175	XXX	R	Nov04	A13	Limited Cytopathology Re-Screening		CLFS					No	
88333	XXX	N	Feb05	75	Intraoperative Consult and Touch Prep	UU1	Apr05	29 CAP	1.20	1.20		Yes	
88334	XXX	N	Feb05	75	Intraoperative Consult and Touch Prep	UU2	Apr05	29 CAP	0.80	0.80		Yes	
88384	XXX	N	Feb05	11	Multiple Molecular Marker Array-Based Evaluation	VV1	Apr05	30 CAP				Yes	Carrier Priced
88385	XXX	N	Feb05	11	Multiple Molecular Marker Array-Based Evaluation	VV2	Apr05	30 CAP	1.50	1.50		Yes	
88386	XXX	N	Feb05	11	Multiple Molecular Marker Array-Based Evaluation	VV3	Apr05	30 CAP	1.88	1.88		Yes	
89049	XXX	N	Nov04	A15	Caffeine Halothane Contracture Test	C1	Feb05	27 ASA	1.40	1.40		Yes	
90649	XXX	N	Feb05	78-9	Human Papilloma Virus		Vaccine					No	
90680	XXX	R	Nov04	A16	Rotavirus Vaccine		Vaccine					No	

CPT Code	Global Coding	CPT Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
90713	XXX	R	Nov04	A18	Intramuscular Polio Vaccine Injection									No	
90714	XXX	N	Nov04	B9	Thimerosal Reduced Diphtheria Vaccine									No	
90715	XXX	R	Nov04	A17	Tetanus Diphtheria Toxoid & Acellular Pertussis Vaccine Booster									No	
90736	XXX	N	Feb05	78-9	Zoster Vaccine									No	
90760	XXX	N	Aug04	07	Drug Administration - Hydration	H1	Oct04	12	ACRh, ADSA, ASH, ASCO, AGA	0.17	0.17			Yes	
90761	ZZZ	N	Aug04	07	Drug Administration - Hydration	H2	Oct04	12	ACRh, ADSA, ASH, ASCO, AGA	0.13	0.09			Yes	
90765	XXX	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Infusions	H3	Oct04	12	IDSA, ASH, ASCO	0.24	0.21			Yes	
90766	ZZZ	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Infusions	H5	Oct04	12	IDSA, ASH, ASCO	0.21	0.18			Yes	
90767	ZZZ	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Infusions	H4	Oct04	12	IDSA, ASH, ASCO	0.21	0.19			Yes	

CPT Code	Global Coding Period	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
90768	ZZZ	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Infusions	H6	Oct04	12	IDSA, ASH, ASCO	0.17	0.17		Yes	
90772	XXX	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	H7	Oct04	12	ACRrh, ASH, ASCO, ACG	0.17	0.17		Yes	
90773	XXX	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	H8	Oct04	12	ACRrh, ASH, ASCO, ACG				Yes	No RUC Recommendation
90774	XXX	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	H9	Oct04	12	ACRrh, ASH, ASCO, ACG	0.20	0.17		Yes	
90775	ZZZ	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	H10	Oct04	12	ACRrh, ASH, ASCO, ACG	0.16	0.10		Yes	
90779	YYY	N	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections		Oct04	12					Yes	Carrier Priced
90780	XXX	D	Aug04	07	Drug Administration - Hydration		Oct04	12	ACRrh, ADSA, ASH, ASCO, AGA				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 as last year?	RVU	MFS	Comments
90781	ZZZ	D	Aug04	07	Drug Administration - Hydration	Oct04	12	ACR <sub>h</sub> , ADSA, ASH, ASCO. AGA					Yes
90782	XXX	D	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	Oct04	12						Yes
90783	XXX	D	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	Oct04	12						Yes
90784	XXX	D	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	Oct04	12						Yes
90788	XXX	D	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	Oct04	12						Yes
90799	YYY	D	Aug04	07	Drug Administration - Therapeutic and Diagnostic Injections	Oct04	12						Yes
90870	000	R	Feb05	81	Electroconvulsive Therapy	Editorial			1.88	<b>1.88</b>	Yes	Yes	
90871	000	D	Feb05	81	Electroconvulsive Therapy	Deleted							Yes
90939	XXX	D	Feb05	83	Hemodialysis Access Flow Study	Deleted							Yes
90940	XXX	R	Feb05	83	Hemodialysis Access Flow Study	Editorial			0.00	<b>0.00</b>	Yes	Yes	
91022	000	N	Aug04	08	Antroduodenal Manometry	11	Feb05	28	ASGE, AGA, ACG	1.50	<b>1.44</b>		Yes
92330	XXX	D	Nov04	A20	Ocular Prosthetics	Deleted							Yes

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
92335	XXX	D	Nov04	A20	Ocular Prosthetics			Deleted						Yes	
92390	XXX	D	Aug04	24	Supply of Ophthalmological Materials			Deleted						Yes	
92391	XXX	D	Aug04	24	Supply of Ophthalmological Materials			Deleted						Yes	
92392	XXX	D	Aug04	24	Supply of Ophthalmological Materials			Deleted						Yes	
92393	XXX	D	Aug04	24	Supply of Ophthalmological Materials			Deleted						Yes	
92395	XXX	D	Aug04	24	Supply of Ophthalmological Materials			Deleted						Yes	
92396	XXX	D	Aug04	24	Supply of Ophthalmological Materials			Deleted						Yes	
92520	XXX	R	May04	07	Laryngeal Function Studies	B1	Feb05	10	ASHA, AAO-HNS	0.75	0.75			Yes	
92568	XXX	R	Feb05	84	Acoustic Reflex Threshold			Editorial		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
92569	XXX	R	Feb05	84	Acoustic Reflex Threshold			Editorial		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
95250	XXX	R	Aug04	26	Continuous Glucose Monitoring		Feb05	29		0.00	0.00	Yes	Yes	Yes	PE Inputs Only
95251	XXX	N	Aug04	26	Continuous Glucose Monitoring	J1	Feb05	29	AACE	0.85	0.85			Yes	
95858	XXX	D	Nov04	A22	Tensilon Test			Deletion						Yes	
95865	XXX	N	Feb05	91	Complex EMG	YY4	Apr05	A	AAN, AANEM, AAPMR, AAO-HNS	1.57	1.57			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 as last year?	RVU	MFS	Comments
95866	XXX	N	Feb05	91	Complex EMG	YY5	Apr05	A	AAN, AANEM, AAPMR	1.25	1.25		Yes
95867	XXX	R	Feb05	91	Complex EMG	YY1	Apr05	A	AAN, AANEM, AAPMR	0.79	0.79	Yes	Yes
95868	XXX	R	Feb05	91	Complex EMG	YY2	Apr05	A	AAN, AANEM, AAPMR	1.18	1.18	Yes	Yes
95870	XXX	R	Feb05	91	Complex EMG	YY3	Apr05	A	AAN, AANEM, AAPMR	0.37	0.37	Yes	Yes
95873	ZZZ	N	Feb05	92	Needle EMG with Chemodenervation	XX1	Apr05	31	AAN, AANEM, AAPMR	0.96	0.56		Yes
95874	ZZZ	N	Feb05	92	Needle EMG with Chemodenervation	XX2	Apr05	31	AAN, AANEM, AAPMR	0.96	0.56		Yes
96400	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12					Yes
96401	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H11	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG	0.21	0.21		Yes

CPT Code	Global Coding Period	CPT Change	CPT Issue Date	CPT Issue Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
96402	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H12	Oct04	12	ACR <sub>h</sub> , AUA, ASH, ASCO, AGA, ACG	0.19	0.19			Yes	
96405	000	R	Aug04	07	Drug Administration - Chemotherapy		Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	0.52	0.52	Yes	Yes		
96406	000	R	Aug04	07	Drug Administration - Chemotherapy		Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	0.80	0.80	Yes	Yes		
96408	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12						Yes	
96409	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H13	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	0.27	0.24			Yes	
96410	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12						Yes	
96411	ZZZ	N	Aug04	07	Drug Administration - Chemotherapy	H14	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	0.23	0.20			Yes	

CPT Code	Global Coding Period	Coding Change	CPT Date	Issue Date	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
96412	ZZZ	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12						Yes	
96413	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H15	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG	0.31	0.28			Yes	
96414	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12						Yes	
96415	ZZZ	N	Aug04	07	Drug Administration - Chemotherapy	H16	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG	0.22	0.19			Yes	
96416	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H17	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG	0.24	0.21			Yes	
96417	ZZZ	N	Aug04	07	Drug Administration - Chemotherapy	H18	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG	0.24	0.21			Yes	
96420	XXX	R	Aug04	07	Drug Administration - Chemotherapy	H19	Oct04	12	ACRrh, ASH, ASCO, AGA, ACG					Yes	No RUC Recommendation

CPT Code	Global Coding Period	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
96422	XXX	R	Aug04	07	Drug Administration - Chemotherapy	H20	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG				Yes	No RUC Recommendation
96423	ZZZ	R	Aug04	07	Drug Administration - Chemotherapy	H21	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG				Yes	No RUC Recommendation
96425	XXX	R	Aug04	07	Drug Administration - Chemotherapy	H22	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG				Yes	No RUC Recommendation
96450	000	R	Aug04	07	Drug Administration - Chemotherapy	H23	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	1.53	1.53		Yes	
96520	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12					Yes	
96521	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H24	Oct04	12	ACR <sub>h</sub> , ASH, ASCO, AGA, ACG	0.24	0.21		Yes	



CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
96522	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H26	Oct04	12	ACRrh, ASH, ASCO, AGA	0.24	0.21			Yes	
96523	XXX	N	Aug04	07	Drug Administration - Chemotherapy	H25	Oct04	12	ACRrh, ASH, ASCO, AGA	0.04	0.04			Yes	
96530	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12						Yes	
96542	XXX	R	Aug04	07	Drug Administration - Chemotherapy	H27	Oct04	12	ACRrh, ASH, ASCO, AGA	0.75	0.75			Yes	
96545	XXX	D	Aug04	07	Drug Administration - Chemotherapy		Oct04	12						Yes	
97020	XXX	D	Nov04	A26	Physical Therapy Modality - Microwave		Deleted							Yes	
97024	XXX	R	Nov04	A26	Physical Therapy Modality - Microwave		Editorial			0.06	0.06	Yes	Yes		
97504	XXX	D	Feb05	95	Orthotic and Prosthetic Management		Deleted							Yes	
97542	XXX	R	Nov04	A27	Wheelchair Management		Editorial			0.45	0.45	Yes	Yes		
97703	XXX	D	Feb05	95	Orthotic and Prosthetic Management		Deleted							Yes	
97760	XXX	N	Feb05	95	Orthotic and Prosthetic Management		Renumb			0.45	0.45			Yes	Renumbered from 97504
97761	XXX	N	Feb05	95	Orthotic and Prosthetic Management		Renumb			0.45	0.45			Yes	Renumbered from 97520

CPT Code	Global Coding	CPT Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
97762	XXX	N	Feb05	95	Orthotic and Prosthetic Management		Renumb			0.25	0.25		Yes	Renumbered from 97703
97810	XXX	R	Aug04	M	Acupuncture		Editorial			0.00	0.00	Yes	Yes	
97811	ZZZ	R	Aug04	M	Acupuncture		Editorial			0.00	0.00	Yes	Yes	
97813	XXX	R	Aug04	M	Acupuncture		Editorial			0.00	0.00	Yes	Yes	
97814	ZZZ	R	Aug04	M	Acupuncture		Editorial			0.00	0.00	Yes	Yes	
98960	XXX	N	Aug04	09	Education and Training for Patient Self Management	K1	Feb05	30 AACE, ADiA		0.00	0.00		Yes	PE Inputs Only
98961	XXX	N	Feb05	1	Education and Training for Patient Self Management	K2	Apr05	B AACE, ADiA		0.00	0.00		Yes	PE Inputs Only
98962	XXX	N	Feb05	1	Education and Training for Patient Self Management	K3	Apr05	B AACE, ADiA		0.00	0.00		Yes	PE Inputs Only
99050	XXX	R	Feb04	14	Special Services, Procedures and Reports		Not MFS						No	
99051	XXX	N	Feb04	14	Special Services, Procedures and Reports		Not MFS						No	
99052	XXX	D	Feb05	14	Special Services, Procedures and Reports		Deleted						No	
99053	XXX	N	Feb05	14	Special Services, Procedures and Reports		Not MFS						No	
99054	XXX	D	Feb05	14	Special Services, Procedures and Reports		Deleted						No	
99056	XXX	R	Feb05	14	Special Services, Procedures and Reports		Not MFS						No	
99058	XXX	R	Feb05	14	Special Services, Procedures and Reports		Not MFS						No	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments	
99060	XXX	N	Feb05	14	Special Services, Procedures and Reports									Not MFS	No
99141	XXX	D	Feb05	15	Moderate (Conscious) Sedation		Apr05	C							Yes
99142	XXX	D	Feb05	15	Moderate (Conscious) Sedation		Apr05	C							Yes
99143	XXX	N	Feb05	15	Moderate (Conscious) Sedation	FFF1	Apr05	C	AAOMS, ACEP, AAP, NASS	0.85	0.70				Yes
99144	XXX	N	Feb05	15	Moderate (Conscious) Sedation	FFF2	Apr05	C	AAOMS, ACEP, AAP, NASS	0.80	0.66				Yes
99145	ZZZ	N	Feb05	15	Moderate (Conscious) Sedation	FFF3	Apr05	C	AAOMS, ACEP, AAP, NASS	0.27	0.23				Yes
99148	XXX	N	Feb05	15	Moderate (Conscious) Sedation	FFF4	Apr05	C	AAOMS, ACEP, AAP, NASS	1.84	1.75				Yes
99149	XXX	N	Feb05	15	Moderate (Conscious) Sedation	FFF5	Apr05	C	AAOMS, ACEP, AAP, NASS	1.73	1.64				Yes
99150	ZZZ	N	Feb05	15	Moderate (Conscious) Sedation	FFF6	Apr05	C	AAOMS, ACEP, AAP, NASS	0.47	0.47				Yes

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99261	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99262	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99263	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99271	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99272	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99273	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99274	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99275	XXX	D	Nov04	D7	Elimination of Inpatient Follow-up and Confirmatory Consultation		Apr05	H						Yes	
99298	XXX	R	Feb05	18	Continuing Neonatal Intensive Care Services		Apr05	D		2.75	2.75	Yes	Yes		
99299	XXX	R	Feb05	18	Continuing Neonatal Intensive Care Services		Apr05	D		2.50	2.50	Yes	Yes		
99300	XXX	N	Feb05	18	Continuing Neonatal Intensive Care Services	AAA1	Apr05	D	AAP	2.40	2.40		Yes		
99301	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	
99302	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	

CPT Code	Global	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
99303	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	
99304	XXX	N	Feb05	19	Nursing Facility Services	BBB1	Apr05	E	AMDA, AAFP	1.20	1.20			Yes	
99305	XXX	N	Feb05	19	Nursing Facility Services	BBB2	Apr05	E	AMDA, AAFP	1.61	1.61			Yes	
99306	XXX	N	Feb05	19	Nursing Facility Services	BBB3	Apr05	E	AMDA, AAFP	2.01	2.01			Yes	
99307	XXX	N	Feb05	19	Nursing Facility Services	BBB4	Apr05	E	AMDA, AAFP	0.60	0.60			Yes	
99308	XXX	N	Feb05	19	Nursing Facility Services	BBB5	Apr05	E	AMDA, AAFP	1.00	1.00			Yes	
99309	XXX	N	Feb05	19	Nursing Facility Services	BBB6	Apr05	E	AMDA, AAFP	1.42	1.42			Yes	
99310	XXX	N	Feb05	19	Nursing Facility Services	BBB7	Apr05	E	AMDA, AAFP	1.77	1.77			Yes	
99311	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	
99312	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	
99313	XXX	D	Feb05	19	Nursing Facility Services		Apr05	E						Yes	
99318	XXX	N	Feb05	19	Nursing Facility Services	BBB8	Apr05	E	AMDA, AAFP	1.20	1.20			Yes	
99321	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	E						Yes	
99322	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	E						Yes	
99323	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	E						Yes	

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
99324	XXX	N	Feb05	20	Domiciliary Care Services	CCC1	Apr05	F	APMA, AGS	1.01	1.01	Yes	
99325	XXX	N	Feb05	20	Domiciliary Care Services	CCC2	Apr05	F	APMA, AGS	1.52	1.52	Yes	
99326	XXX	N	Feb05	20	Domiciliary Care Services	CCC3	Apr05	F	AGS	2.27	2.27	Yes	
99327	XXX	N	Feb05	20	Domiciliary Care Services	CCC4	Apr05	F	AGS	3.03	3.03	Yes	
99328	XXX	N	Feb05	20	Domiciliary Care Services	CCC5	Apr05	F	AGS	3.78	3.78	Yes	
99331	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	F				Yes	
99332	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	F				Yes	
99333	XXX	D	Feb05	20	Domiciliary Care Services		Apr05	F				Yes	
99334	XXX	N	Feb05	20	Domiciliary Care Services	CCC6	Apr05	F	AGS	0.76	0.76	Yes	
99335	XXX	N	Feb05	20	Domiciliary Care Services	CCC7	Apr05	F	AGS	1.26	1.26	Yes	
99336	XXX	N	Feb05	20	Domiciliary Care Services	CCC8	Apr05	F	AGS	2.02	2.02	Yes	
99337	XXX	N	Feb05	20	Domiciliary Care Services	CCC9	Apr05	F	AGS	3.03	3.03	Yes	
99339	XXX	N	Feb05	22	Care Plan Oversight	DDD1	Apr05	G	AAP, AGS	1.25	1.25	Yes	
99340	XXX	N	Feb05	22	Care Plan Oversight	DDD2	Apr05	G	AAP, AGS	1.80	1.80	Yes	

## Specialty and Acronym

<u>Society</u>	<u>Acronym</u>
AMA CPT Editorial Panel	AMA/CPT
AMA Staff	AMA
AMA Staff	AMA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology	AAD
American Academy of Facial Plastic and Reconstructive Surgery	AAFPRS
American Academy of Family Physicians	AAFP
American Academy of Hospice and Palliative Medicine	AAHPM
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
American Academy of Pediatrics	AAP
American Academy of Pharmaceutical Physicians	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 Neuromuscular and Electrodiagnostic Medicine	AANEM
American Association of Plastic Surgeons	AAPS
American Burn Association	ABA
American Chiropractic Association	ACA

**Society****Acronym**

American Clinical Neurophysiology Society	ACNS
American College of Cardiology	ACC
American College of Chest Physicians	ACCP
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 <sub>h</sub>
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

**Society****Acronym**

American Psychological Association	APA
American Roentgen Ray Society	ARRS
American Society for Dermatologic Surgery	ASDS
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society for Therapeutic Radiology and Oncology	ASTRO
American Society of Abdominal Surgeons	ASAS
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Cataract and Refractive Surgery	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 Neuroimaging	ASN
American Society of Neuroradiology	ASNR
American Society of Neuroradiology	ASNR
American Society of Ophthalmic Plastic and Reconstructive Surgery	ASOPRS
American Society of Plastic Surgeons	ASPS
American Society of Transplant Surgeons	ASTS
American Speech, Language, and Hearing Association	ASHA
American Thoracic Society	ATS
American Urological Association	AUA
Association Military Surgeons of the U.S.	AMSUS
Centers for Medicare and Medicaid Services	CMS
CMD	CMD
College of American Pathologists	CAP

**Society**

**Acronym**

Congress of Neurological Surgeons  
Consultants  
Consultants  
Consultants  
Consultants  
Contact Lens Society of America  
Former PEAC Members  
Former RUC Members

CNS  
Abt  
CMS  
consultant  
PPRC  
CLSA  
AAO-HNS  
AAOS  
ACC  
ACOG  
ACRr  
ACS  
ANA  
ASC  
ASCO  
RPA  
AACAP  
AAFP  
AAN  
AANS  
AAO  
AAO-HNS  
AAOS  
AAP  
AAPA  
ACC  
ACEP  
ACHr  
ACOG  
ACP  
ACR  
AGA

**Society****Acronym**

Former RUC Members	AGS
Former RUC Members	AMA
Former RUC Members	AOA
Former RUC Members	APSA
Former RUC Members	ASA
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
Infectious Diseases Society of America	IDSA
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**

Society of Interventional Radiology  
Society of Nuclear Medicine  
Society of Thoracic Surgeons  
The American Society for Aesthetic Plastic Surgery  
The Association of University Radiologists  
The Endocrine Society  
The Triological Society

**Acronym**

SIR  
SNM  
STS  
ASAPS  
AUR  
TES  
TTS

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Open Cryoablation of Renal Tumor**

The CPT Editorial Panel created a new code to describe open cryoablation of renal tumors. Open cryoablation of renal tumor(s) is an extension of technology, which is available to treat renal cancers in a select group of patients that include those who have tumors 4cm or less and may be poor surgical candidates, who refuse a radical or a partial nephrectomy, have multiple co-morbid illnesses, a solitary kidney or renal insufficiency. Currently, a CPT code exists for laparoscopic surgical ablation of renal mass lesion(s), CPT code 50542, and open cryoablation of liver tumor(s), CPT code 47381, but no specific code exists for open cryoablation of renal tumors.

The RUC reviewed the survey data for 50250 *Ablation, open, one or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound, if performed* and found that 50250 has similar total time, mental effort, technical skill and psychological stress as its reference code 50542 *Laparoscopy, surgical; ablation of renal mass lesion(s)* (work RVU=19.97). Additionally, the RUC reviewed the IWPUT for this new procedure and found that it is similar to the reference code, 50250 IWPUT=0.061 and 50542 IWPUT=0.073. **The RUC recommends the survey median RVU of 19.97 for 50250.**

Practice Expense

The RUC assessed and approved the practice expense for 50250.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
49200		<i>Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas;</i>	090	10.23  (No Change)
49201		<i>extensive</i>  <u>(For open cryoablation of renal tumor, use 50250)</u>	090	14.82  (No Change)

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>(For percutaneous cryotherapy ablation of renal tumors use Category III code 01135T)</u>		
●50250	MM1	Ablation, open, one or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound, if performed  (For laparoscopic ablation of renal mass lesions, use 50542)  (For percutaneous cryotherapy ablation of renal tumors use 0135T)	090	19.97
50541		<i>Laparoscopy, surgical; ablation of renal cysts</i>	090	15.98  (No Change)
50542		<i>ablation of renal mass lesion(s)</i>  <u>(For open cryosurgical ablations, use 50250)</u>  <u>(For percutaneous cryotherapy ablation of renal tumors, use 0135T)</u>	090	19.97  (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:50250 Tracking Number: MM1 Global Period: 090

**Recommended Work Relative Value**Specialty Society RVU: **19.97****RUC RVU: 19.97**

CPT Descriptor: Ablation, open, one or more renal mass lesion (s), cryosurgical, including intraoperative ultrasound if performed

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 59 year-old female with intermittent nausea and vomiting undergoes an abdominal CT which reveals an incidental 2.5 cm solid mass of the anterior midpole of the right kidney. The patient has chronic renal failure with a baseline creatinine of 3.2. The patient is referred to a urologist and focal cryoablation of the mass is decided upon in order to preserve renal function. Since the patient has undergone multiple prior abdominal procedures, an open approach is selected. 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: 79%

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:****1. Pre-service Work- Day before surgery:**

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed/emailed to hospital)

**2. Pre-service work- Day of surgery:**

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments are available

**Description of Intra-Service Work:****3. Description of Intra-Service Work:**

- A 16 F Foley catheter placed in the bladder and the patient is placed in the flank position
- A flank incision is made, the 11th or 12th rib is resected and the mass is exposed
- The kidney is mobilized, the ureter is identified, fatty tissue is dissected from the kidney
- A cryosurgical probe is inserted into the mass
- The freeze depth may be monitored with ultrasound
- A second freeze if performed
- Meticulous hemostasis is carried out
- Drains are placed
- The incision is closed in layers

**Description of Post-Service Work:****4. Description of Post-Service Work:**

**Post-op Same day work through discharge from recovery**

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative report

**Post-op Same day work after discharge from recovery**

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record
- The patient may be admitted to the hospital or discharged home depending on the particular requirements of each patient

**Post-op Other Hospital Work – Beginning on post op-day 1, until discharge day**

- Examine and talk to patient
- Review lab tests
- Check wounds and dressings
- Check drain, decide when to remove
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound at home Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

**Discharge day work:**

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of wound with patient and family
- Dictate detailed hospital discharge summary

**Post-op Office work- After discharge from hospital:**

- Examine patient, check vital signs
- Review lab tests
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures/drains/catheter as may be indicated
- Schedule next office visit

- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	James Regan, M.D.				
<b>Specialty(s):</b>	Urology				
<b>CPT Code:</b>	50250				
<b>Sample Size:</b>	707	<b>Resp n:</b>	33	<b>Response:</b> 4.66 %	
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RWV:</b>	10.96	17.00	19.97	20.00	37.00
<b>Pre-Service Evaluation Time:</b>			17.5		
<b>Pre-Service Positioning Time:</b>			20.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			17.5		
<b>Intra-Service Time:</b>	45.00	120.00	145.00	180.00	300.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>30.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>158.0</u>	99231x 3.0	99232x 2.0	99233x 1.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>76.0</u>	99211x 0.0	12x 2.0	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>
50542	090	19.97

CPT Descriptor Laparoscopy, Surgical Ablation of Renal Mass Lesion(s)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
50220	090	17.12

CPT Descriptor 1 Nephrectomy, including partial ureterectomy, any open approach including rib resection;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
50546	090	20.45

CPT Descriptor 2 Laparoscopy, surgical; nephrectomy, including partial ureterectomy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
N/A		

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 42.4 %

**TIME ESTIMATES (Median)**

<b>New/Revised CPT Code: 50250</b>	<b>Key Reference CPT Code: 50542</b>
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<u>TIME ESTIMATES (Median)</u>	<b>New/Revised CPT Code: 50250</b>	<b>Key Reference CPT Code: 50542</b>
Median Pre-Service Time	55.00	75.00
Median Intra-Service Time	145.00	180.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	158.0	30.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	76.0	84.00
Median Total Time	<b>500.00</b>	<b>435.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.31	4.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.15	3.92
Urgency of medical decision making	3.62	3.46

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.31	4.46
Physical effort required	4.23	4.15
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.15	3.92
Outcome depends on the skill and judgment of physician	4.38	4.23
Estimated risk of malpractice suit with poor outcome	4.15	4.31

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.75	3.75
Intra-Service intensity/complexity	3.92	3.92
Post-Service intensity/complexity	3.42	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.*

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 survey responses are compiled, the AUA RUC Workgroup examines the data.

The Workgroup also reviewed the IWPUT for the new code and the reference code, (see attached) which are:

50250, IWPUT = 0.068

50542, IWPUT = 0.073



Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? No

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

<b>IWPUT Calculator</b>
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50250

**Building Block Method**  
**Proposed RVW**

**RVW**

**19.97**

<b>Pre-service</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x intensity)</b>
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	15	0.0081	0.12
<b>Pre-service total</b>			<b>1.47</b>
<b>Post-service</b>	<b>Time</b>	<b>Intensity</b>	
Immediate post	30	0.0224	0.67
<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVU</b>	<b>(=n x E/M RVU)</b>
ICU 99291	0.0	4.00	0.00
99233	1.0	1.51	1.51
99232	2.0	1.06	2.12
99231	3.0	0.64	1.92
Discharge 99238	1.0	1.28	1.28
99215	0.0	1.73	0.00
99214	0.0	1.08	0.00
99213	2.0	0.65	1.30
99212	2.0	0.43	0.86
99211	0.0	0.17	0.00
<b>Post-service total</b>			<b>9.66</b>
<b>Intra-service</b>	<b>Time</b>	<b>IWPUT</b>	
	145		<b>8.84</b>

<b>IWPUT Calculator</b>
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**50542 (Reference code for 50250)**

**Building Block Method**  
**Proposed RVW**

<b>RVW</b>
<b>19.97</b>

<b>Pre-service</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x intensity)</b>
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	15	0.0081	0.12
<b>Pre-service total</b>			<b>1.47</b>

<b>Post-service</b>	<b>Time</b>	<b>Intensity</b>	
Immediate post	30	0.0224	0.67

<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVU</b>	<b>(=n x E/M RVU)</b>
ICU 99291	0.0	4.00	0.00
99233	0.0	1.51	0.00
99232	1.0	1.06	1.06
99231	0.0	0.64	0.00
Discharge 99238	1.0	1.28	1.28
99215	0.0	1.73	0.00
99214	1.0	1.08	1.08
99213	2.0	0.65	1.30
99212	0.0	0.43	0.00
99211	0.0	0.17	0.00

**Post-service total** **5.39**

	<b>Time</b>	<b>IWPUT</b>	
<b>Intra-service</b>	180		<b>13.11</b>

	A	B	C	D	E
1					
2				50250	
3	Meeting Date: April 2005			Ablation, open, one or more renal mass lesion(s), including intraoperative ultrasound if performed	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
5	GLOBAL PERIOD				90
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	198.0
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	126.0
10					
11	Start: Following visit when decision for surgery or procedure made				
12	Complete pre-service diagnostic & referral forms				5
13	Coordinate pre-surgery services				20
14	Schedule space and equipment in facility				8
15	Provide pre-service education/obtain consent				20
16	Follow-up phone calls & prescriptions				7
17	Other Clinical Activity (please specify)				
18	End:When patient enters office/facility for surgery/procedure				
19					
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				12
41	Other Clinical Activity (please specify)				
42	End: Patient leaves office				
43					
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		2
50	99213 36 minutes		36		2
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54					
55	Total Office Visit Time			0	126
56	Other Activity (please specify)				
57	End: with last office visit before end of global period				

RUC Recommendation

	A	B	C	D	E
2				50250	
3	Meeting Date: April 2005			Ablation, open, one or more renal mass lesion(s), including intraoperative ultrasound if performed	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
58					
59	pack, minimum multi-specialty visit	SA048	pack		4
60	pack, post-op incision care (staple)	SA052	pack		1
61					
62	table, exam	EF023			1
63	light, exam	EQ168			1

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

**Ureteral Stent Exchange/Removal**

The CPT Editorial Panel created four new codes and revised one code to provide more specificity in the exchange or removal of a ureteral stent. Ureteral strictures and obstructions are relatively common and often treated with the placement of ureteral stents. Ureteral stents are thin catheters threaded into the ureter to divert the urine either internally into the bladder or externally into a collection system. Ureteral stents must be monitored while in place, removed when no longer needed, and changed periodically especially when chronically indwelling. The new family of codes, for the exchange or removal of a ureteral stent (which typically traverses the entire ureter from the renal pelvis to the bladder) differentiates between externally and internally dwelling devices. In addition, the exchange and removal of an indwelling stent, appropriate differentiation is made between a transurethral and percutaneous approach.

**50382 and 50384**

The RUC first reviewed the survey results presented for new codes 50382 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation (For bilateral procedure, use modifier 50)* and 50384 *Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation*. The RUC believed that for the type of services the recommended median work RVU was too high. The RUC believed the intensity of these procedures was approximately 0.07, and that the 25<sup>th</sup> percentile survey results reflected the true physician work. **The RUC recommends a work relative value of 5.50 for code 50382 and 5.00 for code 50384. In addition, conscious sedation was determined to be inherent in these codes.**

**50387**

The RUC then reviewed codes 50387 *Removal and replacement of externally accessible transnephric ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation*. Code 50387 was explained to have additional pre-service work in reviewing imaging studies and evaluating the patient, and less time for the actual procedure. The RUC compared the service to code 49423 *Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)* (Work RVU = 1.46) and believed the intensity was greater. The specialty's survey results indicated a median work RVU of 2.63 which the presenters and the RUC believed was too high, however the 25<sup>th</sup> percentile of 1.50 was too low. The RUC believed that a building block approach of using the reference code as a base, and adding an additional 0.54 RVUs for the supervision and interpretation (S&I) component of the code should be used to establish the value for 50387. The RUC cited RUC reviewed code 74475 *Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection*,

*percutaneous, radiological supervision and interpretation* (Work RVU = 0.54), as a code that could be used for the S&I portion of the work RVU. **The RUC recommends a work relative value of 2.00 for code 50387. In addition, conscious sedation was determined to be inherent in this code.**

**50389**

*50389 Removal of nephrostomy tube requiring fluoroscopic guidance (e.g. with concurrent indwelling ureteral stent)* was then reviewed in relation to the other codes in the family, its key reference code, and its survey results. The presenters stated that this new code typically did not require a full diagnostic examination and was less intense than code 50387. The key reference code 50394 *Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter* (Work RVU = 0.76) was said to be typically billed with a supervision and interpretation code, and was viewed as an appropriate reference for this new code. The RUC believed the specialty’s survey results were consistent for the physician work involved and agreed with the recommended median work value of 1.10 work RVUs. **The RUC recommends a work relative value of 1.10 for code 50389. In addition, conscious sedation was determined to be inherent in this code.**

**Practice Expense**

The RUC reviewed the practice expense recommendations presented by the specialty society and believed that there was too much clinical labor assistance physician time in the specialty recommendation. The specialty agreed to eliminate the time of one assistant and to other minor changes to medical supplies.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•50382	NN1	Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation	000	5.50

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(For bilateral procedure, use modifier 50)		
•50384	NN2	Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation  (For bilateral procedure, use modifier 50)  (Do not report 50382, 50384, with 50395)	000	5.00
•50387	NN3	Removal and replacement of externally accessible transnephric ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation  (For bilateral procedure, use modifier 50)  (For removal and replacement of externally accessible ureteral stent via ureterostomy or ileal conduit, see 50688)  (For removal without replacement of an externally accessible ureteral stent not requiring fluoroscopic guidance see <b>Evaluation and Management</b> services codes)	000	2.00
•50389	NN4	Removal of nephrostomy tube requiring fluoroscopic guidance (e.g. with concurrent indwelling ureteral stent)  (Removal of nephrostomy tube not requiring fluoroscopic guidance is considered inherent to E/M services, report appropriate level E/M provided)	000	1.10

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 50688		Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit  (If imaging guidance is performed, use 75984)	010	1.17  (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:50382 Tracking Number: NN1 Global Period: 000

**Recommended Work Relative Value  
Specialty Society RVU: 6.74  
RUC RVU: 5.50**

CPT Descriptor: Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation  
(For bilateral procedure, use modifier 50)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An 80-year-old with a chronic indwelling double-J ureteral stent placed for ureteral obstruction is seen after failed attempt to exchange the stent was made via cystoscopy. The stent was inadvertently fractured, with the distal end removed at cystoscopy, and is now inaccessible from a urethral approach. It is therefore elected to retrieve and exchange the stent percutaneously from a transnephric approach.

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? No

**Description of Pre-Service Work:**

The physician:

- Sees the patient in the interventional suite and briefly examined
- Reviews prior imaging studies and other test results.
- Obtains a brief history assuring that there has been no intercurrent changes or complaints.
- Discusses the procedure with the patient and family and informed consent is obtained for retrieval and replacement of the fractured ureteral stent.
- Supervises staff establishing an intravenous site and places the patient in a prone position on the table.
- Confirms proper room set up including sterile preps and drapes and selects appropriate devices such as catheters, sheaths, guidewires, and ureteral stents. Proper positioning of the patient is confirmed and the guide puncture site is externally examined, prepped and draped with sterile technique.

**Description of Intra-Service Work: The physician**

- Orders medication for conscious sedation.
- A small skin incision is made after infiltration of the skin and subcutaneous tissues with 1% lidocaine of the selected entry site
- Introduces a needle into the appropriate renal calyx, using imaging guidance to assure appropriate needle position.
- Injects contrast once the needle is in place and fluoroscopy is used to confirm position and to identify relevant anatomy.
- Introduces a guidewire into the renal pelvis, the needle removed, and the tract is serially dilated to the appropriate diameter.
- Introduces a guidewire into the renal pelvis, followed by sheath placement over the wire into the renal pelvis.
- Introduces a safety guidewire into bladder, traversing the ureter, under fluoroscopic imaging guidance with periodic contrast injection
- Under fluoroscopic guidance, a snare device is negotiated into the renal pelvis through the sheath and used to grasp the proximal end of the indwelling stent, and the stent is partially pulled out through the sheath. Once the proximal end of the indwelling stent has been externalized, it is cannulated with a guidewire, which is then maneuvered past the side holes into the ureter. The old ureteral stent is then completely removed over the guidewire, leaving the guidewire in place in the bladder. The physician confirms the length of the replacement stent. The replacement stent is then advanced over the wire until the distal loop is in the bladder. (If balloon dilation of the ureter is necessary for stent passage this is

separately reportable.) The distal loop is deployed. Once stent position is confirmed to be satisfactory, the wire is withdrawn, allowing the proximal loop to reform in the renal pelvis. The guide/sheath/safety wire are removed. Images are obtained documenting final stent position.

Description of Post-Service Work: A note is made in the patient record and orders are written. The patient is transferred to the recovery unit. The referring physician is notified of the outcome of the procedure, and of subsequent procedures to be done. Outcome of the procedure is discussed with the patient and family and instructions are given. A report is dictated for the permanent record.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Bibb Allen, MD Zachary Rattner, MD Robert Vogelzang, MD					
<b>Specialty(s):</b>	American College of Radiology Society of Interventional Radiology					
<b>CPT Code:</b>	50382					
<b>Sample Size:</b>	100	<b>Resp n:</b>	17	<b>Response:</b> 17.00 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		3.00	5.50	6.74	8.25	15.00
<b>Pre-Service Evaluation Time:</b>				30.0		
<b>Pre-Service Positioning Time:</b>				10.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0		
<b>Intra-Service Time:</b>		30.00	53.00	60.00	75.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>15.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
50392	000	3.37

CPT Descriptor Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
45385	000	5.30

CPT Descriptor 1 Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 58.8 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 50382</u>	<u>Key Reference CPT Code: 50392</u>
Median Pre-Service Time	50.00	27.00
Median Intra-Service Time	60.00	36.00
Median Immediate Post-service Time	15.00	24.00
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	125.00	87.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.79	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.62	2.40
Urgency of medical decision making	2.54	2.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	3.20
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Physical effort required	3.43	2.80
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.29	3.00
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Outcome depends on the skill and judgment of physician	3.79	3.20
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Estimated risk of malpractice suit with poor outcome	2.64	2.60
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	2.83
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Intra-Service intensity/complexity	3.77	3.33
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Post-Service intensity/complexity	2.87	2.67
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**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 comparison to its key reference code (50392), code 503X2 includes snaring the indwelling stent using a larger catheter than that associated with 50392. This carries with it more risk of bleeding and a larger hole in the collecting system because it is less dilated. Snaring the stent in 503X2 requires several manipulations necessary to grab the stent which poses additional risks to the collecting system. Replacing the double pig-tail catheter needs proper measurement and deployment more so than 50392. Also, the patient for 503X2 typically has had a failed cystoscopic attempt because the tube is old, brittle, and encrusted, thus prone to fracture.



Specialty Interventional radiology	Frequency 500	Percentage 50.00 %
Specialty Radiology	Frequency 500	Percentage 50.00 %
Specialty	Frequency	Percentage %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 36478

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**

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CPT Code:50384 Tracking Number: NN2 Global Period: 000

**Recommended Work Relative Value**

Specialty Society RVU: **5.30**

RUC RVU: **5.00**

CPT Descriptor: Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation  
(For bilateral procedure, use modifier 50)

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 75-year-old male with chronic ureteral obstruction has been maintained for 2 years with a chronic indwelling ureteral stent. However, the patient now has end-stage renal disease and no urine output, and it is elected to remove the ureteral stent. An attempt to remove the stent cystoscopically has failed, with removal of the distal portion of the catheter, but retention of the proximal and ureteral portions after the stent was inadvertently fractured. The patient is therefore referred for percutaneous removal of the indwelling stent.

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? No

**Description of Pre-Service Work: The physician:**

- Sees the patient in the interventional suite and briefly examined
- Reviews prior imaging studies and other test results.
- Obtains a brief history assuring that there has been no intercurrent changes or complaints.
- Discusses the procedure with the patient and family and informed consent is obtained for retrieval and replacement of the fractured ureteral stent.
- Supervises staff establishing an intravenous site and places the patient in a prone position on the table.
- Confirms proper room set up including sterile preps and drapes and selects appropriate devices such as catheters, sheaths, guidewires, and ureteral stents. Proper positioning of the patient is confirmed and the guide puncture site is externally examined, prepped and draped with sterile technique.

**Description of Intra-Service Work:**

The physician:

- Orders medication for conscious sedation.

A small skin incision is made after infiltration of the skin and subcutaneous tissues with 1% lidocaine of the selected entry site

- Introduces a needle into the appropriate renal calyx, using imaging guidance to assure appropriate needle position.
- Injects contrast once the needle is in place and fluoroscopy is used to confirm position and to identify relevant anatomy.
- Introduces a guidewire into the renal pelvis, the needle removed, and the tract is serially dilated to the appropriate diameter.
- Introduces a guidewire into the renal pelvis, followed by sheath placement over the wire into the renal pelvis.
- Introduces a safety guidewire into bladder, traversing the ureter, under fluoroscopic imaging guidance with periodic contrast injection

Next, under fluoroscopic guidance, a snare device is negotiated into the renal pelvis through the sheath and used to grasp the proximal end of the indwelling stent, and the stent is pulled out through the sheath, maintaining wire position in the bladder. Once the proximal end of the indwelling stent has been externalized, it is cannulated with a guidewire, which is

then maneuvered past the side holes into the ureter. The old ureteral stent is then completely removed over the guidewire. The guidewire(s)/sheath are removed. A sterile dressing is applied.

Description of Post-Service Work: Images are obtained documenting final stent position. A note is made in the patient record and orders are written. The patient is transferred to the recovery unit. The results are discussed with the patient and family. Instructions are given to the patient and family. Findings are discussed with the referring physician, and a procedure report is dictated for the permanent record.

### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>		Bibb Allen, MD Zachary Rattner, MD Robert Vogelzang, MD			
<b>Specialty(s):</b>		American College of Radiology Society of Interventional Radiology			
<b>CPT Code:</b>		50384			
<b>Sample Size:</b>	100	<b>Resp n:</b>	17	<b>Response:</b> 17.00 %	
<b>Sample Type:</b>		Random			
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		3.00	5.00	5.30	5.94
<b>Pre-Service Evaluation Time:</b>				25.0	
<b>Pre-Service Positioning Time:</b>				7.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		30.00	45.00	55.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>15.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
50392	000	3.37

CPT Descriptor Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
45385	000	5.30

CPT Descriptor 1 Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 58.8 %

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 50384</b>	<b>Key Reference CPT Code: 50392</b>
Median Pre-Service Time	42.00	27.00
Median Intra-Service Time	55.00	36.00
Median Immediate Post-service Time	15.00	24.00
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	112.00	87.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.85	2.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.62	2.25
Urgency of medical decision making	2.54	1.75

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.27	3.00
Physical effort required	3.62	2.50
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	3.23	3.00
Outcome depends on the skill and judgment of physician	3.85	3.00
Estimated risk of malpractice suit with poor outcome	2.77	2.25

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.07	2.80
Intra-Service intensity/complexity	3.86	3.20
Post-Service intensity/complexity	2.86	2.60

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

In comparison to its key reference code (50392), code 503X4 includes snaring the indwelling stent using a larger catheter than that associated with 50392. This carries with it more risk of bleeding and a larger hole in the collecting system because it is less dilated. Snaring the stent in 503X4 requires several manipulations necessary to grab the stent which poses additional risks to the collecting system. The patient for 503X4 typically has had a failed cystoscopic attempt because the tube is old, brittle, and encrusted, thus prone to fracture.



Specialty Interventional radiology                      Frequency 500                      Percentage 50.00 %

Specialty Radiology                      Frequency 500                      Percentage 50.00 %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States?

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 37203

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:50387 Tracking Number: NN3 Global Period: 000

**Recommended Work Relative Value  
Specialty Society RVU: 2.63  
RUC RVU: 2.00**

CPT Descriptor: Removal and replacement of externally accessible transnephric ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation

(For bilateral procedure, use modifier 50)

(For removal and replacement of externally accessible ureteral stent via ureterostomy or ileal conduit, see 50688)

(For removal without replacement of an externally accessible ureteral stent not requiring fluoroscopic guidance see Evaluation and Management services codes)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 64 year old male with a current right transnephric single piece internal/external (tube hub accessible at the patient's flank) capped ureteral stent presents for routine fluoroscopically guided catheter exchange.

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? 83%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician:

- Sees the patient in the interventional suite and briefly examined
- Reviews prior imaging studies and other test results.
- Obtains a brief history assuring that there has been no intercurrent changes or complaints.
- Discusses the procedure with the patient and family and informed consent is obtained for retrieval and replacement of the fractured ureteral stent.
- Supervises staff establishing an intravenous site and places the patient in a prone position on the table.
- Confirms proper room set up including sterile preps and drapes and selects appropriate devices such as catheters, sheaths, guidewires, and ureteral stents. Proper positioning of the patient is confirmed and the guide puncture site is externally examined, prepped and draped with sterile technique.

Description of Intra-Service Work: The physician infiltrates the skin and subcutaneous tissues with 1% lidocaine at the catheter entry site. Contrast may be injected into the catheter to assess anatomy and to help with subsequent positioning of both pigtailed of the new stent. The suture fixing the proximal pigtail in position is cut, and a selective guidewire is introduced through the hub of the stent, and advanced through the stent into the bladder. Fluoroscopy is used to help maneuver the wire through the catheter lumen (the guidewire often is difficult to position due to multiple side holes in the catheter). Once the guide wire has exited the distal end hole of the stent, the indwelling catheter is removed over the guidewire and discarded. A new nephroureteral stent is advanced over the wire, with diameter and length chosen to fit the patient's anatomy. Once in the bladder, the guidewire is partially removed to allow formation of the distal loop within the bladder. Fluoroscopic assessment of the proximal portion of the catheter is done to be certain that the proximal pigtail will reform within the renal pelvis. Once the catheter is appropriately positioned, the guidewire is removed, and the suture is pulled to cinch the proximal pigtail in position. Minor adjustments to the catheter position are performed to decrease patient discomfort from the catheter tip poking into the wall of the bladder or renal collecting system. Contrast may be injected to assure appropriate positioning and functioning of the new catheter. Once final adjustments are made, the catheter site is dressed appropriately. It may be sutured to the skin. The catheter may be capped to internal drainage, or a drainage bag may be attached for partial external drainage. An image is obtained documenting final catheter position for the patient record.

Description of Post-Service Work: A note is made in the patient record and orders are written. The patient may be discharged directly, or may be sent to the recovery unit if conscious sedation was required or if bleeding occurs. The results of the procedure are discussed with the patient and family, and instructions are given for subsequent catheter care. The time frame for the next routine maintenance on the stent is discussed with the patient, and a follow-up appointment may be made. A report is dictated for the permanent record.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Bibb Allen, MD Zachary Rattner, MD Robert Vogelzang, MD					
<b>Specialty(s):</b>	American College of Radiology Society of Interventional Radiology					
<b>CPT Code:</b>	50387					
<b>Sample Size:</b>	100	<b>Resp n:</b>	18	<b>Response:</b> 18.00 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RWV:</b>		0.72	1.50	2.63	3.19	6.50
<b>Pre-Service Evaluation Time:</b>				19.0		
<b>Pre-Service Positioning Time:</b>				9.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0		
<b>Intra-Service Time:</b>		10.00	15.00	18.00	20.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>10.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
49423	000	1.46

CPT Descriptor Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
36556	000	2.50

CPT Descriptor 1 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 61.1 %

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 50387	Key Reference CPT Code: 49423
Median Pre-Service Time	38.00	15.00
Median Intra-Service Time	18.00	30.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	66.00	60.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.00	1.83
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.08	1.83
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Urgency of medical decision making	1.77	1.33
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.54	1.67
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Physical effort required	2.23	1.50
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.15	1.67
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Outcome depends on the skill and judgment of physician	2.31	1.67
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Estimated risk of malpractice suit with poor outcome	1.85	1.50
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.23	2.00
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Intra-Service intensity/complexity	2.69	1.83
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Post-Service intensity/complexity	2.08	1.50
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**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.*

Code 503X5 in comparison to code 49423 involves the difficulty of getting the wire through holes in the catheter which are usually encrusted. The new pigtail catheter has to be exactly measured so it does not pull between the ureter and kidney. Code 503X5 requires more crucial manipulation of the guidewire than code 49423. Also, code 503X5 includes imaging (code 75984; RVW of 0.72) which is separately reportable from code 49423.



Specialty	Interventional radiology	Frequency	500	Percentage	50.00 %
Specialty	Radiology	Frequency	500	Percentage	50.00 %
Specialty		Frequency		Percentage	%

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 36556

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:50389 Tracking Number: NN4 Global Period: 000

**Recommended Work Relative Value  
Specialty Society RVU: 1.10  
RUC RVU: 1.10**

CPT Descriptor: Removal of nephrostomy tube requiring fluoroscopic guidance (e.g. with concurrent indwelling ureteral stent)

(Removal of nephrostomy tube not requiring fluoroscopic guidance is considered inherent to E/M services, report appropriate level E/M provided)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 62 year old male with bladder carcinoma had a left internal ureteral stent placed 5 days earlier via transnephric approach. A nephrostomy catheter had been left in place due to moderate bleeding at the time of the stent placement. He now presents for removal of the nephrostomy catheter under fluoroscopic guidance to avoid displacing the previously placed ureteral stent.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 28%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient is seen in the interventional suite and briefly examined. The nephrostomy drainage is evaluated for active bleeding or the presence of blood clots. A history of urinary output from the bladder is obtained to be certain that the patient is successfully voiding without significant bleeding. Vital signs show no fever. Lab results are reviewed. The procedure is discussed with the patient and family, and informed consent is obtained. Staff establishes an intravenous site and places the patient in a prone position on the table. The physician confirms proper room set up, including sterile preps and drapes, and selects appropriate devices such as guidewires. Proper positioning of the patient is confirmed, and the exit site for the nephrostomy tube is prepped and draped with sterile technique.

Description of Intra-Service Work: Contrast is injected through the indwelling nephrostomy catheter, confirming that the ureteral stent is in place and functioning. Note is made that no large thrombus is present in the collecting system. The skin site is then anesthetized with local Xylocaine. The suture fixing the nephrostomy pigtail in position is released, and a wire is carefully introduced through the indwelling nephrostomy catheter into the collecting system. This maneuver is watched fluoroscopically to be certain that the nephrostomy catheter pigtail and/or retention suture do not hook the proximal pigtail of the double-J stent. Adjustments are made with fluoroscopic guidance to assure that the ureteral stent is not dislodged as the nephrostomy catheter is pulled out over the wire. Once the nephrostomy catheter is out, a permanent image of the final ureteral stent position is made for the patient's record. A thick sterile dressing is applied to the flank site.

Description of Post-Service Work: A note is made in the patient record and orders are written. The patient and family are instructed on care of the flank site. Instructions for follow-up visit for ureteral stent maintenance are given to the patient and family. The referring physician is notified of the outcome of the procedure and need for subsequent follow-up. A report is dictated for the permanent record.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)

04/2005

<b>Presenter(s):</b>	Bibb Allen, MD Zachary Rattner, MD Robert Vogelzang, MD					
<b>Specialty(s):</b>	American College of Radiology Society of Interventional Radiology					
<b>CPT Code:</b>	50389					
<b>Sample Size:</b>	100	<b>Resp n:</b>	18	<b>Response:</b> 18.00 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		0.40	0.85	1.10	1.25	3.00
<b>Pre-Service Evaluation Time:</b>				5.0		
<b>Pre-Service Positioning Time:</b>				10.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0		
<b>Intra-Service Time:</b>		5.00	5.00	10.00	15.00	45.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>5.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
50394	000	0.76

CPT Descriptor Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheterous

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
31231	000	1.10

CPT Descriptor 1 Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
74425	XXX	0.36

CPT Descriptor Urography, antegrade, (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.

Number of respondents who choose Key Reference Code: 9      % of respondents: 50.0 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 50389</u>	<u>Key Reference CPT Code: 50394</u>
Median Pre-Service Time	25.00	16.00
Median Intra-Service Time	10.00	19.00
Median Immediate Post-service Time	5.00	13.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	40.00	48.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	1.54	1.40
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.69	1.60
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Urgency of medical decision making	1.62	1.40
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	1.92	1.40
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Physical effort required	1.62	1.40
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	1.83	1.40
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Outcome depends on the skill and judgment of physician	2.17	1.60
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Estimated risk of malpractice suit with poor outcome	2.00	1.58
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.23	1.58
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Intra-Service intensity/complexity	2.23	1.58
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Post-Service intensity/complexity	1.77	1.58
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**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.*

Code 503X6 includes contrasts injection, local pain control, sterile prep, and wire insertion not associated with 50394. The physician must carefully watch to avoid snaring the indwelling stent while trying to remove one pigtail and leave the other undisturbed. There is more bleeding associated with 503X6 than 50394 which must be compressed by the physician. There are more wound care instructions with 503X6 than 50394. Also, code 503X6 includes imaging guidance. Imaging is separately reportable from 50394.



Specialty Radiology                      Frequency 1000                      Percentage 50.00 %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States?

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 36584

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							
2	Meeting Date: April 2005			CPT Code: 50382 Code Descriptor: Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation (For bilateral procedure, use modifier 50)		CPT Code: 50384 Code Descriptor: Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation (For bilateral procedure, use modifier 50)	
3							
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD						
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	11.0	3.0	11.0	0.0
7	TOTAL CLINICAL LABOR TIME	L041B	RT	59.0	0.0	55.0	0.0
8	TOTAL CLINICAL LABOR TIME	L051A	RN	77.0	0.0	72.0	0.0
9	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA				
10	TOTAL PRE-SERV CLINICAL LABOR TIME	L041B	RT	3.0	0.0	3.0	0.0
11	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN				
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	8.0	0.0	8.0	0.0
13	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L041B	RT	56.0	0.0	52.0	0.0
14	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	77.0	0.0	72.0	0.0
15	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3.0	3.0	3.0	0.0
16	TOTAL POST-SERV CLINICAL LABOR TIME	L041B	RT				
17	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN				
18	Start: Following visit when decision for surgery or procedure made						
19	Complete pre-service diagnostic & referral forms						
20	Coordinate pre-surgery services						
21	Schedule space and equipment in facility						
22	Provide pre-service education/obtain consent						
23	Follow-up phone calls & prescriptions						
24	Other Clinical Activity (please specify) Retrieve prior imaging exams	L041B	RT	3		3	
25	End: When patient enters office/facility for surgery/procedure						
26							
27	Start: When patient enters office/facility for surgery/procedure						
28	Pre-service services						
29	Review charts						
30	Greet patient and provide gowning						
31	Obtain vital signs						
32	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5	
33	Prepare room, equipment, supplies	L041B	RT	2		2	
34	Setup scope (non facility setting only)						
35	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	2		2	
36	Sedate/apply anesthesia	L051A	RN	2		2	
37	Intra-service						
38	Assist physician in performing procedure (60 percent)	L037D	RN/LPN/MTA	0		0	
39	Assist physician in performing procedure (80 percent)	L041B	RT	48		44	
40	Assist physician in performing procedure	L051A	RN	60		55	
41	Post-Service						
42	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	15		15	
43	Clean room/equipment by physician staff	L041B	RT	2		2	
44	Clean Scope						
45	Clean Surgical Instrument Package						
46	Complete diagnostic forms, lab & X-ray requisitions						
47	Review/read X-ray, lab, and pathology reports						
48	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3	
49	Discharge day management 99238 –12 minutes						
50	Other Clinical Activity Process and hang films	L041B	RT	2		2	
51	End: Patient leaves office						
52							

	A	B	C	D	E	F	G
2	Meeting Date: April 2005			CPT Code: 50382 Code Descriptor: Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation (For bilateral procedure, use modifier 50)		CPT Code: 50384 Code Descriptor: Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation (For bilateral procedure, use modifier 50)	
3							
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
53							
54	Start: Patient leaves office/facility						
55	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	
56	Office visits:						
57	List Number and Level of Office Visits						
58	99211 16 minutes		16				
59	99212 27 minutes		27				
60	99213 36 minutes		36				
61	99214 53 minutes		53				
62	99215 63 minutes		63				
63	Other						
64							
65	Total Office Visit Time			0	0	0	0
66	Other Activity (please specify)						
67	End: with last office visit before end of global period						
68							
69	pack, conscious sedation	SA044	kit	1		1	
70	gown, surgical, sterile	SB028	item	2		2	
71	gloves, sterile	SB024	pair	2		2	
72	mask, surgical, with face shield	SB034	item	2		2	
73	cap, surgical	SB001	item	2		2	
74	shoe covers, surgical	SB039	pair	2		2	
75	drape, sterile, fenestrated 16in x 29in	SB011	item	1		1	
76	drape-towel, sterile 18inx26in	SB019	item	2		2	
77	kit, suture removal	SA031	kit	1		1	
78	tray, shave prep	SA067	tray	1		1	
79	underpad 2ftx3ft (Chux)	SB044	item	1		1	
80	povidone soln (Betadine)	SJ041	ml	60		60	
81	applicator, sponge-tipped	SG009	item	4		4	
82	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10		10	
83	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	2		2	
84	3 way stop cock (for irrigation)	SC049	item	1		1	
85	syringe 60ml (for irrigation)	SC056	item	2		2	
86	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1	
87	closed flush system, angiography	SC010	item	1		1	
88	sodium chloride 0.9% flush syringe	SH065	item	2		2	
89	sheath (Pee!Away)	SD026	item				
90	catheter, drainage (Flexima)	SD161	item	1		1	
91	percutaneous catheter fastener (Percu-Stay)	SD146	item	1		1	
92	pouch, nephrostomy-biliary drainage	SD163	item	1		1	
93	guidewire	SD088	item	1		1	
94	guidewire, hydrophilic (Glidewire)	SD089	item				
95	gauze, sterile 4in x 4in	SG055	item	6		6	
96	tape, surgical paper 1in (Micropore)	SG079	item	12		12	
97	x-ray envelope	SK091	item	1		1	
98	film, x-ray 14inx17in	SK034	item	1		1	
99	x-ray developer solution	SK089	oz	0.5		0.5	
100	x-ray fixer solution	SK092	oz	0.5		0.5	
101	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1		1	
102	computer media, dvd	SK013	item	1		1	
103	stent		item	1		1	
104							
105	angiographic room	EL011		X		X	
106	film alternator	ER029		X		X	
107	laser printer for CT angiography	ED024		X		X	
108	3 channel ECG/BP monitor	EQ010		X		X	
109	IV infusion pump	EQ032		X		X	
110	oxygen tank			X		X	
111	pulse oximeter with printer	EQ211		X		X	

	A	B	C	H	I	J	K
1							
2				<b>CPT Code: 50387</b>		<b>CPT Code: 50389</b>	
3	Meeting Date: April 2005			Code Descriptor: Removal and replacement of externally accessible transurethral ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation (For bilateral procedure, use modifier 50) (For removal and replacement of externally accessible ureteral stent via ureterostomy or ileal conduit, see 50688) (For removal without replacement of an externally accessible ureteral stent not requiring fluoroscopic guidance see Evaluation and Management services codes)		Code Descriptor: Removal of nephrostomy tube requiring fluoroscopic guidance (e.g. with concurrent indwelling ureteral stent) (Removal of nephrostomy tube not requiring fluoroscopic guidance is considered inherent to E/M services, report appropriate level E/M provided)	
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>						
6	<b>TOTAL CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	11	0.0	11.0	0.0
7	<b>TOTAL CLINICAL LABOR TIME</b>	L041B	RT	25.4	0.0	11.0	0.0
8	<b>TOTAL CLINICAL LABOR TIME</b>	L051A	RN	35.0	0.0	0.0	0.0
9	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA				
10	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L041B	RT	3.0	0.0	3.0	0.0
11	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L051A	RN				
12	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	8	0.0	8.0	0.0
13	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L041B	RT	22.4	0.0	8.0	0.0
14	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L051A	RN	35.0	0.0	0.0	0.0
15	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	3.0	0.0	3.0	0.0
16	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	L041B	RT				
17	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	L051A	RN				
18							
19	<b>Start: Following visit when decision for surgery or procedure made</b>						
20	Complete pre-service diagnostic & referral forms						
21	Coordinate pre-surgery services						
22	Schedule space and equipment in facility						
23	Provide pre-service education/obtain consent						
24	Follow-up phone calls & prescriptions						
25	Other Clinical Activity (please specify) <i>Retrieve prior imaging exams</i>	L041B	RT	3		3	
26	<b>End: When patient enters office/facility for surgery/procedure</b>						
27							
28	<b>Start: When patient enters office/facility for surgery/procedure</b>						
29	<b>Pre-service services</b>						
30	Review charts						
31	Greet patient and provide gowning						
32	Obtain vital signs						
33	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5	
34	Prepare room, equipment, supplies	L041B	RT	2		2	
35	Setup scope (non facility setting only)						
36	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	2		2	
37	Sedate/apply anesthesia	L051A	RN	2		0	
38	<b>Intra-service</b>						
39	Assist physician in performing procedure (60 percent)	L037D	RN/LPN/MTA	0		0	
40	Assist physician in performing procedure (80 percent)	L041B	RT	14		0	
41	Assist physician in performing procedure	L051A	RN	18		0	
42	<b>Post-Service</b>						
43	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	15		0	
44	Clean room/equipment by physician staff	L041B	RT	2		2	
45	Clean Scope						
46	Clean Surgical Instrument Package						
47	Complete diagnostic forms, lab & X-ray requisitions						
48	Review/read X-ray, lab, and pathology reports						
49	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3	
50	Discharge day management 99238 –12 minutes						
51	Other Clinical Activity <i>Process and hang films</i>	L041B	RT	2		2	
52	<b>End: Patient leaves office</b>						

	A	B	C	H	I	J	K
2				CPT Code: 50387		CPT Code: 50389	
3	Meeting Date: April 2005			Code Descriptor: Removal and replacement of externally accessible transnephric ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation (For bilateral procedure, use modifier 50) (For removal and replacement of externally accessible ureteral stent via ureterostomy or ileal conduit, see 50688) (For removal without replacement of an externally accessible ureteral stent not requiring fluoroscopic guidance see Evaluation and Management services codes)		Code Descriptor: Removal of nephrostomy tube requiring fluoroscopic guidance (e.g. with concurrent indwelling ureteral stent) (Removal of nephrostomy tube not requiring fluoroscopic guidance is considered inherent to E/M services, report appropriate level E/M provided)	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
53							
54	Start: Patient leaves office/facility						
55	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3		3	
56	Office visits:						
57	List Number and Level of Office Visits						
58	99211 16 minutes		16				
59	99212 27 minutes		27				
60	99213 36 minutes		36				
61	99214 53 minutes		53				
62	99215 63 minutes		63				
63	Other						
64							
65	Total Office Visit Time			0	0	0	0
66	Other Activity (please specify)						
67	End: with last office visit before end of global period						
68							
69	pack, conscious sedation	SA044	kit	1		0	
70	gown, surgical, sterile	SB028	item	2		2	
71	gloves, sterile	SB024	pair	2		2	
72	mask, surgical, with face shield	SB034	item	2		2	
73	cap, surgical	SB001	item	2		2	
74	shoe covers, surgical	SB039	pair	2		2	
75	drape, sterile, fenestrated 16in x 29in	SB011	item	1		1	
76	drape-towel, sterile 18inx26in	SB019	item	2		2	
77	kit, suture removal	SA031	kit	1		1	
78	tray, shave prep	SA067	tray	1		1	
79	underpad 2fx3ft (Chux)	SB044	item	1		1	
80	povidone soln (Betadine)	SJ041	ml	60		60	
81	applicator, sponge-tipped	SG009	item	4		4	
82	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10		10	
83	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	2		2	
84	3 way stop cock (for irrigation)	SC049	item	1		1	
85	syringe 60ml (for irrigation)	SC056	item	2		2	
86	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1	
87	closed flush system, angiography	SC010	item	1		1	
88	sodium chloride 0.9% flush syringe	SH065	item	2		2	
89	sheath (PeelAway)	SD026	item				
90	catheter, drainage (Flexima)	SD161	item	1		1	
91	percutaneous catheter fastener (Percu-Stay)	SD146	item	1		1	
92	pouch, nephrostomy-biliary drainage	SD163	item	1		1	
93	guidewire	SD088	item	1		1	
94	guidewire, hydrophilic (Glidewire)	SD089	item				
95	gauze, sterile 4in x 4in	SG055	item	6		6	
96	tape, surgical paper 1in (Micropore)	SG079	item	12		12	
97	x-ray envelope	SK091	item	1		1	
98	film, x-ray 14inx17in	SK034	item	1		1	
99	x-ray developer solution	SK089	oz	0.5		0.5	
100	x-ray fixer solution	SK092	oz	0.5		0.5	
101	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1		1	
102	computer media, dvd	SK013	item	1		1	
103	stent		item				
104							
105	angiographic room	EL011		X		X	
106	film alternator	ER029		X		X	
107	laser printer for CT angiography	ED024		X		X	
108	3 channel ECG/BP monitor	EQ010		X			
109	IV infusion pump	EQ032		X			
110	oxygen tank			X			
111	pulse oximeter with printer	EQ211		X			

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

**Percutaneous Radiofrequency Ablation of Renal Tumors**

In February 2005, the CPT Editorial Panel added one code to adequately describe percutaneous cryotherapy ablation of renal tumors which is an expansion of existing technology to a new anatomic site and tumor type that was not currently described in CPT.

The RUC first reviewed the specialty society's survey results for code 50592 *Ablation one or more renal tumor(s), percutaneous, unilateral; radiofrequency*. The RUC and the presenters believed that the survey results demonstrated that the new service required physician work than liver radiofrequency ablation, code 47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency* (Work RVU = 15.17). This belief was inaccurate as liver tumor RFA requires a significant more time and physician work than 50592. The RUC agreed that a better key reference code is code 20982 *Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance* (Work RVU = 7.27), although slightly more intense. Since the RUC believed key reference code should have been different, the RUC and the specialty thought it would be appropriate to change two components of the surveyed physician time. **The RUC recommends the total pre-service time to equal 30 minutes from 75 minutes, and eliminate the physician work of a level one hospital visit.**

The RUC, based on these physician time changes, a comparison the work and time of 20982, and a building block approach, determined the relative value for 50592.

**Building Block Approach**

20 minutes of pre-service evaluation and positioning at an intensity of 0.0224 = 0.45

10 minutes of pre-service scrub and dress at an intensity of 0.0081 = 0.08

60 minutes of intra-service work at an intensity of 0.075 = 4.48

30 minutes of immediate post service work with an intensity of 0.0224 = 0.67

½ of a discharge day management service with a RVU = 0.64

1 level two post-operative office follow-up visit with an RVU = 0.43

**RUC recommends a relative work value of 6.75, for code 50592. In addition, conscious sedation was determined to be inherent in this code.**

**Practice Expense**

The RUC reviewed the practice expense inputs for code 50592 in relation with bone ablation code 20982 and made minor changes in clinical labor time and medical equipment.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•50592	OO1	Ablation one or more renal tumor(s), percutaneous, unilateral; radiofrequency  (For bilateral procedure, use modifier 50) (For percutaneous cryotherapy ablation of renal tumors use 0135T).	010	6.75

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

<p>CPT Code:50592 Tracking Number: OO1 Global Period: 010</p> <p>CPT Descriptor: Ablation one or more renal tumor(s), percutaneous, unilateral; radiofrequency (For bilateral procedure, use modifier '-50') (For imaging guidance and monitoring, see code 76362, 76394, 76940)</p>	<p><b>Recommended Work Relative Value</b> Specialty Society RVU: <b>8.11</b> RUC RVU: <b>6.75</b></p>
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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 76-year-old man with poor cardiac function and history of previous open-heart surgery has a 3.0 cm enhancing solid renal mass that was incidentally found as result of a CT scan performed due to patient's complaint of abdominal pain. The patient's comorbidities rule out open total or partial nephrectomy as too risky. The patient is referred for percutaneous renal tumor ablation.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 82%

Is conscious sedation inherent in your reference code? Yes

**Description of Pre-Service Work:**

**The physician:**

- Obtains and reviews pertinent imaging studies and lab results
- Discusses procedure and alternatives with patient and family; answers questions
- Orders blood work including a coagulation profile
- Instructs patient and/or relative to pre-procedural diet and alterations in medication
- Obtains informed consent
- Calls patient ensure compliance with dietary and medication instructions and to answer any remaining questions

**Description of Intra-Service Work:**

**The physician:**

- Supervises the start of an IV and the administration of 0.625mg intravenous droperidol
- Oversees the equipping of the room, the positioning of the patient, and the dispersement of electrodes (ground pads) and skin temperature sensors
- Obtains and interprets initial localization image (included in 76362, 76394 or 76940 – separately reportable) for for selection of the site for initial electrode placement
- Supervises nurse's administration of a dose (or doses) of i.v. conscious sedation which typically is 50ugs fentanyl and 1mg midazolam
- Makes small incision to facilitate RF needle electrode placement
- Introduces 17 gauge, internally cooled radiofrequency needle electrode into the center of the lesion under imaging guidance (imaging included in 76362, 76394 or 76940) to avoid organs and major blood vessels
- Confirms needle tip location using imaging guidance (imaging included in 76362, 76394 or 76940)
- Applies RF power is applied as many times as needed until satisfactory core heating is achieved
- Monitors intratumoral temperature is monitored before and after each treatment (based on the type of RFA device used) to confirm the completion of treatment
- Repeats the process for overlapping ablations as needed to assure complete tumor necrosis and satisfactory margins
- Withdraws the RF electrode, after satisfactory necrosis, and cauterizesto achieve hemostasis along the needle tract
- Cleans incision sites and applies sterile adhesive dressings

## Description of Post-Service Work:

## The physician:

- Follows patient to recovery
- Writes orders for additional pain medication
- Discusses procedure and the planned subsequent course of therapy with the patient and the patient's family
- Checks on patient in recovery for complications and comfort
- Discharges patient with post-procedure instructions
- Dictates, review, and sign report of the procedure
- Discusses outcome with referring physician
- Follows patient with telephone calls
- Sees patient in office for follow-up

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Bibb Allen, MD Robert L. Vogelzang, MD Zachary Rattner, MD				
<b>Specialty(s):</b>	American College of Radiology (ACR) Society of Interventional Radiology (SIR)				
<b>CPT Code:</b>	50592				
<b>Sample Size:</b>	175	<b>Resp n:</b>	39	<b>Response:</b> 22.28 %	
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>
<b>Survey RWV:</b>		8.25	13.50	15.00	15.17
<b>Pre-Service Evaluation Time:</b>				10.0	
<b>Pre-Service Positioning Time:</b>				10.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.0	
<b>Intra-Service Time:</b>		45.00	60.00	60.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>30.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>18.0</u>	99238x 0.50	99239x 0.00		
<b>Office time/visit(s):</b>	<u>15.0</u>	99211x 0.0	12x 1.0	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>
47382	010	15.17

CPT Descriptor Ablation, one or more liver tumor(s), percutaneous, radiofrequency

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
33973	000	9.75

CPT Descriptor 1 Insertion of intra-aortic balloon assist device through the ascending aorta

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
31600	000	7.17

CPT Descriptor 2 Tracheostomy, planned (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
20982	000	7.27

CPT Descriptor Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 34      % of respondents: 87.1 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 50592</u>	<u>Key Reference CPT Code: 47382</u>
Median Pre-Service Time	30.00	30.00
Median Intra-Service Time	60.00	180.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	18.00
Median Office Visit Time	15.0	15.00
Median Total Time	153.00	273.00
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	3.58	3.84
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.84	4.05
Urgency of medical decision making	2.78	3.05

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.11	4.29
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Physical effort required	3.45	3.55
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.05	4.11
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Outcome depends on the skill and judgment of physician	4.47	4.29
--	------	------

Estimated risk of malpractice suit with poor outcome	3.74	3.55
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.79	3.69
----------------------------------	------	------

Intra-Service intensity/complexity	4.28	3.87
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Post-Service intensity/complexity	3.44	3.51
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**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.*

Codes 47382 (liver RF) and 20982 (bone RF) are good comparators to renal RF (code 505XX). Both reference codes utilize the same ablation technology (radiofrequency) and percutaneous techniques to achieve tumor necrosis and margin. However, ranking the three RF applications in terms of physician work, liver came first, followed by renal, and then bone. Renal tumors tend to be smaller and singular than in the liver, which tends to have more and larger tumors. Renal RF presents the same risks associated with heating surrounding soft tissue and hemorrhage as in the liver that are

not present in bone RF. For these reasons, the recommended RVW (8.11) falls within the range of RVWs for liver RF (15.17) and bone RF (7.27).

The recommended RVW for 505XX was derived the building block approach, standard IWPUTs, and RUC-approved IWPUT for previous ablation services.

IWPUT	Survey CPT code:	505XX		
ANALYSIS				
1		MEDIAN Svy		
2	Survey Data	RUC	Standard	RVW
Pre-service		Time Intensity (=time x intensity)		
4	Pre-service eval & positioning	60	0.0224	1.344
5	Pre-service scrub, dress, wait	15	0.0081	0.1215
6	Pre-service total			1.4655
7	Post-service	Time Intensity (=time x intensity)		
8	Immediate post	30	0.0224	0.672
9	Subsequent visits:	Visit n	E/M	RVW
16	99231	1	0.64	0.64
17	Discharge 99238	0.5	1.28	0.64
22	99212	1	0.43	0.43
24	Post-service total			2.382
25		Time	IWPUT	INTRA-RVW
26	Intra-service:	60	0.071	4.26

ACR and SIR chose the IWPUT for 505XX (0.071) based on previous RUC decisions. When liver RF went through the RUC in February 2002, the facilitation committee "agreed that this service was as least as intense as cryosurgical ablation of the prostate (IWPUT=0.71) and that the total work of code 55873 (February 2001 RUC recommendation = 19.19) is comparable to (or less than) the total work of the ablation of the liver tumor 47382, when the radiologic guidance code (76362, 76394, or 76490) is added to this code". When bone RF went through the RUC in September 2003, "the RUC believed that the intra-service work intensity could be compared to code 47382 Ablation, one or more liver tumor(s), percutaneous, radiofrequency (010 day global, Work RVU = 15.19)".

Recommended RVW is equal to the sum of the RVWs for pre- (1.47), intra- (4.26), and post-procedure (2.38) work or 8.11. It is significant to note, that the recommended value is below the lowest value from the survey.

In comparison to codes on the MPC, code 31600 [(Tracheostomy, planned (separate procedure))] is a 0-day global procedure with a RVW of 7.17 and lower intraservice and total service time than 505XX. Code 33973 (Insertion of intra-aortic balloon assist device through the ascending aorta) is a 0-day global procedure with a RVW of 9.75 with 15 minutes more intraservice time than 505XX. Code 33973 has significantly more post-service time than 505XX.

## 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.



Specialty Radiology                      Frequency 400                      Percentage 20.00 %

Specialty Urology                      Frequency 800                      Percentage 40.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 20982

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

	A	B	C	D	E
2				CPT Code 50592	
3	Meeting Date: April 2005			Code Descriptor: Ablation one or more renal tumor(s), percutaneous, unilateral, radiofrequency	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
5	GLOBAL PERIOD			10	10
6	TOTAL CLINICAL LABOR TIME			198	29
7	TOTAL CLINICAL LABOR TIME	I037D	RN/LPN/MTA	64	29
8	TOTAL CLINICAL LABOR TIME	L041B		57	0
9	TOTAL CLINICAL LABOR TIME	L051A		77	0
10	TOTAL PRE-SERV CLINICAL LABOR TIME	I037D	RN/LPN/MTA	14	23
11	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A		0	0
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	I037D	RN/LPN/MTA	23	6
13	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A		77	0
14	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L041B		57	0
15	TOTAL POST-SERV CLINICAL LABOR TIME	I037D	RN/LPN/MTA	27	0
16					
17	Start: Following visit when decision for surgery or procedure made				
18	Complete pre-service diagnostic & referral forms	I037D	RN/LPN/MTA	5	5
19	Coordinate pre-surgery services	I037D	RN/LPN/MTA	3	10
20	Schedule space and equipment in facility	I037D	RN/LPN/MTA		5
21	Provide pre-service education/obtain consent	I037D	RN/LPN/MTA	3	
22	Follow-up phone calls & prescriptions	I037D	RN/LPN/MTA	3	3
23	Other Clinical Activity (please specify)				
24	End:When patient enters office/facility for surgery/procedure				
25					
26	Start: When patient enters office/facility for surgery/procedure				
27	Pre-service services				
28	Review charts				
29	Greet patient and provide gowning	I037D	RN/LPN/MTA	3	
30	Obtain vital signs	I037D	RN/LPN/MTA	5	
31	Provide pre-service education/obtain consent	I037D	RN/LPN/MTA	6	
32	Prepare room, equipment, supplies	L041B		2	
33	Setup scope (non facility setting only)				
34	Prepare and position patient/ monitor patient/ set up IV	L041B		2	
35	Sedate/apply anesthesia	L051A		2	
36	Intra-service				
37	Assist physician in performing procedure - CS	L051A		60	
38	Assist physician in performing procedure (80 percent)	L041B		48	
39	Assist physician in performing procedure –imaging	L041B		0	
40	Post-Service				
41	Monitor pt. following service/check tubes, monitors, drains	L051A		15	
42	Clean room/equipment by physician staff	I037D	RN/LPN/MTA	3	
43	Clean Scope	L041B		5	
44	Clean Surgical Instrument Package				
45	Complete diagnostic forms, lab & X-ray requisitions	I037D	RN/LPN/MTA	3	
46	Review/read X-ray, lab, and pathology reports				
47	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	I037D	RN/LPN/MTA	3	
48	Discharge day management 99238 –12 minutes 99239 –15 minutes	I037D	RN/LPN/MTA		6
49	Other Clinical Activity (please specify)				
50	End: Patient leaves office				
51					
52	Start: Patient leaves office/facility				
53	Conduct phone calls/call in prescriptions				
54	Office visits:				
55	List Number and Level of Office Visits				
56	99211 16 minutes		16		
57	99212 27 minutes		27	1	
58	99213 36 minutes		36		
59	99214 53 minutes		53		
60	99215 63 minutes		63		
61	Other				
62					
63	Total Office Visit Time	I037D		27	0
64	Other Activity (please specify)				
65	End: with last office visit before end of global period				

	A	B	C	D	E
2	Meeting Date: April 2005			CPT Code :50592	
3				Code Descriptor: Ablation one or more renal tumor(s), percutaneous, unilateral, radiofrequency	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
66					
67	pack, minimum multi-specialty visit	SA048		2	1
68	pack, conscious sedation	SA044		1	
69					
70	gown, surgical, sterile [one included with CS pack]	SB028		2	
71	gloves, sterile [one pair included with CS pack]	SB024		2	
72	applicator, sponge-tipped	SG009		4	
73	betadine (ml)	SJ041		60	
74	biopsy tray	SA061		1	
75	blade, surgical (Bard-Parker)	SF033		1	
76	container, sterile 12 oz	SL038		1	
77	cup, biopsy-specimen sterile 4oz	SL036		1	
78	drape, sterile, fenestrated 16in x 29in	SB011		1	
79	drape, sterile, three-quarter sheet	SB014		1	
80	drape-towel, sterile 18inx26in	SB019		4	
81	gauze, sterile 4in x 4in	SG055		3	
82	grounding pad ground	SF021		1	
83	lidocaine 1%-2% inj (Xylocaine)	SH047		10	
84	mask, surgical, with face shield	SB034		3	
85	needle, 18-27g	SC029		2	
86	RF introducer kit	SA026		1	
87	RF probe	SD109		1	
88	shoe covers, surgical	SB039		3	
89	silver nitrate stick	SJ046		1	
90	sodium chloride 0.9% irrigation (500-1000ml)	SH069		1	
91	steri-strips	SG074		6	
92	syringe 10 cc	SC051		1	
93	syringe 20 cc	SC053		1	
94	tape, surgical paper 1in (Micropore)	SG079		12	
95	tincture benzoin swab	SJ060		1	
96	tray, shave prep	SA067		1	
97	underpad 2ftx3ft (Chux)	SB044		1	
98					
99					
100					
101	light exam	EQ168		0	
102	stretcher	EF018		1	
103	CT room	EL007		1	
104	3 channel ECG/BP monitor	EQ010		1	
105	IV infusion pump	EQ032		1	
106	oxygen tank			1	
107	RF generator	EQ241		1	
108	pulse oximeter with printer	EQ211		1	
109	Exam table	EF023		1	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

**Revision-Removal of Vaginal Graft**

The clinical practice involving vaginal reconstructive techniques has expanded and improved to include the use of prosthetic materials. The CPT Editorial Panel created one code to address the surgical problems associated with prosthetic materials that are revised and removed.

The RUC reviewed the specialty's survey results and its rationale for their recommended value. The survey results were well proportioned and supported the recommended physician work value. The specialty calculated the intra-service work per unit of time to be approximately 0.063, which was considered appropriate in comparison to RUC reviewed code 49505 *Repair initial inguinal hernia, age 5 years or over; reducible* (090 day global, Work RVU = 7.59). The RUC also compared code 57295 to RUC reviewed code 46262 *Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy* (090 day global, Work RVU = 7.49) and determined it is also similar in work, complexity, and intensity. The RUC agreed with the specialty's median survey results and recommendation. **The RUC recommends a relative work value of 7.45 for code 57295.**

**Practice Expense**

The RUC reviewed and agreed with the recommended 090 global standard inputs for code 57295 and agreed to add a second drape sheet under medical supplies.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•57295	PP1	Revision (including removal) of prosthetic vaginal graft, vaginal approach	090	7.45

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:57295 Tracking Number: PP1 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: 7.45  
RUC RVU: 7.45

CPT Descriptor: Revision (including removal) of prosthetic vaginal graft, vaginal approach

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65 y/o G4 P4 female patient presents complaining of vaginal discharge, discomfort, and painful intercourse. She underwent abdominal sacral colpopexy using mesh about one year ago, which was uncomplicated. Her past medical history is negative. Her pertinent physical examination reveals mesh eroding through the apex of the vagina. Vaginal apical support is adequate. The surgeon decides that excision is necessary and performs this via the vaginal route.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 3%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes: taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; indications for the procedure and its appropriateness are reviewed; informed consent is obtained; the physician will admit the patient to the hospital; prepare the hospital records and chart in accordance with hospital policy; will check on the patient, and will review labs, x-rays and records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

**Description of Intra-Service Work:**

Access to the vaginal apex is achieved using deep vaginal retractors. Dissection around the eroding mesh is performed sharply. Care is taken not to dissect too deeply to avoid entering the bladder or rectum. The vaginal epithelium is dissected sharply around the eroding mesh, creating a plane between the vaginal epithelium and the endopelvic fascia. This dissection is taken circumferentially about 2 centimeters. The eroding mesh is grasped placing tension outward. All of the eroding material is excised sharply being careful to avoid rectum, bladder, and small bowel. Once excision is complete, the remaining edges of the endopelvic fascia are re-approximated with delayed absorbable suture and the vaginal epithelium is also closed in layers. Irrigation is carried out and a urinary catheter and vaginal packing is placed to complete the procedure.

Description of Post-Service Work: Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. The physician visits the patient in the hospital for 1 day. The patient is discharged on post op day 1 with instructions for follow-up care. The patient has 2-3 visits during the post operative period.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	Robert L. Harris, MD, FACOG; George Hill, MD, FACOG		
<b>Specialty(s):</b>	American College of Obstetricians and Gynecologists		
<b>CPT Code:</b>	57295		
<b>Sample Size:</b>	70	<b>Resp n:</b>	31
		<b>Response:</b>	44.28 %

Sample Type: Panel					
	Low	25 <sup>th</sup> pctl	Median*	75th pctl	High
Survey RWV:	3.18	6.50	7.45	10.60	21.00
Pre-Service Evaluation Time:			15.0		
Pre-Service Positioning Time:			15.0		
Pre-Service Scrub, Dress, Wait Time:			15.0		
Intra-Service Time:	20.00	60.00	60.00	90.00	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
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>36.0</u>	99238x 1.00	99239x 0.00		
Office time/visit(s):	<u>38.0</u>	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>
11008	ZZZ	5.00

CPT Descriptor Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
46262	090	7.49

CPT Descriptor 1 Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
14060	090	8.49

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
57260	090	8.26

CPT Descriptor Combined anteroposterior colporrhaphy

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11      % of respondents: 35.4 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 57295	Key Reference CPT Code: 11008
Median Pre-Service Time	45.00	0.00
Median Intra-Service Time	60.00	60.00
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	36.0	0.00
Median Office Visit Time	38.0	0.00
Median Total Time	199.00	60.00
Other time if appropriate		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	3.36	3.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.64	3.27
Urgency of medical decision making	3.27	2.91

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.36	3.91
Physical effort required	4.09	3.73

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.73	3.55
Outcome depends on the skill and judgment of physician	4.27	3.73
Estimated risk of malpractice suit with poor outcome	4.18	3.91

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.45	3.09
Intra-Service intensity/complexity	4.18	3.82
Post-Service intensity/complexity	3.18	3.09

**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 ACOG Attachment A for Additional Rationale for 572XX.



Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 57260

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

	A	B	C	D	E
1					
2					
3	Meeting Date: April 2005				57295 Revision (including removal) of prosthetic vaginal graft, vaginal approach
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>				90
6	<b>TOTAL CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	0.0	135.0
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	0.0	60.0
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	0.0	12.0
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	0.0	63.0
10					
11	<b>Start: Following visit when decision for surgery or procedure made</b>				
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	<b>End:When patient enters office/facility for surgery/procedure</b>				
19					
20	<b>Start: When patient enters office/facility for surgery/procedure</b>				
21	<b>Pre-service services</b>				
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	<b>Intra-service</b>				
31	Assist physician in performing procedure				
32	<b>Post-Service</b>				
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 min-99239 –15 minutes	L037D	RN/LPN/MTA		12
41	Other Clinical Activity (please specify)				
42	<b>End: Patient leaves office</b>				
43					
44	<b>Start: Patient leaves office/facility</b>				
45	Conduct phone calls/call in prescriptions				
46	<b>Office visits</b>				
47	<i>List Number and Level of Office Visits</i>				
48	99211 16 minutes		16		
49	99212 27 minutes	L037D	27		1
50	99213 36 minutes	L037D	36		1
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54	<b>Total Office Visit Time</b>			0	63
55	Other Activity (please specify)				
56	<b>End: with last office visit before end of global period</b>				
57					
58	drape, non-sterile, sheet 40inX60in	SB006			2
59	kit, suture removal	SA031			1
60	pack, minimum multi-specialty visit	SA048			2
61	pack, pelvic exam	SA051			2
62					
63	power table	E11003			63
64	fiberoptic exam light	E11006			63

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

**Endometrial Sampling**

The CPT Editorial Panel created an add on code upon request by CMS to the specialty society to provide more specificity to endometrial sampling. Code 58100 *Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method* (work RVU = 1.53), was valued by the RUC as though it was performed in absence of a related procedure (separate procedure), and it was not appropriate to report 58100 with 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s)* (work RVU = 2.20), after the completion of a colposcopy procedure. CMS believed that an add-on code for the endometrial sampling would more appropriately reflect the value of this procedure.

58100 had been surveyed in 2001 and RUC reviewed, the specialty society did not survey then new code, but used an expert panel to develop their recommendation. The RUC reviewed the specialty society's panel recommendation in comparison to code 58100, which included a building block approach. The RUC agreed that the intensity for code 58110 is similar to 58100, and to the following building block approaches, that support the specialty recommended value of 0.77 work RVUs.

**Building Block Approaches used to Support Recommended Work RVU**

- 1) The intra-service work per unit of time of 0.097, from code 58100, multiplied by 10 minutes yields a work relative value of 0.97.
- 2) Beginning with the work relative value of 1.53, from code 58100, and subtracting out the pre-service work of 0.56 RVUs (25 minutes x .0224 IWP/UT), yields a work relative value of 0.97.
- 3) Using 99213 as a proxy for the pre-service time on code 58100, involving 23 minutes of physician time, and subtracting this physician work (work RVU = 0.67) from code 58100 (work RVU=1.53), yields a work relative value of 0.86.

In addition, the RUC and the specialty used the standard payment rules whereas services are usually reimbursed at 50% when a -51 modifier is used to establish the RVU for code 58110. Therefore, 50% of the work RVU of 58100 (Work RVU = 1.53) is equal to 0.77. The RUC agreed with this rationale.

**The RUC recommends a relative work value of 0.77 for new code 58110.**

**Practice Expense**

The RUC reviewed and agreed with the practice expense recommendation presented, and there were no adjustments made.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<i>(For speculoscopy, see Category III codes 0031T, 0032T)</i>				
57420		<i>Colposcopy of the entire vagina, with cervix if present;</i>	000	1.60  (No Change)
▲57421		<i>with biopsy(s) of <u>vagina/cervix</u></i>	000	2.20  (No Change)
●+58110	QQ1	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)  (Use 58110 in conjunction with 57420, 57421, 57452, 57454, 57455, 57456, 57460, 57461)	ZZZ	0.77
▲58100		<i>Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)</i>  <i>(For endocervical curettage only, use 57505)</i> <i><u>(For endometrial sampling (biopsy) performed in conjunction with colposcopy (57420, 57421, 57452, 57454, 57455, 57456, 57460, 57461), use 58110)</u></i>	000	1.53  (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:58110 Tracking Number: QQ1 Global Period: ZZZ

**Recommended Work Relative Value**  
Specialty Society RVU: **0.77**  
RUC RVU: **0.77**

CPT Descriptor: Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)  
(Use 574X1 in conjunction with 57420, 57421, 57452, 57454, 57455, 57456, 57460, 57461)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 48 y/o female presents for evaluation of an abnormal cervical cytology result which shows "atypical glandular cells". An interval history and physical examination, including a pelvic exam is performed. Colposcopy of the cervix is performed, and the exocervix appeared normal. In order to evaluate the patient for a lesion in either the endocervix or endometrium, both an endocervical curettage and an endometrial biopsy were performed to determine the source of the atypical glandular cells in the lower genital tract.

NOTE: Survey results for 58100 were used to develop this recommendation.

Percentage of Survey Respondents who found Vignette to be Typical:

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: This is an add-on code. There is no additional pre- or post-service work.

Description of Intra-Service Work: Since the speculum has already been properly positioned, the physician work for this add-on begins by prepping the cervix with an anti-septic solution. The anterior lip of the cervix is grasped with a tenaculum and the uterus is sounded with a uterine sound to gage the depth of the endometrial cavity. The endometrial curette is passed through the cervix to the fundus of the uterus. The endometrial biopsy is performed in four quadrants by applying suction with a syringe attached to the hollow curette. Three passes with the suction curette are typically performed. The curette is withdrawn and the tissue is placed in formalin. The tenaculum is removed. Pressure is applied to the cervix to control any post operative bleeding. The speculum is removed and the patient is taken down from the lithotomy position.

Description of Post-Service Work:

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	George Hill, MD, FACOG				
Specialty(s):	American College of Obstetricians and Gynecologists				
CPT Code:	58110				
Sample Size:	0	Resp n:	0	Response:	0.00 %
Sample Type:					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
Survey RVW:					
Pre-Service Evaluation Time:			0.0		
Pre-Service Positioning Time:			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>				<b>9.00</b>		
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>0.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
58100	000	1.53

CPT Descriptor Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99213	XXX	.67

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
11100	000	.81

CPT Descriptor 2 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 58110</u>	<u>Key Reference CPT Code: 58100</u>
Median Pre-Service Time	0.00	20.00
Median Intra-Service Time	9.00	10.00
Median Immediate Post-service Time	0.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	9.00	35.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		3.00
Urgency of medical decision making		3.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required		3.00
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Physical effort required		3.00
--------------------------	--	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		2.00
---	--	------

Outcome depends on the skill and judgment of physician		3.00
--	--	------

Estimated risk of malpractice suit with poor outcome		3.00
--	--	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity		3.00
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Intra-Service intensity/complexity		3.00
------------------------------------	--	------

Post-Service intensity/complexity		2.00
-----------------------------------	--	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Please see Attachment A entitled "Additional Rational for +574X1". The Summary of Recommendation for 58100 is also included. This is the RUC Rationale that was included with the recommendation to HCFA (now CMS) in 2002, when CPT code 58100 was surveyed:

"HCFA requested that the RUC review CPT codes 56605, 56810, and 58100. The RUC is recommending no change in codes 56605 and 56810 as explained below. The RUC is recommending an increase for code 58100 and recommending revised direct practice expense inputs for this service.



Specialty	Frequency	Percentage	%
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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	Frequency	Percentage	%
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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

	A	B	C	D	E
1					
2				<b>58110</b>	
3	Meeting Date: April 2005			Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure) (Use 574X1 in conjunction with 57420, 57421, 57452, 57454, 57455, 57456, 57460, 57461)	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
5	GLOBAL PERIOD			ZZZ	
6	TOTAL CLINICAL LABOR TIME	L039D	RN/LPN/MTA	6.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			6.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0
10					
11	<b>Start: Following visit when decision for surgery or procedure made</b>				
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	<b>End: When patient enters office/facility for surgery/procedure</b>				
19					
20	<b>Start: When patient enters office/facility for surgery/procedure</b>				
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	L039D	RN/LPN/MTA	6	
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	<b>End: Patient leaves office</b>				
43					
44	<b>Start: Patient leaves office/facility</b>				
45	Conduct phone calls/call in prescriptions				
46	Office visits:				
47	List Number and Level of Office Visits				
48	99211 16 minutes		16		
49	99212 27 minutes		27		
50	99213 36 minutes		36		
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54	Total Office Visit Time			0	0
55	Other Activity (please specify)				
56	<b>End: with last office visit before end of global period</b>				
57					
58	curette, suction, endometrial (Pipelle)	SD039		1	
59					
60	power table	E11003		6	
61	fiberoptic exam light	E11006		6	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

**Intracranial Angioplasty and Stenting**

The CPT Editorial Panel created five new CPT Codes to describe new procedures involving intracranial angioplasty and stenting. Prior to the Panel's action, there were no codes to describe this treatment of patients with impaired cerebral circulation due to arterial narrowing. Angioplasty and stenting of the arteries supplying the brain is more complex than peripheral and coronary angioplasty and stenting cases.

**61630 and 61635**

The RUC first reviewed codes 61630 *Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous* and 61635 *Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty if performed*. Both codes were reviewed in comparison to their key reference service 61624 *Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord) (000 day global, Work RVU = 20.12)*, their intra-service work per unit of time, and physician time. Several of the surveyed respondents chose the specialty society's reference service as the code that they believed best represented the intensity of this service. The RUC believed that the specialty's survey results were well distributed reflected the intensity of these services. However, the RUC and the presenters agreed, that the specialty's survey results of 61630 and 61635, needed some adjustments in physician time and recommended work value to reflect the typical patient encounter. **The RUC recommends a reduction in the level of one hospital visit from a level two to a level one, and the reduction of the level four office visit to a level three, for codes 61630 and 61635.** This reduction in the levels of post operative visits were used to reduce the physician work recommendation below the surveyed, and specialty recommended, 25<sup>th</sup> percentile work relative value of 21.50. **In addition, the RUC recommends relative work values of 21.08 for code 61630 and 23.08 for code 61635.**

**61640**

The presenters stated that CPT Code 61640 *Balloon dilatation of intracranial vasospasm, percutaneous, initial vessel* was surveyed as a 090 day global code prior to the change in the global to a 000 day global code. CMS representatives at the RUC meeting were comfortable with the code having a 000 day global period. The specialty society's survey results reflected the work of a 090 global code which skewed the median work RVU upward. The RUC compared code 61640 to RUC reviewed code 37216 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection* (090 day global, Work

RVU = 17.98), and realized the intensity for the new code was high, but not as high as code 37216. The RUC discussed the specialty's recommended value and believed reductions in physician time and recommended work value were necessary to reflect the 000 day global period and the typical patient encounter. **The RUC recommends the pre-service evaluation and positioning be reduced from 70 and 18 minutes to 45 and 12 minutes respectively.** While agreeing with the pre-service time change specialty society suggested a building block approach consisting of an IWPUT of 0.107, to arrive at the work RVU. The RUC agreed with the intensity recommended by the specialty and from the changes in pre-service time, the RUC used the following building block approach to establish a work relative value for code 61640.

### **Building Block Approach**

57 minutes of pre-service evaluation and positioning at an intensity of  $0.0224 = 1.28$

20 minutes of pre-service scrub and dress at an intensity of  $0.0081 = 0.16$

90 minutes of intra-service work at an intensity of  $0.107 = 9.54$

60 minutes of immediate post service work with an intensity of  $0.0224 = 1.34$

**The RUC recommends a relative work value of 12.32 for code 61640.**

### **61641 and 61642**

The RUC reviewed the two add-on codes 61641 *Balloon dilatation of intracranial vasospasm, percutaneous, initial vessel; each additional vessel in same vascular family* and 61642 *Balloon dilatation of intracranial vasospasm, percutaneous, initial vessel; each additional vessel in different vascular family* and believed that the intensity for the codes was justified as there is no surgical rescue for procedural complications that occur in the cerebral vasculature. The RUC agreed that based on the specialty society's survey results indicating a very high intensity, and the RUC reviewed comparison service of 37216 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection* (090 day global, Work RVU = 17.98), the intensity of these two add on codes was approximately 0.144. The RUC multiplied the physician time in the intra-service period by the agreed upon intensity to arrive at a relative work value for each code. The resulting work RVUs were deemed appropriate even though they were below the median survey results. The RUC and the specialty also agreed that although the survey results indicated pre and post service physician time, the typical patient encounter did not include this time, and it was extracted from the survey results. **The RUC recommends a relative work value of 4.33 for code 61641 and 8.66 for code 61642.**

### **Practice Expense**

The RUC approved the standard inputs for all of these facility only codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
61624		<p><i>Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)</i></p> <p><i>(See also 37204)</i></p> <p><i>(For radiological supervision and interpretation, use 75894)</i></p>	000	20.12  (No Change)
61626		<p><i>non-central nervous system, head or neck (extracranial, brachiocephalic branch)</i></p> <p><i>(See also 37204)</i></p> <p><i>(For radiological supervision and interpretation, use 75894)</i></p>	000	16.60  (No Change)
•61630	RR1	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	090	21.08
•61635	RR2	<p>Transcatheter placement of intravascular stent(s) , intracranial (eg, atherosclerotic stenosis), including balloon angioplasty if performed</p> <p>(61630 and 61635 include all selective vascular catheterization of the target vascular family, all diagnostic imaging for arteriography of the target vascular family and all related radiological supervision and interpretation. When diagnostic arteriogram (including imaging and selective catheterization) confirms the need for angioplasty or stent placement, 61630 and 61635 are inclusive of these services. If angioplasty or stenting are not indicated, then the appropriate codes for selective catheterization and imaging should be reported in lieu of 61630 and 61635)</p>	090	23.08
•61640	RR3	Balloon dilatation of intracranial vasospasm, percutaneous, initial vessel	000	12.32
•+61641	RR4	each additional vessel in same vascular family (List separately in addition to code for primary procedure)	ZZZ	4.33

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•+61642	RR5	<p>each additional vessel in different vascular family (List separately in addition to code for primary procedure)</p> <p>(Use 61641 and 61642 in conjunction with 61640)</p> <p>(61640, 61641, 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for the balloon dilatation)</p>	ZZZ	8.66

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:61630 Tracking Number: RR1 Global Period: 090

**Recommended Work Relative Value  
Specialty Society RVU: 21.50  
RUC RVU: 21.08**

CPT Descriptor: Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous

(61630 and 61635 include all selective vascular catheterization of the target vascular family, all diagnostic imaging for arteriography of the target vascular family and all related radiological supervision and interpretation. When the diagnostic arteriogram (including imaging and selective catheterization) confirms the need for angioplasty or stent placement, 61630 and 61635 are inclusive of these services. If angioplasty or stenting are not indicated, then the appropriate codes for selective catheterization and imaging should be reported in lieu of code 61630 and 61635.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Vignette Used in Survey:

A 66-year-old male with history of left hemisphere transient ischemic attacks, which persist on medical therapy. Carotid duplex exam demonstrated no significant stenosis of the left carotid bifurcation. MR angiography of the head is suspicious for significant stenosis of the M1 segment of the left middle cerebral artery. The patient is referred for possible intracranial angioplasty. NOTE: The proposed new code includes all selective vascular catheterization of the target vascular family, all diagnostic imaging for arteriography of the target vascular family and all related radiological supervision and interpretation. Additionally, when the diagnostic arteriogram (including imaging and selective catheterization) confirms the need for angioplasty or stent placement, 61630 is inclusive of these services. If angioplasty or stenting are not indicated, then the appropriate codes for selective catheterization and imaging should be reported in lieu of code 61635

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?

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work: PRE-PROCEDURE WORK** Previous radiographic imaging studies are reviewed including CT and MRI scans of the brain and diagnostic cervico-cerebral angiography. Clinical history and physical findings are reviewed. Based on review of all previous diagnostic studies, the physician estimates the range of guiding catheters/sheaths, guide wires, selective catheters and balloons, that may be required, and ensures that all are available for use. (Final device selection requires precise, quantitative measurements of the artery to be treated that are usually not obtained during routine diagnostic angiography.) 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. 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 technique and are fully familiar with all required devices. Prior films/studies are located and reviewed. Don radiation protection Position (or supervise proper positioning of) patient

**Description of Intra-Service Work:** The common femoral artery is accessed and a sheath placed under sterile conditions. A bolus dose of intravenous heparin is administered. The ACT is checked. Additional heparin is given as necessary throughout the procedure, and the ACTs are monitored at appropriate intervals. Pressurized,

continuous heparin/saline flush systems are prepared. Meticulous examination of these systems is performed by the physician to exclude the possibility of residual air bubbles. Left common carotid artery selectively catheterized with 5 Fr catheter. Biplane AP and lateral angiograms of the cervical common carotid artery are obtained. If necessary, oblique views are obtained to profile carotid the carotid bifurcation. Biplane AP and lateral (and possibly oblique) angiograms of the intracranial vessels are also obtained to determine that no interval change has occurred since the original diagnostic angiogram. Advance catheter into the external carotid artery over a steerable guidewire.

Utilizing an exchange wire placed into the external carotid artery, a neuroguide catheter is placed into the common carotid artery. A common carotid artery angiogram is obtained to confirm appropriate positioning of the guide catheter below the carotid bifurcation and to exclude the possibility of arterial spasm, dissection or thromboembolus during guide catheter placement. The guide catheter is then advanced into the internal carotid artery over a steerable guide wire. A cervical internal carotid artery angiogram is obtained to confirm appropriate positioning of the guide catheter and to exclude the possibility of arterial spasm, dissection or thromboembolus. Guide catheter is placed on continuous heparin flush utilizing a flow control Y-connector. Biplane AP, lateral and oblique angiograms of the cerebral vessels are obtained. High magnification biplane angiograms are then obtained, centered upon the arterial stenosis. The target lesion must be carefully reassessed for subtle changes that indicate the development of subacute intraluminal thrombus, which is a contraindication to performance of angioplasty. Precise, quantitative measurements of the stenotic artery are obtained to determine the proper diameter and length of the angioplasty balloon to be used. External reference markers may be placed on the skin in order to calculate the precise dimensions. Prepare appropriate size angioplasty balloon. Meticulous preparation is done by the physician to eliminate the air within the balloon. Advance a steerable micro-guidewire and a low profile microcatheter through the guide catheter into the intracranial arteries using an angiographic roadmap. Gently advance micro-guidewire and microcatheter across the arterial stenosis. Remove the guidewire and replace with an exchange length wire, leaving the wire tip beyond the stenotic area. Remove microcatheter. Advance micro-angioplasty balloon over the exchange wire and across the stenosis. Slowly inflate balloon to dilate the lesion under fluoroscopic control while monitoring balloon pressure. Deflate balloon and withdraw into internal carotid artery, leaving the guidewire across the stenosis. Obtain post-angioplasty angiograms by injecting contrast through the guide catheter to confirm satisfactory dilation of vessel lumen and antegrade filling of distal blood vessels. Wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosis. If evidence of rebound stenosis, replace balloon to re-dilate the lesion or exchange for a larger angioplasty balloon if needed. Again wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosis. After a fifteen-minute period of observation with no further evidence of restenosis or acute arterial occlusion, remove the balloon and wire; then obtain final angiograms of the regional circulation to check for possible embolic complications. Remove guide catheter. All fluoroscopy, contrast injection, angiography and image interpretation associated with the arterial stenosis treated is included in the procedure up to this point

Description of Post-Service Work: A brief operative note is made in the medical record. Write post-op orders. Communicate with family & referring physicians. A complete neurological examination is repeated as soon as the patient has emerged from the effects of the anesthesia. Angiographic images are reviewed and post-processed including quantitative measurement of any residual arterial stenosis. Final copies are stored in the permanent patient record. A detailed operative note is dictated. The femoral artery sheath is removed after the ACT has returned to an acceptable level. 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**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	John Barr, MD; John Wilson, MD; Robert Vogelzang, MD
<b>Specialty(s):</b>	American Society of Interventional and Therapeutic Neuroradiology, American Society of Neuroradiology, American Association of Neurological Surgeons, Society of Interventional Radiology
<b>CPT Code:</b>	61630

<b>Sample Size:</b> 175	<b>Resp n:</b> 41	<b>Response:</b> 23.42 %			
<b>Sample Type:</b> Random					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	12.40	21.50	25.00	30.00	50.00
<b>Pre-Service Evaluation Time:</b>			30.0		
<b>Pre-Service Positioning Time:</b>			15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			20.0		
<b>Intra-Service Time:</b>	45.00	120.00	140.00	180.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>45.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>49.0</u>	99231x 1.0	99232x 1.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<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:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
37216	090	17.98

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
61624	000	20.12

CPT Descriptor Transcatheter permanent occlusion or embolization (eg, for tumor destruction to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8      % of respondents: 19.5 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 61630	Key Reference CPT Code: 37216
Median Pre-Service Time	65.00	90.00
Median Intra-Service Time	140.00	97.00
Median Immediate Post-service Time	45.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	49.0	30.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	46.0	46.00
Median Total Time	381.00	329.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.27	4.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.59	3.80
Urgency of medical decision making	4.29	3.70

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.73	4.10
Physical effort required	4.27	3.90

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.95	4.30
Outcome depends on the skill and judgment of physician	4.85	4.50
Estimated risk of malpractice suit with poor outcome	4.71	4.50

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.28	3.80
Intra-Service intensity/complexity	4.70	4.30
Post-Service intensity/complexity	4.23	3.80

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Surveys were distributed to physicians representing specialties and sub-specialties in radiology and surgery. Response rate was excellent, and the data are tightly clustered. The procedure selected most often as reference services were CPT 61624- transcatheter embolization, and CPT 37216-carotid stent placement. We chose 37216 as our key reference service because it has been recently surveyed by the RUC and is a 90-day global, whereas 61624 has never been RUC surveyed and is a 000-day global. The carotid angioplasty and stent code is appropriate comparison from a clinical perspective since the endovascular techniques using the balloon in the intracranial artery are similar to the endovascular



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 IR/Rad/Neurorad	Frequency 15000	Percentage	%
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Specialty Neurosurgery	Frequency 15000	Percentage	%
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Specialty	Frequency 0	Percentage	%
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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:61635 Tracking Number: RR2 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **23.5**  
RUC RVU: **23.08**

CPT Descriptor: Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty if performed.

(61630 and 61635 include all selective vascular catheterization of the target vascular family, all diagnostic imaging for arteriography of the target vascular family and all related radiological supervision and interpretation. When the diagnostic arteriogram (including imaging and selective catheterization) confirms the need for angioplasty or stent placement, 61630 and 61635 are inclusive of these services. If angioplasty or stenting are not indicated, then the appropriate codes for selective catheterization and imaging should be reported in lieu of code 61630 and 61635.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 66-year-old male with history of left hemisphere transient ischemic attacks, which persist on medical therapy. Carotid duplex exam demonstrated no significant stenosis of the left carotid bifurcation. MR angiography of the head is suspicious for significant stenosis of the M1 segment of the left middle cerebral artery. The patient is referred for possible intracranial stent.

NOTE: The proposed new code includes all selective vascular catheterization of the target vascular family, all diagnostic imaging for arteriography of the target vascular family and all related radiological supervision and interpretation. Additionally, when the diagnostic arteriogram (including imaging and selective catheterization) confirms the need for angioplasty or stent placement, 61635 is inclusive of these services. If angioplasty or stenting are not indicated, then the appropriate codes for selective catheterization and imaging should be reported in lieu of code 61635.

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?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service 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 technique and are fully familiar with all required devices. Prior films/studies are located and reviewed. · Don radiation protection. · Position (or supervise proper positioning of) patient

Description of Intra-Service Work: · The common femoral artery is accessed and a 5 Fr. sheath placed under sterile conditions. · A bolus dose of intravenous heparin is administered. · Right common carotid artery selectively catheterized with 5 Fr catheter. · Advance catheter into the internal carotid artery over guidewire. · Utilizing a neuro exchange wire, a neuroguide catheter is placed into the internal carotid artery. · Biplane AP and lateral angiograms of the cerebral vessels are obtained. High magnification biplane angiograms are then obtained centered upon the arterial stenosis. Precise, quantitative measurements of the stenotic artery are obtained to determine the proper diameter and length of the angioplasty balloon to be used. External reference markers may be placed on the skin to calculate the precise dimensions. · Inject contrast in PA and lateral images with external marker in place to measure diameter and length of stenotic segment and assess local flow dynamics. · Prepare appropriate size angioplasty balloon and stent systems. · Advance hydrophilic guidewire and a low profile microcatheter through the guide catheter using angiographic roadmap into the stenotic vessel. · Pass microcatheter across the middle cerebral artery stenosis. · Remove the guidewire and replace with an exchange wire, leaving tip beyond the stenotic area. · Advance micro-angioplasty balloon over the exchange wire and across the stenosis. ·

Slowly inflate the balloon to pre-dilate the lesion under fluoroscopic control while monitoring balloon pressure. Deflate balloon and withdraw into internal carotid artery, leaving the guidewire across the stenosis.

Obtain post-angioplasty angiograms by injecting contrast through the guide catheter to confirm satisfactory pre-dilation of vessel lumen such that subsequent passage of stent will be possible. If pre-dilation appears to be insufficient to allow subsequent stent placement, replace balloon to re-dilate the region or change to larger angioplasty balloon and repeat angioplasty as necessary. Remove angioplasty balloon, leaving the micro-exchange wire across the lesion. Advance the stent delivery system across stenosis; deploy stent. Withdraw stent delivery catheter into the internal carotid artery, leaving the microguidewire across stenosis. Obtain post-stent placement angiograms by injecting contrast through the guide catheter to confirm satisfactory dilation of vessel lumen and antegrade filling of distal blood vessels. Wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion. Remove guidewire. Obtain final angiograms of the entire vascular circulation to check for possible embolic complications. Remove guide catheter.

Description of Post-Service Work: A brief operative note is made in the medical record. Write post-op orders. Communicate with family & referring physicians. A complete neurological examination is repeated as soon as the patient has emerged from the effects of the anesthesia. A detailed operative note is dictated. The femoral artery sheath is removed. 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

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	John Barr, MD; John Wilson, MD; Robert Vogelzang, MD				
<b>Specialty(s):</b>	American Society of Interventional and Therapeutic Neuroradiology, American Society of Neuroradiology, American Association of Neurological Surgeons, Society of Interventional Radiology				
<b>CPT Code:</b>	61635				
<b>Sample Size:</b>	175	<b>Resp n:</b>	41	<b>Response:</b>	23.42 %
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		16.00	22.00	23.50	35.00
<b>Pre-Service Evaluation Time:</b>				30.0	
<b>Pre-Service Positioning Time:</b>				15.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				20.0	
<b>Intra-Service Time:</b>		50.00	120.00	150.00	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>45.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>60.0</u>	99231x 0.0	99232x 2.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>36.0</u>	99238x 1.00	99239x 0.00		
<b>Office time/visit(s):</b>	<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:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
37216	090	17.98

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
61624	000	20.12

CPT Descriptor Transcatheter permanent occlusion or embolization (eg, for tumor destruction to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9      % of respondents: 21.9 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 61635</u>	<u>Key Reference CPT Code: 37216</u>
Median Pre-Service Time	65.00	90.00
Median Intra-Service Time	150.00	97.00
Median Immediate Post-service Time	45.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	60.0	30.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	46.0	46.00
Median Total Time	402.00	329.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.41	3.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.51	3.78
Urgency of medical decision making	4.29	3.56

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.80	4.11
Physical effort required	4.41	3.89

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.93	4.22
Outcome depends on the skill and judgment of physician	4.85	4.56
Estimated risk of malpractice suit with poor outcome	4.71	4.44

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.39	3.78
Intra-Service intensity/complexity	4.76	4.33
Post-Service intensity/complexity	4.27	3.67

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Overview:**

Surveys were distributed to physicians representing specialties and sub-specialties in radiology and surgery. Response rate was excellent, and the data are tightly clustered. The procedures selected most often as reference services were CPT 61624- transcatheter embolization and CPT 37216-carotid stent placement, which was recently surveyed by the RUC. The transcatheter embolization comparison is appropriate from a clinical perspective since the microvascular

surgical techniques using the balloon in the intracranial artery are similar. Both procedures have a similar level of extreme intensity and potential patient risk to the patient. However, while intravascular stent placement has been assigned a 90-day global period, transcatheter embolization has a 000-day global. Therefore we did not use this code as the key reference.

Carotid stent placement 37216 is also an excellent comparison service because both carotid and intracranial stent placement require superior catheter skills. Both procedures are methods to treat severe or critical stenosis of the cerebrovascular circulation. The new code has a higher level of intensity because the catheterization involves the intracranial vessels which are significantly smaller and more fragile than the cervical carotid. Likewise, the consequences of a bad outcome in both situations are extreme including stroke or death. However, the level of potential patient risk is greater in the intracranial procedure.

#### Rationale and IWP/UT Analysis

We believe that the survey results and the following IWP/UT analysis serve to justify the median survey response of 23.50 as an appropriate RVW for this new service. The key reference code of carotid angioplasty and stent has been RUC surveyed with an intra-service time of 97 minutes and an IWP/UT of 0.122. The intra-service time of the new code is 150 minutes with an IWP/UT of 0.111. These values appropriately reflect the increased intensity and work that was demonstrated by the median survey values. This proposed value is also appropriate relative to code 6162X1 as the placement and expansion of the intravascular stent is significantly more intense with greater risks than the angioplasty alone because the stent must be navigated over a wire through the tortuous carotid siphon and then through the intracranial vessels.

#### 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) 37799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty IR/Rad/Neurorad                      How often? Sometimes

Specialty Neurosurgery                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty IR/Rad/Neurorad                      Frequency 20000                      Percentage 0.00 %

Specialty Neurosurgery                      Frequency 20000                      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 IR/Rad/Neurorad                      Frequency 15000                      Percentage 0.00 %

Specialty Neurosurgery                      Frequency 15000                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States?

### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? 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:61640 Tracking Number: RR3 Global Period: 000

**Recommended Work Relative Value**  
Specialty Society RVU: **12.71**  
RUC RVU: **12.32**

CPT Descriptor: Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel

(61640, 61641, and 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 42 year-old female with recent subarachnoid hemorrhage deteriorates clinically. She undergoes complete cerebral angiography (separately reportable even if performed on the same day), which demonstrates significant spasm of the supraclinoid segment of the right internal carotid artery. After reporting this finding to the attending neurosurgeon, he requests balloon dilatation of the spastic segment.

**NOTE:** The proposed new code includes all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

**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?

**Is conscious sedation inherent in your reference code? No**

**Description of Pre-Service 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 technique and are fully familiar with all required devices. Prior films/studies are located and reviewed. · Don radiation protection · Position (or supervise proper positioning of) patient

**Description of Intra-Service Work:** · The common femoral artery is accessed and a sheath placed under sterile conditions. · A bolus dose of intravenous heparin is administered. · The ACT is checked. Additional heparin is given as necessary throughout the procedure, and the ACTs are monitored at appropriate intervals. · Pressurized, continuous heparin/saline flush systems are prepared. Meticulous examination of these systems is performed by the physician to exclude the possibility of residual air bubbles. · Left common carotid artery selectively catheterized with 5 Fr catheter. · Biplane AP and lateral angiograms of the cervical common carotid artery are obtained. If necessary, oblique views are obtained to profile carotid the carotid bifurcation. Biplane AP and lateral (and possibly oblique) angiograms of the intracranial vessels are also obtained to determine that no interval change has occurred since the original diagnostic angiogram. · Advance catheter into the external carotid artery over a steerable guidewire. ·

Utilizing an exchange wire placed into the external carotid artery, a neuroguide catheter is placed into the common carotid artery. · A common carotid artery angiogram is obtained to confirm appropriate positioning of the guide catheter below the carotid bifurcation and to exclude the possibility of arterial spasm, dissection or thromboembolus during guide catheter placement. · The guide catheter is then advanced into the internal carotid artery over a steerable guide wire. · A cervical internal carotid artery angiogram is obtained to confirm appropriate positioning of the guide catheter and to exclude the possibility of arterial spasm, dissection or thromboembolus. · Guide catheter is placed on continuous heparin flush utilizing a flow control Y-connector. · Biplane AP, lateral and oblique angiograms of the cerebral vessels are obtained. High magnification biplane angiograms are then obtained, centered upon the arterial stenosis. The target lesion must be carefully reassessed for subtle changes that indicate the development of subacute intraluminal thrombus, which is a contraindication to performance of angioplasty. Precise, quantitative measurements of the stenotic artery are obtained to determine the proper diameter and length of the

angioplasty balloon to be used. External reference markers may be placed on the skin in order to calculate the precise dimensions. Prepare appropriate size angioplasty balloon. Meticulous preparation is done by the physician to eliminate the air within the balloon. Advance a steerable micro-guidewire and a low profile microcatheter through the guide catheter into the intracranial arteries using an angiographic roadmap. Gently advance micro-guidewire and microcatheter across the arterial stenosis. Remove the guidewire and replace with an exchange length wire, leaving the wire tip beyond the stenotic area. Remove microcatheter. Advance micro-angioplasty balloon over the exchange wire and across the stenosis. Slowly inflate balloon to dilate the lesion under fluoroscopic control while monitoring balloon pressure. Deflate balloon and withdraw into internal carotid artery, leaving the guidewire across the stenosis. Obtain post-angioplasty angiograms by injecting contrast through the guide catheter to confirm satisfactory dilation of vessel lumen and antegrade filling of distal blood vessels. Wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosis. If evidence of rebound stenosis, replace balloon to re-dilate the lesion or exchange for a larger angioplasty balloon if needed. Again wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosis. After a fifteen-minute period of observation with no further evidence of restenosis or acute arterial occlusion, remove the balloon and wire; then obtain final angiograms of the regional circulation to check for possible embolic complications. Remove guide catheter. All fluoroscopy, contrast injection, angiography and image interpretation associated with the arterial stenosis treated is included in the procedure up to this point

Description of Post-Service Work: A brief operative note is made in the medical record. Write post-op orders. Communicate with family & referring physicians. A complete neurological examination is repeated as soon as the patient has emerged from the effects of the anesthesia. Angiographic images are reviewed and post-processed including quantitative measurement of any residual arterial stenosis. Final copies are stored in the permanent patient record. A detailed operative note is dictated. The femoral artery sheath is removed after the ACT has returned to an acceptable level. Review, revise, sign final report. Send formal report to PCP and referring providers

## SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	John Barr, MD; John Wilson, MD; Robert Vogelzang, MD				
<b>Specialty(s):</b>	American Society of Interventional and Therapeutic Neuroradiology, American Society of Neuroradiology, American Association of Neurological Surgeons, Society of Interventional Radiology				
<b>CPT Code:</b>	61640				
<b>Sample Size:</b>	175	<b>Resp n:</b>	41	<b>Response:</b>	%
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	9.47	19.00	20.00	25.00	40.00
<b>Pre-Service Evaluation Time:</b>			40.0		
<b>Pre-Service Positioning Time:</b>			17.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			20.0		
<b>Intra-Service Time:</b>	30.00	60.00	90.00	150.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>60.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30);

99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
61624	000	20.12

CPT Descriptor Transcatheter permanent occlusion or embolization (eg, for tumor destruction to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
37216	090	17.98

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without 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: 23      % of respondents: 56.0 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 61640	Key Reference CPT Code: 61624
Median Pre-Service Time	77.00	0.00
Median Intra-Service Time	90.00	0.00
Median Immediate Post-service Time	60.00	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	227.00	0.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.10	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.15	3.60
Urgency of medical decision making	4.85	3.50

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.67	4.10
Physical effort required	4.15	3.80
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.83	3.98
Outcome depends on the skill and judgment of physician	4.75	4.10
Estimated risk of malpractice suit with poor outcome	4.45	4.03

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.03	3.73
Intra-Service intensity/complexity	4.53	4.15
Post-Service intensity/complexity	3.95	3.53

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Overview:

Surveys were distributed to physicians representing specialties and sub-specialties in radiology and surgery. Response rate was excellent, and the data are tightly clustered. The procedure selected most often as reference services were CPT 61624 transcatheter embolization, and CPT 37216 carotid stent placement, which was recently surveyed by the RUC. The transcatheter embolization comparison is appropriate from a clinical perspective since the microvascular surgical

techniques using the balloon in the intracranial artery are similar. Both procedures have a similar level of extreme intensity and potential patient risk to the patient

### Rationale and IWP/UT Analysis

We believe that the survey results and the following IWP/UT analysis serve to justify 12.71 as an appropriate RVW for this new service if valued with a 000-day global. Although a 90-day global period was assigned to the intracranial vasospasm code we believe that this assignment was done in error and had subsequently asked for pre-facilitation to discuss this matter. A 90-day global for this code is problematic for several reasons: the typical patient has previously undergone a procedure for definite treatment of a ruptured aneurysm. The patient subsequently develops cerebral vasospasm during the 90-day global period of the original procedure. The patients that will undergo this new procedure are symptomatic from cerebral ischemia, are in an ICU and are refractory to medical management consisting of hypertensive, hypervolemic therapy. These patients are generally critically ill. After undergoing cerebral angioplasty for treatment of this vasospasm they will still require intensive, and potentially prolonged, medical management that will still fall under the original 90-day global period. These patients may subsequently develop vasospasm in other vascular territories or recurrent vasospasm within the treated vessel(s). Balloon dilatation may thus be required on more than one occasion. This may be performed by another physician because a group of physicians is typically available to provide continuous coverage of this procedure. It was clear that our survey respondents had enormous difficulty quantifying the post-procedure care. We feel this was because there is enormous variability both in the length of stay and the level of post-operative E&M visits. We felt that a 000-day global was most appropriate for this code, however, it was assigned a 90-day global by CMS. We surveyed this code with the 90-day global and have included that data in this summary recommendation form. We requested pre-facilitation in an attempt to address the issue of the global period. At the pre-facilitation committee meeting, CMS indicated a willingness to reconsider the global period. We have calculated what we feel is an appropriate value for 6162X3 with a 000-day global utilizing a reverse building block analysis in which we backed out the value of all of the post procedure E&M not accounted for in a 000-day global. On the basis of this analysis, we are recommending an RVW of 12.71 with a calculated IWP/UT of 0.106. This value is appropriate relative to the key reference service of 61624 in terms of rank order comparison. Unfortunately, this key reference service does not have RUC survey data and is not on the RUC MPC. We did compare this code to several 000-day global codes on the MPC and our values look appropriate in comparison (see the following table) .

### 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) 37799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty IR/Rad/Neurorad                      How often? Sometimes

Specialty Neurosurgery                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty IR/Rad/Neurorad                      Frequency 20000                      Percentage                      %

Specialty Neurosurgery                      Frequency 20000                      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 IR/Rad/Neurorad                      Frequency 15000                      Percentage                      %

Specialty Neurosurgery                      Frequency 15000                      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:61641 Tracking Number: RR4 Global Period: ZZZ

**Recommended Work Relative Value**  
Specialty Society RVU: 5.00  
RUC RVU: 4.33

CPT Descriptor: Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in the same vascular family (List separately in addition to code for primary procedure)

(Use 61641 and 61642 in conjunction with 61640)

(61640, 61641, and 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 55 year-old male with recent subarachnoid hemorrhage. Complete cerebral angiography (separately reportable even if performed on the same day) demonstrated significant vasospasm in the supraclinoid left internal carotid artery and the M1 segment of the left middle cerebral artery. After reporting this finding to the attending neurosurgeon, he/she requests balloon dilatation of the spastic segments. The internal carotid spasm balloon dilatation is completed (separately reportable) and the M1 segment spasm is now to be balloon dilated.

NOTE: 61641 is considered an ADD-ON procedure code that should be reported in conjunction with 61640. Additionally, the proposed new code includes all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

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?

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Description of Intra-Service Work: · A second bolus dose of intravenous heparin may be administered. · The ACT is checked. Additional heparin is given as necessary throughout the procedure, and the ACTs are monitored at appropriate intervals. · Biplane AP, lateral and oblique angiograms of the cerebral vessels are obtained. High magnification biplane angiograms are then obtained, centered upon the arterial stenosis. The target lesion must be carefully reassessed for subtle changes that indicate the development of subacute intraluminal thrombus, which is a contraindication to performance of angioplasty. Precise, quantitative measurements of the stenotic artery are obtained to determine the proper diameter and length of the angioplasty balloon to be used. External reference markers may be placed on the skin in order to calculate the precise dimensions. · Prepare appropriate size angioplasty balloon. Meticulous preparation is done by the physician to eliminate the air within the balloon. · Advance a steerable micro-guidewire and a low profile microcatheter through the guide catheter into the 2nd target intracranial arterie(s) (additional vessel, same vascular family) using an angiographic roadmap. · Gently advance micro-guidewire and microcatheter across the arterial stenosis. · Remove the guidewire and replace with an exchange length wire, leaving the wire tip beyond the stenotic area. · Remove microcatheter. · Advance micro-angioplasty balloon over the exchange wire and across the stenosis. · Slowly inflate balloon to dilate the lesion under fluoroscopic control while monitoring balloon pressure. · Deflate balloon and withdraw into internal carotid artery, leaving the guidewire across the stenosis. · Obtain post-angioplasty angiograms by injecting contrast through the guide catheter to confirm satisfactory dilation of vessel lumen and antegrade filling of distal blood vessels. · Wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosis. · If evidence of rebound stenosis, replace balloon to re-dilate the lesion or exchange for a larger angioplasty balloon if needed. · Again

wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosis. After a fifteen-minute period of observation with no further evidence of restenosis or acute arterial occlusion, remove the balloon and wire; then obtain final angiograms of the regional circulation to check for possible embolic complications. Remove guide catheter. All fluoroscopy, contrast injection, angiography and image interpretation associated with the arterial stenosis treated is included in the procedure up to this point

## Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	John Barr, MD; John Wilson, MD; Robert Vogelzang, MD					
<b>Specialty(s):</b>	American Society of Interventional and Therapeutic Neuroradiology, American Society of Neuroradiology, American Association of Neurological Surgeons, Society of Interventional Radiology					
<b>CPT Code:</b>	61641					
<b>Sample Size:</b>	175	<b>Resp n:</b>	41	<b>Response:</b> 23.42 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		4.00	5.00	9.95	13.00	37.89
<b>Pre-Service Evaluation Time:</b>				0.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		8.00	30.00	30.00	60.00	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>0.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
61624	000	20.12

CPT Descriptor Transcatheter permanent occlusion or embolization (eg, for tumor destruction to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
37216	090	17.98

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without 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: 23      % of respondents: 56.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 61641	Key Reference CPT Code: 61624
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	30.00	0.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	30.00	0.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.68
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.36
Urgency of medical decision making	4.91	3.32

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.70	4.14
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Physical effort required	4.04	3.73
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.91	3.77
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Outcome depends on the skill and judgment of physician	4.74	4.05
--	------	------

Estimated risk of malpractice suit with poor outcome	4.39	3.82
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.85	3.70
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Intra-Service intensity/complexity	4.43	4.05
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Post-Service intensity/complexity	3.45	3.45
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**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.*

**Overview** Surveys were distributed to physicians representing specialties and sub-specialties in radiology and surgery. Response rate was excellent, and the data are tightly clustered. The procedure selected most often as reference services were CPT 61624 transcatheter embolization, and CPT 37216 carotid stent placement, which was recently surveyed by the RUC. The transcatheter embolization comparison is appropriate from a clinical perspective since the microvascular surgical techniques using the balloon in the intracranial artery are similar. Both procedures have a similar level of extreme intensity and potential patient risk to the patient. However, the RUC will have to take into consideration the fact



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 IR/Rad/Neurorad                      Frequency 20000                      Percentage 0.00 %

Specialty Neurosurgery                      Frequency 20000                      Percentage 0.00 %

Specialty                      Frequency                      Percentage                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty IR/Rad/Neurorad                      Frequency 15000                      Percentage 0.00 %

Specialty Neurosurgery                      Frequency 15000                      Percentage 0.00 %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? 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:61642 Tracking Number: RR4 Global Period: ZZZ  
 Recommended Work Relative Value  
 Specialty Society RVU: 9.03  
 RUC RVU: 8.66

CPT Descriptor: Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family (List separately in addition to code for primary procedure)

(Use 61641 and 61642 in conjunction with 61640)

(61640, 61641, and 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 55 year-old male with recent subarachnoid hemorrhage. Complete cerebral angiography (separately reportable even if performed on the same day) demonstrated significant vasospasm in the supraclinoid LEFT internal carotid artery and the M1 segment of the RIGHT middle cerebral artery. After reporting this finding to the attending neurosurgeon, he/she requests balloon dilatation of the spastic segments. The LEFT internal carotid spasm balloon dilatation is completed (separately reportable) and the RIGHT M1 segment spasm is now to be dilated.

NOTE: 61642 is considered an ADD-ON procedure code that should be reported in conjunction with 61640. Additionally, the proposed new code includes all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

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?

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Description of Intra-Service Work: · A second bolus dose of intravenous heparin may be administered. · The ACT is checked. Additional heparin is given as necessary throughout the procedure, and the ACTs are monitored at appropriate intervals. · Pressurized, continuous heparin/saline flush systems are prepared. Meticulous examination of these systems is performed by the physician to exclude the possibility of residual air bubbles. · Left common carotid artery selectively catheterized with 5 Fr catheter. · Biplane AP and lateral angiograms of the cervical common carotid artery are obtained. If necessary, oblique views are obtained to profile carotid the carotid bifurcation. Biplane AP and lateral (and possibly oblique) angiograms of the intracranial vessels are also obtained to determine that no interval change has occurred since the original diagnostic angiogram. · Advance catheter into the external carotid artery over a steerable guidewire. · Utilizing an exchange wire placed into the external carotid artery, a neuroguide catheter is placed into the common carotid artery. · A common carotid artery angiogram is obtained to confirm appropriate positioning of the guide catheter below the carotid bifurcation and to exclude the possibility of arterial spasm, dissection or thromboembolus during guide catheter placement. · The guide catheter is then advanced into the internal carotid artery over a steerable guide wire. · A cervical internal carotid artery angiogram is obtained to confirm appropriate positioning of the guide catheter and to exclude the possibility of arterial spasm, dissection or thromboembolus. · Guide catheter is placed on continuous heparin flush utilizing a flow control Y-connector. ·

Biplane AP, lateral and oblique angiograms of the cerebral vessels are obtained. High magnification biplane angiograms are then obtained, centered upon the arterial stenosis. The target lesion must be carefully reassessed for subtle changes that indicate the development of subacute intraluminal thrombus, which is a contraindication to performance of angioplasty. Precise, quantitative measurements of the stenotic artery are obtained to determine the proper diameter and length of the angioplasty balloon to be used. External reference markers may be placed on the skin

in order to calculate the precise dimensions. · Prepare appropriate size angioplasty balloon. Meticulous preparation is done by the physician to eliminate the air within the balloon. · Advance a steerable micro-guidewire and a low profile microcatheter through the guide catheter into the additional vessel, in different vascular family from vessel coated in 6162X3. · Gently advance micro-guidewire and microcatheter across the arterial stenosis. · Remove the guidewire and replace with an exchange length wire, leaving the wire tip beyond the stenotic area. · Remove microcatheter. · Advance micro-angioplasty balloon over the exchange wire and across the stenosis. · Slowly inflate balloon to dilate the lesion under fluoroscopic control while monitoring balloon pressure. · Deflate balloon and withdraw into internal carotid artery, leaving the guidewire across the stenosis. · Obtain post-angioplasty angiograms by injecting contrast through the guide catheter to confirm satisfactory dilation of vessel lumen and antegrade filling of distal blood vessels. · Wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosis. · If evidence of rebound stenosis, replace balloon to re-dilate the lesion or exchange for a larger angioplasty balloon if needed. · Again wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosis. · After a fifteen-minute period of observation with no further evidence of restenosis or acute arterial occlusion, remove the balloon and wire; then obtain final angiograms of the regional circulation to check for possible embolic complications. · Remove guide catheter. · All fluoroscopy, contrast injection, angiography and image interpretation associated with the arterial stenosis treated is included in the procedure up to this point

## Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	John Barr, MD; John Wilson, MD; Robert Vogelzang, MD				
<b>Specialty(s):</b>	American Society of Interventional and Therapeutic Neuroradiology, American Society of Neuroradiology, American Association of Neurological Surgeons, Society of Interventional Radiology				
<b>CPT Code:</b>	61642				
<b>Sample Size:</b>	175	<b>Resp n:</b>	41	<b>Response:</b> 23.42 %	
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	5.00	10.00	13.50	20.00	37.89
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	20.00	45.00	60.00	90.00	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>0.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
61624	000	20.12

CPT Descriptor Transcatheter permanent occlusion or embolization (eg, for tumor destruction to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
37216	090	17.98

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without 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: 23      % of respondents: 56.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 61642</u>	<u>Key Reference CPT Code: 61624</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	60.00	0.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	60.00	0.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.20	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.32	3.54
Urgency of medical decision making	4.84	3.46

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.72	4.05
Physical effort required	4.16	3.74
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.85	3.85
Outcome depends on the skill and judgment of physician	4.78	4.08
Estimated risk of malpractice suit with poor outcome	4.48	3.95

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.32	3.48
Intra-Service intensity/complexity	4.63	4.09
Post-Service intensity/complexity	4.30	3.27

**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.*

Overview:

Surveys were distributed to physicians representing specialties and sub-specialties in radiology and surgery. Response rate was excellent, and the data are tightly clustered. The procedure selected most often as reference services were CPT 61624 transcatheter embolization, and CPT 37216 carotid stent placement, which was recently surveyed by the RUC. The transcatheter embolization comparison is appropriate from a clinical perspective since the microvascular surgical

techniques using the balloon in the intracranial artery are similar. Both procedures have a similar level of extreme intensity and potential patient risk to the patient. However, the RUC will have to take into consideration the fact that 61624 has a 90-day global period and the intracranial vasospasm code is an add-on procedure with a ZZZ global period.

We will be offering comparisons to other ZZZ codes of similar values from the RUC MPC.

#### Rationale and IWPUT Analysis

The median survey response of 13.50 seemed too high relative to the base code and other ZZZ codes in the MPC. The 25th percentile RVW of 10.00 seemed more appropriate. However, the survey respondents included 20 minutes of additional pre-service time and 23 minutes of additional post-service time. The pre-facilitation committee that discussed this code questioned the appropriateness of this additional pre and post-service time. A multi-specialty consensus panel was unable to justify this additional pre and post-service evaluation time. Using a reverse building block methodology, we backed the value of this pre and post-service time out of the value of 10.00 to arrive at our final recommendation of 9.03.

#### 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) 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 IR/Rad/Neurorad

How often? Sometimes

Specialty Neurosurgery

How often? Sometimes

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty IR/Rad/Neurorad                      Frequency 20000                      Percentage 0.00 %

Specialty Neurosurgery                      Frequency 20000                      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 IR/Rad/Neurorad                      Frequency 15000                      Percentage 0.00 %

Specialty Neurosurgery                      Frequency 15000                      Percentage 0.00 %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States?

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical



	A	Recommendation C	D	E	F	G	H	I
2			61630	61635	61640			
3		CMS 2005 STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Balloon angioplasty, Intracranial (eg, arteriosclerotic stenosis), percutaneous	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection	Balloon dilatation of Intracranial vasospasm, percutaneous; Intra vessel			
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
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 X 1 (6162X1-X2)	36		72		72		
51	99214 53 minutes X 1 (6162X1) X 2 (6162X2)	53		0		0		
52	99215 63 minutes	63						
53	Other							
54								
55	Total Office Visit Time	L037D RN/LPN/MTA		72		72		
56	Other Activity (please specify)							
57	End: with last office visit before end of global period							
58	MEDICAL SUPPLIES							
59	PEAC multispecialty supply package			2		2		2
60								
61	EQUIPMENT							
62	exam table	E11001		1		1		1



	A	Recommendation	C	J	K	L	M
2				<b>61641</b>		<b>61642</b>	
3			<b>CMS 2005 STAFF TYPE, MED SUPPLY, OR EQUIP CODE</b>	<b>Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in the same vascular family</b>		<b>Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in a different vascular family</b>	
4	<b>LOCATION</b>			<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
43	<b>POST-SERVICE Period</b>						
44	<b>Start: Patient leaves office/facility</b>						
45	Conduct phone calls/call in prescriptions						
46	<i>Office visits:</i>						
47	<i>List Number and Level of Office Visits</i>						
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes X 1 (6162X1-X2)		36				
51	99214 53 minutes X 1 (6162X1) X 2 (6162X2)		53				
52	99215 63 minutes		63				
53	Other						
54							
55	<i>Total Office Visit Time</i>	L037D	RN/LPN/MTA				
56	<i>Other Activity (please specify)</i>						
57	<b>End: with last office visit before end of global period</b>						
58	<b>MEDICAL SUPPLIES</b>						
59	PEAC multispecialty supply package				0		0
60							
61	<b>EQUIPMENT</b>						
62	exam table		E11001		0		0

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Needle EMG with Chemodenervation**

CPT created two new codes for guidance in conjunction with chemodenervation. Existing codes 64612 *Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)* (work RVU = 1.93), 64613 *Chemodenervation of muscle(s); cervical spinal muscle(s) (eg, for spasmodic torticollis)* (work RVU = 1.96), and 64614 *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* (work RVU = 2.20) were also reviewed because the presenters were requesting to change the values of these codes. During the presentation it was clarified that the new codes would not be used with 64612 since guidance is not used. Therefore the RUC suggested that CPT remove the reference to 64612 from the parenthetical for code 95874. The RUC then voted to withdraw code 64612 from consideration of the work RVU. The RUC examined the data for 64613 and 64614 and concluded to maintain the current values. The RUC also discussed the possibility that these codes contained needle guidance work. Only code 64614 has been reviewed by the RUC and after reviewing both the RUC rationale as well as the PEAC approved inputs, the RUC could not determine conclusively if the work value actually included the guidance work. The PE inputs included a nerve stimulator machine but it appeared that the code was reviewed as part of a large submission by the North American Spine Society who are not the dominant provider of the service, and the inclusion may have been in error. In order to obtain the proper value for both codes based on accurate vignettes, the RUC felt that both codes should be included in the Five-Year Review. CMS will conclude whether to add these codes to the Five-Year Review.

**The RUC supports the specialty societies' request to CMS to submit codes 64613 and 64614 in the Five-Year Review.**

For the new guidance codes 95873 and 95874, the RUC concluded that the survey respondents overestimated the work involved in the guidance. The RUC examined reference code 95860 *Needle electromyography; one extremity with or without related paraspinal areas* (work RVU = 0.96, intraservice time = 34 minutes). The RUC determined that the intensity for the new procedures and the reference procedure were the same so a proper value for both new codes should be based on the ratio of time with the reference code. Therefore, the new codes' survey intra-service times of 20 minutes divided by the reference code time of 34 minutes was multiplied by the reference value of 0.96 resulting in a recommended work RVU of 0.56 for both codes. This value would place the new codes in proper rank order with the reference code.

**The RUC recommends a work RVU of 0.56 for codes 95873 and 95874.**

**Practice Expense**

The RUC agreed to five minutes of clinical staff assist time and several additional supplies and equipment that would be used for the add-on codes 95873 and 95874. For codes 64612, 64613, and 64614, the RUC revised the PE inputs to specify the individual supplies used rather than the basic injection pack.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Neurologic services are typically consultative, and any of the levels of consultation (99241-<del>99263</del>99255) may be appropriate.</p> <p><i>In addition, services...</i></p> <p>The EEG, autonomic function, evoked potential, reflex tests, EMG, NCV, and MEG services (95812-95829 and 95860-95967) include recording, interpretation by a physician, and report. For interpretation only, use modifier 26. For EMG guidance, see 95873-95874.</p>				
<p><b><i>Electromyography and Nerve Conduction Tests</i></b></p>				
●+95873	XX1	Electrical stimulation for guidance in conjunction with chemodenervation(List separately in addition to code for primary procedure)	ZZZ	0.56
●+95874	XX2	<p>Needle electromyography for guidance in conjunction with chemodenervation(List separately in addition to code for primary procedure)</p> <p>(Use 95873, 95874 in conjunction with, 64613, 64614)</p> <p>(Do not report 95874 in conjunction with 958573)</p> <p>(Do not report 95873, 958574 in conjunction with 95860-95870)</p>	ZZZ	0.56

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 64613	XX4	neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)	010	1.96  (No Change)
64614	XX5	<i>extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)</i>  <i>(For chemodenervation for strabismus involving the extraocular muscles, use 67345)</i>  <i>(For chemodenervation guided by needle electromyography or muscle electrical stimulation, see 95873, 95874)</i>	010	2.20  (No Change)

April 25, 2005

William Rich, M.D.  
Chair, AMA/Specialty Society RVS Update Committee (RUC)  
Relative Value Systems  
American Medical Association  
515 N. State Street  
Chicago, Illinois 60610

RE: 95867 *Needle electromyography, cranial nerve supplied muscle(s), unilateral*  
95868 *Needle electromyography, cranial nerve supplied, muscle(s),bilateral*  
95870 *Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve muscles, or sphincters*  
64613 *Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)*  
64614 *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (e.g. dystonia, cerebral palsy, multiple sclerosis)*

Dear Dr. Rich:

On behalf of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM), the American Academy of Neurology, and the American Academy of Physical Medicine and Rehabilitation (AAPMR), we would like to share our comments regarding the relative value units we submitted to the RUC.

These codes are being presented to the RUC for valuation because new code proposals were accepted during the last CPT meeting. These codes previously did not have a vignette or survey data (with the exception of 64614). Therefore, vignettes were developed based on the typical patient and sent to the AMA RUC staff for approval. The RUC vignettes were approved and sent with the surveys. The societies surveying these codes believe that the previous valuation for the codes was incorrect because of a flawed mechanism. The codes did not have vignettes and therefore could not be appropriately valued. Therefore, with appropriate vignettes and surveys now complete, the societies believe there is compelling evidence to appropriate value these codes as the surveys demonstrate.

95867 *Needle electromyography, cranial nerve supplied muscle(s), unilateral*

95868 *Needle electromyography, cranial nerve supplied, muscle(s),bilateral*

The survey was sent to physicians around the nation in different practice types. CPT code 95867 would require similar work to a full-limb needle electromyography study where multiple muscles are studied and the physician must interpret the studies. Therefore, the procedure would require similar physician work as a full-limb and should receive similar valuation units. The consensus panel agreed that the relative value units should be the same. Similarly, a bilateral study would require additional work and therefore requires a higher reimbursement rate than a unilateral code. In both cases, the societies surveying the codes decided to request the median number calculated from the surveys.

95870      *Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve muscles, or sphincters*

CPT code 95870 did not previously have a vignette and/or survey completed. Once the survey process was completed a consensus panel discussed the results. The members of the consensus panel felt that a limited electromyography procedure was almost as much work as a full-limb study. There is an anomalous relationship between a full limb study (95860) and a limited study (95870). A limited study requires the same equipment set-up and the physician performs on average 3 or 4 needle sticks when examining the patient. This is actually three-fourths the work of a full-limb rather than half. Therefore, the lack of a vignette and the current valuation units are inaccurate as they provide less than half the valuation units from a full-limb. A full-limb has a RVU of .96. The proposed RVU is closer to three-fourths the work of a full-limb.

64613      *Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)*

CPT code 64613 in the RUC database does not have information regarding a previous survey. There are notes that indicate the numbers should not be used for physician work only practice expense. The vignette was modified slightly to accommodate chemodenervation in the neck rather than just cervical spine. There is an increase between the proposed and current value units based on an appropriate vignette. Previously, a vignette was not available. The associations that surveyed this code agreed to take the median of the survey results that slightly increase the code. Due to the change in the code, adding neck, injecting chemodenervation into the neck is a more difficult procedure and requires more time. The neck musculature is very complex and identifying which muscles are overactive is challenging, time consuming, and requires considerable clinical judgment and experience. If the physician is not careful when injecting the chemodenervation agent, the patient could develop swallowing and/or choking difficulties, in addition to the risk of developing head drop following injection of cervical extensor muscles. Therefore, this procedure is more complex than originally valued.

64614      *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (e.g. dystonia, cerebral palsy, multiple sclerosis)*

CPT code 64614 received a new vignette that better identifies the “typical” patient. The previous vignette identified that the patient was receiving chemodenervation injections in one limb. However, since the code was originally introduced, a more accurate typical patient has been identified. The new vignette accurately identifies the patient as receiving chemodenervation in two limbs. This code was previously surveyed, however, it was surveyed with an inaccurate vignette. The change in the vignette requires that the physician spend more time with the patient to inject the patient appropriately in two areas of the body. Currently, physicians use CPT code 64614 when performing chemodenervation in the limbs or trunk. Regardless if the physician performs chemodenervation on one limb or 4 limbs only one unit is reported. Therefore, the code was revised to appropriately reflect physician work and the typical patient and the relative value units increased to reflect the appropriate amount of work the physician is performing. The societies used the median number reported on the surveys.

The societies appreciate the opportunity to work with the RUC to develop appropriate relative value units for these codes.

Sincerely,

James J. Anthony, MD  
AAN RUC Advisor

Benn Smith, MD  
AANEM RUC Advisor

Robert Goldberg, DO  
AAPMR RUC Advisor

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:95873 Tracking Number: XX1 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: 0.96

RUC RVU: 0.56

CPT Descriptor: Electrical stimulation for guidance in conjunction with chemodenerivation

(Use 95873, 95874 in conjunction with 64613, 64614)

(Do not report 95874 in conjunction with 95873)

(Do not report 958573, 95874 in conjunction with 95860-95870)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 50 year-old man with a two-year history of progressive task-specific dystonia associated with writing (writer's cramp). He is now unable to sign checks or make handwritten notes which are important functions of his job. Botulinum toxin treatment is discussed and precise localization with electrical stimulation of the small hand and forearm muscles is determined to be necessary to avoid incapacitating weakness.

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? 10%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Description of Intra-Service Work: The physician attaches the stimulating needle electrode and hypodermic containing botulinum toxin to the stimulating apparatus. The targeted forearm muscles are identified by anatomical surface markers and the needle is advanced through the skin. The stimulating apparatus is activated at low frequency and relatively higher intensity and the needle is relocated until muscle contraction is seen or palpated by the physician. The stimulus is then decreased and the needle position adjusted to achieve the maximal muscle contraction at that intensity. This procedure is repeated until a maximal muscle contraction is achieved at a minimal stimulus intensity. This procedure ensures that the needle tip is in the correct small muscle and is also closest to the motor endplate so the minimum amount of toxin achieves the maximum clinical response. Toxin is then injected cautiously to avoid any movement of the needle tip. The needle is then withdrawn and reinserted into a different muscles and the localization procedure is then repeated until all of the targeted muscle groups are injected.

**Description of Post-Service Work:****SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Andrea Boon, MD; Benn Smith, MD; James Anthony, MD, Robert Goldberg, MD				
<b>Specialty(s):</b>	AAN, AANEM, AAPM&R				
<b>CPT Code:</b>	95873				
<b>Sample Size:</b>	43	<b>Resp n:</b>	21	<b>Response:</b>	48.83 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.50	0.96	2.00	3.00	5.00
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		<b>5.00</b>	<b>15.00</b>	<b>20.00</b>	<b>30.00</b>	<b>120.00</b>
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>0.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
64640	010	2.76

CPT Descriptor Destruction by neurolytic agent; other peripheral nerve or branch**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 38.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 95873</u>	<u>Key Reference CPT Code: 64640</u>
Median Pre-Service Time	0.00	20.00
Median Intra-Service Time	20.00	31.00
Median Immediate Post-service Time	0.00	18.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	12.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	22.00
Median Total Time	20.00	103.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	3.75
Urgency of medical decision making	3.00	3.13

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.75	4.25
Physical effort required	3.88	3.75

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.88	4.25
Outcome depends on the skill and judgment of physician	4.75	4.25
Estimated risk of malpractice suit with poor outcome	4.13	4.00

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.25	4.25
Post-Service intensity/complexity	0.00	0.00

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The work for both add-on codes would be fairly similar. The consensus panel agreed that the 25<sup>th</sup> percentile survey RVW would be appropriate for both codes in this family, putting them both at 0.96. Fewer physicians perform electrical stimulation with chemodenervation than needle EMG with chemodenervation, so there was difficulty getting 30 survey responses.



CPT Code:

Specialty Neurology                      Frequency 350                      Percentage 58.33 %

Specialty PM&R                              Frequency 100                      Percentage 16.66 %

Specialty                                      Frequency                                      Percentage                                      %

Do many physicians perform this service across the United States? No

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 95860 should be used since it has a similar work RVU

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:95874 Tracking Number: XX2 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: 0.96

RUC RVU: 0.56

CPT Descriptor: Needle electromyography for guidance in conjunction with chemodenervation

(Use 95873, 95874 in conjunction with 64612, 64613, 64614)

(Do not report 95874 in conjunction with 95873)

(Do not report 95873, 95874 in conjunction with 95860-95870)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 60 year old man with rotational cervical dystonia (chin to right shoulder) is seen. Prior treatment trials include muscle relaxers and range of motion exercises without benefit. Previous treatment with botulinum toxin resulted in a very good outcome. He presents for follow-up injection 90 days following his most recent injection. He has some focal atrophy in neck muscles in the site of previous injection, and physical examination or identification of the involved muscles only identifies the sternocleidomastoid as being taut on the left and some non-specific tautness over his posterior right neck area.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 8%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

Description of Intra-Service Work: Prior to injecting a muscle with botulinum toxin, the muscle must be precisely localized, which can be initially done based on anatomical knowledge, but in many cases further, physiologic information is required to determine the specific muscle to be injected. After attaching a recording and injection hypodermic, the needle is advanced into the body of the sternocleidomastoid and a small amount of botulinum toxin injected. The needle is advanced further to spread the toxin through this long muscle and the presence of persistent EMG motor unit activity guarantees that the needle is still in the muscle and has not perforated into nearby vessels or has moved into a non-spastic muscle. The needle is then inserted lower in the muscle and the process repeated. Following this the needle is inserted into the right splenius capitis--the first muscle entered is the trapezius, which is electrically silent and the needle is advanced until active motor unit potentials from the splenius capitis are identified injections are made. The needle is advanced further, through the substance of the electrically quiet semispinalis capitis. As it is advanced further, distant motor units become apparent. The needle, now at 35 mm of depth, encounters an area of no insertional activity, but the distant motor unit activity is louder, with a small additional push, the needle enters the oblique capitis inferioris muscle as confirmed by the rise time and amplitude of the motor unit potentials, (a muscle which "... owing to the length of the transverse process of the atlas exerts considerable (rotational) mechanical leverage" --Gray's anatomy) and an additional injection is made. Similar injections are carried out in the right posterior scalene muscle and left semispinalis capitis. Careful notation is made of the muscles involved, their degree of motor unit activity and the specific location of injections. Determine appropriate clinical comments based on the patient's presenting problem.

**Description of Post-Service Work:****SURVEY DATA**

RUC Meeting Date (mm/yyyy)	04/2005
Presenter(s):	Andrea Boon, MD; Benn Smith, MD; James Anthony, MD, Robert Goldberg, DO

<b>Specialty(s):</b>	AAN, AANEM, AAPM&R				
<b>CPT Code:</b>	95874				
<b>Sample Size:</b>	56	<b>Resp n:</b>	37	<b>Response:</b> 66.07 %	
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.50	0.96	1.50	2.00	10.00
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	4.00	11.00	20.00	30.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>0.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
95860	XXX	0.96

CPT Descriptor Needle electromyography, one extremity with or without related paraspinals

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 56.7 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 95874</u>	<u>Key Reference CPT Code: 95860</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	20.00	34.00
Median Immediate Post-service Time	0.00	
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	
Median Total Time	20.00	34.00
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	3.45	3.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.32
Urgency of medical decision making	3.00	2.91

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.36	3.91
Physical effort required	3.36	3.05
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	3.27	2.77
Outcome depends on the skill and judgment of physician	4.32	3.91
Estimated risk of malpractice suit with poor outcome	3.09	2.73

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.82	3.82
Post-Service intensity/complexity	0.00	0.00

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AAN, AANEM, and AAPM&R convened a consensus panel to review survey data. The panel chose to recommend the 25th percentile work RVU as an appropriate value.



			CPT Code:
Specialty Neurology	Frequency 1300	Percentage 65.00 %	
Specialty PM&R	Frequency 500	Percentage 25.00 %	
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? No

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 95860 should be used since it has a similar work RVU

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
ZZZ Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor:

**95873** Electrical stimulation for guidance in conjunction with chemodenervation

(List separately in addition to code for primary procedure)

**95874** Needle electromyography for guidance in conjunction with chemodenervation

(List separately in addition to code for primary procedure)

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: ZZZ

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:

AAN, AANEM, and AAMP&R convened a consensus panel of experts from across the country to develop the recommendations. The panel used needle EMG code 95869 as a crosswalk. The RUC agreed to five minutes of assist time.

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities:

**95858x** Electrical stimulation for guidance in conjunction with chemodenervation

(List separately in addition to code for primary procedure)

Assist with running the EMG machine nerve stimulation to assist physician during nerve localization.

**95859x** Needle electromyography for guidance in conjunction with chemodenervation

(List separately in addition to code for primary procedure)

Enter data from needle examination for the physician. Apply pressure once needle is removed, to prevent bruising.

	A	B	C	D	E	F	G
1							
2	Meeting Date: April 2005			95873 Electrical stimulation for guidance in conjunction with chemodenervation		95874 Needle electromyography for guidance in conjunction with chemodenervation	
3							
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			ZZZ		ZZZ	
6	TOTAL CLINICAL LABOR TIME		L037A	5.0	0.0	5.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		L037A	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		L037A	5.0	0.0	5.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		L037A	0.0	0.0	0.0	0.0
10							
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							
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		L037A	5		5	
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							
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	G
2				95873		95874	
3	Meeting Date: April 2005			Electrical stimulation for guidance in conjunction with chemodenervation		Needle electromyography for guidance in conjunction with chemodenervation	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
58							
59	electrode, ground	SD059	item	1		1	
60	paper, recording (per sheet)	SK059	item	5		5	
61	electrode conductive gel	SJ020	ml	1		1	
62	swab-pad, alcohol	SJ053	item	4		4	
63	gauze, sterile 4in x 4in	SG055	item	0		0	
64	tape, porous-hypoallergenic 2in (Scanpore)	SG077	inch	6		6	
65	electrode needle, injectable (Myoject)	SD050	item	1		1	
66							
67	table, exam	EF023		1		1	
68	EMG-NCV-EP system, 8 channel	EQ024		1		1	

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
010 or 090 Day Global Periods  
Facility Direct Inputs**

CPT Long Descriptor: : Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, blepharospasm, hemifacial spasm)

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 AAO, AAN, AANEM, and AAPMR convened a consensus panel to develop the summary for this code. The panel members were convened via telephone conference call. The panel members reached a consensus regarding practice expense valuation for this code. The members of the panel are well versed in the practice expense survey instrument and developed fair and correct inputs for this summary.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Necessary labs ordered and preoperative medications phoned in. Patient counseled re: logistics. Consent documents reviewed and signed. Patient advised re: anticipated outcomes. Phone call(s) made to answer last minute questions and confirm understanding.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

As part of the post-op visit: greet patient; escort to room; provide gowning, interval history and vital signs and chart; assemble previous test reports/results; prepare prescriptions forms; post-service education, instruction, counseling; clean room/equipment; check supplies; coordinate home or outpatient care.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
010 or 090 Day Global Periods  
Non Facility Direct Inputs**

CPT Long Descriptor: Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, blepharospasm, hemifacial spasm)

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 010

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The AAO, AAN, AANEM, and AAPMR convened a consensus panel to develop the summary for this code. The panel members were convened via telephone conference call. The panel members reached a consensus regarding practice expense valuation for this code. The members of the panel are well versed in the practice expense survey instrument and developed fair and correct inputs for this summary.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Necessary labs ordered and preoperative medications phoned in. Patient counseled re: logistics. Consent documents reviewed and signed. Patient advised re: anticipated outcomes. Phone call(s) made to answer last minute questions and confirm understanding.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

As part of the post-op visit: greet patient; escort to room; provide gowning, interval history and vital signs and chart; assemble previous test reports/results; prepare prescriptions forms; post-service education, instruction, counseling; clean room/equipment; check supplies; coordinate home or outpatient care.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
010 or 090 Day Global Periods  
Facility Direct Inputs**

CPT Long Descriptor: Chemodenervation of muscle(s); ~~cervical-spinal neck~~ muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 010

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AAN, AANEM, AAO-HNS, and AAPMR convened a consensus panel to develop the summary for this code. The panel members were convened via telephone conference call. The panel members reached a consensus regarding practice expense valuation for this code. The staff type is L037D, an RN/LPN/MTA.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Order necessary labs and phone in preoperative medications. Counsel patient re: logistics. Consent documents reviewed and signed. Advise patient advised re: anticipated outcomes. Phone call(s) made to answer last minute questions and confirm understanding.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

As part of the post-op visit: greet patient; escort to room; provide gowning, interval history and vital signs and chart; assemble previous test reports/results; prepare prescriptions forms; post-service education, instruction, counseling; assist with dressing, if necessary, and escort to the waiting room; clean room/equipment; check supplies; coordinate home or outpatient care.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
010 or 090 Day Global Periods  
Non Facility Direct Inputs**

CPT Long Descriptor: Chemodenervation of muscle(s); ~~cervical spinal neck~~ muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 010

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AAN, AANEM, AAO-HNS, and AAPMR convened a consensus panel to develop the summary for this code. The panel members were convened via telephone conference call. The panel members reached a consensus regarding practice expense valuation for this code. The staff type is L037D, an RN/LPN/MTA.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Order necessary labs and phone in preoperative medications. Counsel patient re: logistics. Consent documents reviewed and signed. Advise patient advised re: anticipated outcomes. Phone call(s) made to answer last minute questions and confirm understanding.

Intra-Service Clinical Labor Activities:

Greet and gown. Check vital signs. Prepare room. Position patient. Assist doctor during procedure (including stabilization of the head to protect against injury to vital structures in the neck during multiple needle passes). Assist patient with dressing and wheelchair (if necessary), escort to the waiting room. Clean room and instruments.

Post-Service Clinical Labor Activities:

As part of the post-op visit: greet patient; escort to room; provide gowning, interval history and vital signs and chart; assemble previous test reports/results; prepare prescriptions forms; post-service education, instruction, counseling; assist with dressing, if necessary, and escort to the waiting room; clean room/equipment; check supplies; coordinate home or outpatient care.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
010 or 090 Day Global Periods  
Facility Direct Inputs**

CPT Long Descriptor: Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 010

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:  
The AAN, AANEM, and AAPMR convened a consensus panel to develop the summary for this code. The panel members were convened via telephone conference call. The panel members reached a consensus regarding practice expense valuation for this code. The staff type is L037D, an RN/LPN/MTA.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Order necessary labs and phone in preoperative medications. Counsel patient re: logistics. Consent documents reviewed and signed. Advise patient advised re: anticipated outcomes. Phone call(s) made to answer last minute questions and confirm understanding.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

As part of the post-op visit: greet patient; escort to room; provide gowning, interval history and vital signs and chart; assemble previous test reports/results; prepare prescriptions forms; post-service education, instruction, counseling; assist with dressing, if necessary, and escort to the waiting room; clean room/equipment; check supplies; coordinate home or outpatient care.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
010 or 090 Day Global Periods  
Non Facility Direct Inputs**

CPT Long Descriptor: Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 010

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:  
The AAN, AANEM, and AAPMR convened a consensus panel to develop the summary for this code. The panel members were convened via telephone conference call. The panel members reached a consensus regarding practice expense valuation for this code. The staff type is L037D, an RN/LPN/MTA.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Order necessary labs and phone in preoperative medications. Counsel patient re: logistics. Consent documents reviewed and signed. Advise patient advised re: anticipated outcomes. Phone call(s) made to answer last minute questions and confirm understanding.

Intra-Service Clinical Labor Activities:

Greet and gown. Check vital signs. Prepare room. Position patient. Assist doctor during procedure (including stabilization of the head to protect against injury to vital structures in the neck during multiple needle passes). Assist patient with dressing and wheelchair (if necessary), escort to the waiting room. Clean room and instruments.

Post-Service Clinical Labor Activities:

As part of the post-op visit: greet patient; escort to room; provide gowning, interval history and vital signs and chart; assemble previous test reports/results; prepare prescriptions forms; post-service education, instruction, counseling; assist with dressing, if necessary, and escort to the waiting room; clean room/equipment; check supplies; coordinate home or outpatient care.

	A	B	C	D	E	F	G	H	I
1									
2				64612		64613		64614	
3	Meeting Date: April 2005		L038A for 64612 / L037D for 64613-14	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)		Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)		Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			10	10	10	10	10	10
6	TOTAL CLINICAL LABOR TIME		L038A/L037	50.0	43.0	59.0	43.0	62.0	43.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			5.0	10.0	5.0	10.0	5.0	10.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			18.0	6.0	27.0	6.0	30.0	6.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			27.0	27.0	27.0	27.0	27.0	27.0
10	<b>Start: Following visit when decision for surgery or procedure made</b>								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms			5	5	5	5	5	5
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility				5		5		5
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity (please specify)								
18	End:When patient enters office/facility for surgery/procedure								
19	<b>Start: When patient enters office/facility for surgery/procedure</b>								
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	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV			2		2		2	
29	Sedate/apply anesthesia					2		2	
30	Intra-service								
31	Assist physician in performing procedure			0		7		10	
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		L038A		6		6		6
41	Other Clinical Activity (please specify)								
42	End: Patient leaves office								
43	<b>Start: Patient leaves office/facility</b>								
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	1	1	1	1	1	1
50	99213 36 minutes		36						
51	99214 53 minutes		53						
52	99215 63 minutes		63						
53	Other								
54									
55	Total Office Visit Time			27	27	27	27	27	27
56	Other Activity (please specify)								
57	End: with last office visit before end of global period								

	A	B	C	D	E	F	G	H	I
2				64612		64613		64614	
3	Meeting Date: April 2005		L038A for 64612 / L037D for 64613-14	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)		Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis; spasmodic dysphonia)		Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia; cerebral palsy, multiple scler.	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
58									
59	phosphate buffered saline solution (ml)	SL107	ml	4		1		2	
60	syringe 5ml	SC057	item			1		1	
61	syringe 3ml	SC055	item	1					
62	syringe 1ml	SC052	item	1		2		4	
63	needle, 25g	SC029	item			1		2	
64	needle, 30g	SC031	item	2					
65	swab-pad, alcohol	SJ053	item	1		2		10	
66	gauze non-sterile 4in x 4in	SG051	item	1		2		10	
67	mask, surgical	SB033	item			1		1	
68	bandage, strip 0.75in x 3in	SG021	item			2		5	
69	pack, ophthalmology visit (no dilation)	SA050	pack	1	1				
70	PEAC multispecialty supply package	SA048	pack	1	1	1	1	1	1
71									
72									
73									
74	lane, screening (oph)	E71111		1	1				
75	table, exam	EF023				1		1	
76									

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Hyperhidrosis Chemodenervation**

The CPT Editorial Panel initially created four codes to describe chemodenervation that is performed specifically for hyperhidrosis chemodenervation. After discussion at the RUC, the specialty society requested that CPT delete codes 64651 *Chemodenervation of eccrine glands; hands, including regional nerve blocks* and 64652 *Chemodenervation of eccrine glands; feet, including regional nerve blocks* until the specialty society provide information to the CPT Editorial Panel to clarify whether these codes are typically performed bilaterally or unilaterally. The CPT Editorial Panel rescinded codes for chemodenervation of hands and feet until they receive a new proposal.

The RUC reviewed code 64650 and the specialty society indicated that the survey times appeared to be high. Code 64650 *Chemodenervation of eccrine glands; both axillae* was crosswalked to 11951 *Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc* (work RVU=1.19). The specialty society adjusted the RVU for 64650 by reducing the pre-service and intra-service time and crosswalking the mental effort, technical skill and psychological stress intensity measures to code 11951. **The RUC recommends a work RVU of 0.70 for 64650.**

The RUC reviewed code 64653 and the specialty society indicated that the survey times appeared to be high. Code 64653 *Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day* was crosswalked to 11921 *Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm* (work RVU=1.93). The specialty society adjusted the RVU for 64653 by reducing the pre-service and intra-service time and crosswalking the mental effort, technical skill and psychological stress intensity measures to code 11921. Code 64653 is more intense than 64650 and maintains rank order. **The RUC recommends a work RVU of 0.88 for 64653.**

Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub, Dress, Wait	Intra-Service	Post-Service	RVU
64650	5	2	0	23	5	0.70
64653	5	2	0	23	5	0.88

Practice Expense

The RUC assessed and approved the practice expense for 64650 and 64653.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•64650	Z1	Chemodenervation of eccrine glands, not requiring regional block; both axillae	000	0.70
•64653	Z4	<p>other area(s) (eg, scalp, face, neck), per day</p> <p>(Report the specific service as well as code(s) for the specific substance(s) or drug(s) provided)</p> <p>(For chemodenervation of extremities (eg, hands or feet), where nerve blocks are required report 64999)</p>	000	0.88

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

Specialty Society RVU: 0.70

CPT Code: 64650 Tracking Number: Z1 Global Period: 000

**RUC RVU: 0.70**

CPT Descriptor: Chemodenervation of eccrine glands, not requiring regional block; both axillae

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 26 year old female patient presents with profuse sweating under the arms since puberty. She reports interference in performing her duties in the workplace, interference with interactions with others in the workplace and elsewhere, and multiple daily changes of clothes. She has not responded to over-the-counter, nor prescription-strength antiperspirants. A decision was made to perform botulinum toxin injections in both axillae.

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:** The physician reviews treatment options including treatment with botulinum toxin type A. He reviews chart, and confirms the area of treatment with the patient and obtains informed consent for the treatment with botulinum toxin. He verifies positioning of patient and checks supplies, drugs and equipment.

**Description of Intra-Service Work:** The patient is positioned and draped. Prior to administering botulinum toxin type A, the locations of excessive sweating are mapped, to maximize treatment effectiveness. The physician paints the prepared axillae areas with an iodine solution, and when dry, dusts the areas with starch powder. Over a ten to fifteen minute period, the presence of sweat will cause the prepped areas to turn a dark purple. The physician outlines the reactive area of excessive sweating with a surgical marking pen, and removes the starch/iodine compound. The physician with a surgical marking pen, marks a non-linear staggered pattern of sites 1.5 cm apart as botulinum toxin type A diffuses under the skin to a diameter of approximately 2 cm and this ensures uninterrupted coverage of the entire treatment area. The physician then preps the area with antimicrobial solution.

The physician reconstitutes the vacuum dried botulinum toxin type A (100 U per vial) with 4 ml sterile saline solution and draws four separate 1 ml syringes. The physician administers a series of twelve to fifteen intradermal injections per axilla, to distribute 50 U evenly among the injection sites. At a 10 to 30 degree angle, the physician slowly injects an aliquot of botulinum toxin type A into the dermis to obtain a visible wheal that confirms placement, and avoidsPhysician discusses follow-up assessment. Physician discusses pain management, dressings if required and care of the treated skin area. puncturing the skin at mapping marks to avoid carrying any ink into the skin. Hold compression to facilitate hemostasis. The physician monitors for pain as well as skin surface reaction throughout the process.

**Description of Post-Service Work:** Physician discusses follow-up assessment. Physician discusses pain management, dressings if required and care of the treated skin area.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	Michael E. Bigby, MD, David Pariser, MD for AAD, James Anthony, MD for AAN		
<b>Specialty(s):</b>	American Academy of Dermatology & American Academy of Neurology		
<b>CPT Code:</b>	64650		
<b>Sample Size:</b>	233	<b>Resp n:</b>	37
		<b>Response:</b>	15.87 %

Sample Type: Random					
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Survey RVW:	0.85	1.47	1.93	2.20	4.70
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			2.00		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	8.00	15.00	23.00	25.00	30.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>5.00</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
11951	000	1.19

CPT Descriptor Subcutaneous injection of filling material, (eg collagen), 1.1 cc to 5.0 cc

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
11755	000	1.31

CPT Descriptor 1 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
52000	000	2.01

CPT Descriptor 2 Cystourethroscopy (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10      % of respondents: 27 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 64650</u>	<u>Key Reference CPT Code: 11951</u>
Median Pre-Service Time	7.00	15.00
Median Intra-Service Time	23.00	30.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	35.00	55.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.20	2.20
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.30	2.00
--	------	------

Urgency of medical decision making	2.60	2.00
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.40	3.50
--------------------------	------	------

Physical effort required	3.50	3.30
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.20	2.90
---	------	------

Outcome depends on the skill and judgment of physician	3.90	3.60
--	------	------

Estimated risk of malpractice suit with poor outcome	2.90	2.80
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.20	2.30
----------------------------------	------	------

Intra-Service intensity/complexity	3.80	2.80
------------------------------------	------	------

Post-Service intensity/complexity	2.70	2.50
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) and the American Academy of Neurology (AAN) have each conducted the required PHYSICIAN WORK RVS Update Survey for this code. In addition, a work group comprised of AAD Coding & Reimbursement Task Force and the AAN Medical Economics and Management Committee members have reviewed the results of this survey and agreed to the values and RVU level requested in this Summary of Recommendation. Following pre-facilitation, the societies decided to adjust the RVU to match the intensity of the key reference service. Calculating the service time proportionality, we came up with 0.70.

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**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.

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**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology                      How often? Commonly

Specialty Neurology                        How often? Commonly

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 Dermatology                      Frequency 4000                      Percentage 80.00 %

Specialty Neurology                        Frequency 1000                      Percentage 20.00 %

Specialty                                      Frequency                              Percentage                              %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Dermatology                      Frequency 800                        Percentage 80.00 %

Specialty Neurology                        Frequency 100                        Percentage 10.00 %

Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 11951

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: 64653 Tracking Number: Z4 Global Period: 000

**Recommended Work Relative Value**  
Specialty Society RVU: **0.88**  
RUC RVU: **0.88**

CPT Descriptor: Chemodenervation of eccrine glands, not requiring regional block; other area(s) (eg, scalp, face, neck), per day

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey: Typical Patient/Service:** A 66 year old male patient undergoes a surgical excision of a mixed-cell tumor of the left parotid gland. Following surgery, he develops a complication of gustatory hyperhidrosis where he has excessive sweating when he smells or eats certain foods. He is referred for evaluation and treatment of excessive sweating on the left cheek. A decision was made to perform botulinum toxin injections in the affected area.

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? 3%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:** The physician reviews treatment options including treatment with botulinum toxin type A. He reviews chart, and confirms the area of treatment with the patient and obtains informed consent for the treatment with botulinum toxin. He verifies positioning of patient and checks supplies, drugs and equipment.

**Description of Intra-Service Work:** The patient is positioned and draped. Prior to administering botulinum toxin type A, the locations of excessive sweating are mapped, to maximize treatment effectiveness. The physician paints the area(s) with an iodine solution, and when dry, dusts the area(s) with starch powder. Over a ten to fifteen minute period, the presence of sweat will cause the prepped areas to turn a dark purple. The physician outlines the reactive area of excessive sweating with a surgical marking pen, and removes the starch/iodine compound. The physician with a surgical marking pen, marks a non-linear staggered pattern of sites 1.5 cm apart as botulinum toxin type A diffuses under the skin to a diameter of approximately 2 cm and this ensures uninterrupted coverage of the entire treatment area. The physician then preps the area(s) with antimicrobial solution.

The physician reconstitutes the vacuum dried botulinum toxin type A (100 U per vial) with 4 ml sterile saline solution and draws four separate 1 ml syringes. The physician administers a series of twelve to fifteen intradermal injections per area, to distribute 50 U evenly among the injection sites. At a 10 to 30 degree angle, the physician slowly injects an aliquot of botulinum toxin type A into the dermis to obtain a visible wheal that confirms placement, and avoids puncturing the skin at mapping marks to avoid carrying any ink into the skin. Hold compression to facilitate hemostasis. The physician monitors for pain as well as skin surface reaction throughout the process.

**Description of Post-Service Work:** Physician discusses follow-up assessment. Physician discusses pain management, dressings if required and care of the treated skin area.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	Michael E. Bigby, MD, David Pariser, MD for AAD, James Anthony, MD for AAN		
<b>Specialty(s):</b>	American Academy of Dermatology & American Academy of Neurology		
<b>CPT Code:</b>	64653		
<b>Sample Size:</b>	233	<b>Resp n:</b>	33
<b>Response:</b>		<b>Response:</b>	%
<b>Sample Type:</b>	Random		

	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.85	1.60	2.00	2.63	3.50
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			2.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	5.00	10.00	23.00	25.00	70.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>5.00</b>				
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b>0.0</b>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b>0.0</b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
11921	000	1.93

CPT Descriptor Tatooing, intradermal introduction of insoluble opaque pigments to correct Color defects of skin, including micropigmentation; 6.1 sq cm to 20.0 sq cm

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
52000	000	2.01

CPT Descriptor 1 Cystourethroscopy (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
43235	000	2.39

CPT Descriptor 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time 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: 24.2 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 64653</u>	<u>Key Reference CPT Code: 11921</u>
Median Pre-Service Time	7.00	20.00
Median Intra-Service Time	23.00	45.00
Median Immediate Post-service Time	5.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	35.00	80.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	2.38
Urgency of medical decision making	3.13	2.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.75	3.50
Physical effort required	3.63	2.88

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.00	2.63
Outcome depends on the skill and judgment of physician	4.63	3.50
Estimated risk of malpractice suit with poor outcome	4.00	3.63

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.25	2.88
Intra-Service intensity/complexity	3.88	3.00
Post-Service intensity/complexity	3.13	2.50

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) and the American Academy of Neurology (AAN) have each conducted the required PHYSICIAN WORK RVS Update Survey for this code. In addition, a work group comprised of AAD Coding & Reimbursement Task Force and the AAN Medical Economics and Management Committee members have reviewed the results of this survey and agreed to the values and RVU level requested in this Summary of Recommendation. Following pre-facilitation, the societies agreed to adjust the recommended RVU to match the intensity of the reference service. Calculating the same service time proportionality, we came up with 0.88. This code is much more painful with higher intensity than 64650 and was felt to be an appropriate value in relation to the RVU of 0.70 for 64650.

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**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.

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**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology                      How often? Commonly

Specialty Neurology                      How often? Commonly

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 Dermatology              Frequency 4000              Percentage              %

Specialty Neurology              Frequency 1000              Percentage              %

Specialty                      Frequency                      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 Dermatology              Frequency 800              Percentage              %

Specialty Neurology                      Frequency 200                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. surgical

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. 11951

**AMA/Specialty Society Update Process  
PERC Summary of Recommendation  
000 Day Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor:

64650 - Chemodenervation of eccrine glands, not requiring regional block; both axillae

64653 - Chemodenervation of eccrine glands, not requiring regional block; other areas (eg, scalp, face, neck), per day

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 000 \_\_\_\_\_

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 American Academy of Dermatology (AAD) and the American Academy of Neurology (AAN) have each conducted the required PHYSICIAN WORK RVS Update Survey for this code. In addition, a work group comprised of AAD Coding & Reimbursement Task Force and the AAN Medical Economics and Management Committee members have reviewed the results of this survey and agreed to the practice expense direct inputs provided for clinical staff, medical supplies and equipment provided in the attached PERC spreadsheet.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Clinical staff greets, gowns, and takes patient vital signs.

Intra-Service Clinical Labor Activities: Patient is then positioned and if required draped. Prior to physician administering botulinum toxin type A, staff assists with mapping the locations of excessive sweating. Staff monitors test site for ten to fifteen minute period, until prepped area turns a dark purple. After physician outlines the reactive area of excessive sweating with a surgical marking pen, staff assists with careful removal of starch/iodine compound.

Clinical staff prepares supplies needed for physician to reconstitute the botulinum toxin. type A (100 U per vial) with 4 ml sterile saline solution and four separate 1 ml syringes. Staff assists with patient while physician slowly injects an aliquot of botulinum toxin type A and as needed assists with compression to facilitate hemostasis, monitors dressings.

	A	B	C	D	E	F	G
1							
2				64650		64653	
3	Meeting Date: April 2005			Chemodenervation of eccrine glands; axillae		Chemodenervation of eccrine glands; other areas (e.g. scalp, face, neck) per day	
4	LOCATION	Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			0		0	
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	32.0	0.0	32.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			29.0	0.0	29.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	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						
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	
23	Greet patient and provide gowning			3		3	
24	Obtain vital signs			3		3	
25	Provide pre-service education/obtain consent			2		2	
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			2		2	
30	Intra-service						
31	Assist physician in performing procedure			10		10	
32	Post-Service						
33	monitor pt following service/check tubes, monitors, drains						
34	Clean room/equipment by physician staff			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						
40	99239 --15 minutes						
41	Other Clinical Activity (please specify)						
42	End: Patient leaves office						

	A	B	C	D	E	F	G
2				64650		64653	
3	Meeting Date: April 2005			Chemodervation of eccrine glands; axillae		Chemodervation of eccrine glands; other areas (e.g. scalp face neck) per day	
4	LOCATION	Code	Staff Type	Non Facility	Facility	Non Facility	Facility
43	POST-SERVICE PERIOD						
44	Start: Patient leaves office/facility						
45	Conduct phone calls/call in prescriptions <i>Office visits: Greet patient, escort to room; provide gowning; interval history &amp; vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or</i>			3		3	
46							
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	CMS Code	Unit				
59	pack, minimum multi-specialty visit	SA048	pack	1		1	
60	mask, surgical, with face shield	SB034	Item	1		1	
61	gown, staff, impervious	SB027	Item	1		1	
62	cap, surgical	SB001	Item	1		1	
63	Starch powder, fine, 1 oz	0	oz	1		1	
64	povidone soln (Betadine)	SJ041	ml	5ml		5ml	
65	swab-pad, alcohol	SJ053	Item	10		10	
66	Surgical skin marking pen	SK076	Item	1		1	
67	Saline solution, sterile, 0.9% non preserved	SH068	ml	5ml		5ml	
68	syringe 5ml	SC057	Item	1		1	
69	syringe 1ml	SC052	Item	4		4	
70	needle, 30g	SC031	Item	4		4	
71	Needle, 20g, transfer	SC029	Item	1		1	
72	gauze, sterile, 4 x 4" (10 pack)	SG056	Item	1		1	
73							
74	Equipment	CMS Code	Unit				
75	light, surgical	E30009		1		1	
76	table, power	E11003		1		1	
77	surgical loupes	E30018		1		1	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Blepharoptosis Repair, Harvest of Fascia**

The CPT Editorial Panel revised two existing codes, 67901 *Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)* and 67902 *frontalis muscle technique with autologous fascial sling (includes obtaining fascia)* to differentiate between repair of blepharoptosis frontalis muscle technique with autologous fascial sling requiring harvesting and blepharoptosis frontalis muscle technique with suture or banked graft.

At the November 2004 CPT Editorial Panel, the specialty society requested that both codes be resurveyed since there was clarification on how the fascia is being obtained and these services had never been reviewed before. Previously 67901 would be reported for either banked fascia or other methods of obtaining grafts. This coding change directs all banked fascia to be reported with 67901 and all autologous fascia be reported the 67902. Typically, the RUC would have expected a work neutrality adjustment. However, the specialty society felt that both codes are currently undervalued. Specialty societies must present compelling evidence in such a review and this was not presented in February 2005.

The specialty society re-presented in April 2005 with compelling evidence available for the change in codes 67901 and 67902 values. Codes 67901 and 67902 had never been RUC reviewed and the difference between the values of the two codes was 0.06, which did not adequately represent the higher intensity of work involved in 67902 when the physician must obtain autologous fascia from the patient.

The revised descriptor for 67901 adds a parenthetical to the existing descriptor. The parenthetical indicates that 67901 is the appropriate code when banked fascia is used as the suspension device. The revised 67901 is not fundamentally different in terms of pre- or intra-service work when compared to the previous version of 67901. However, an additional 99212 post-operative visit is typical and the RUC accepted 67901 to total four 99212 visits. The specialty society used a building block approach and added an additional 99212 (work RVU=0.43) to the current value for 67901 (work RVU=6.96), which results a work RVU of 7.39. This work RVU value falls slightly below the 25<sup>th</sup> percentile identified by survey respondents. **The RUC recommends a work RVU of 7.39 for 67901.**

The RUC reviewed code 67902, which had only a 0.06 difference in work RVU with 67901. The specialty society used a building block approach to develop a work RVU of 9.35 for 67902. The specialty society used code 20920 *Fascia lata graft; by stripper* (work RVU=5.30). Harvard data lists 20920 pre-service time as 21 minutes for pre-service evaluation time and 25 minutes for dress, scrub, and wait time. Therefore, the pre-service time for 20920 is  $(21 * 0.0224) + (25 * 0.0081) = 0.67$ . Harvard data also lists 20920 post-operative visits as three 99212, one half of a 99231, and one 99238. Therefore, the post-service RVU =  $(3 * 0.43) + (0.5 * 0.64) + (1 * 1.28) = 2.89$ . The intra-service RVUs for 20920 are 5.30 (total) - 0.67 (pre-service) - 2.89 (post-service) = 1.74. The 1.74 represents additional intensity to maintain proper rank order.

The specialty society also indicated that the three 99212 post-operative visits for 67902, listed as Harvard data, did not accurately reflect the postoperative service. A more typical scenario would include three 99212 post-operative visits and one 99213 post-operative visit as supported by survey data. This change adds an additional 99213 visit or 0.65 work RVUs. The specialty society then added 1.74 and 0.65 to the existing work RVUs of 7.02 for 67902, which results in a work RVU of 9.41. However, the specialty society felt that slightly high and recommended 9.35 work RVUs for 67902. This value was between the 25th percentile and the median from the survey data. **The RUC recommends a work RVU of 9.35 for 67902.**

Practice Expense

The RUC amended and approved the practice expense for 67901 and 67902.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
67900		<i>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</i> <i>(For forehead rhytidectomy, use 15824)</i>	010	6.13  (No Change)
▲67901	AA1	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	090	7.39
▲67902	AA2	frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	090	9.35

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:67901    Tracking Number: AA1 Global Period: 090    Recommended Work Relative Value  
Specialty    Society    RVU:    7.39

**RUC RVU: 7.39**

CPT Descriptor: Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g. banked fascia)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 57-year-old female with complete upper eyelid ptosis due to damage to the ipsilateral oculomotor nerve. Levator function is absent.

Percentage of Survey Respondents who found Vignette to be Typical: 46%

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 patient history and physical exam are reviewed as are the appropriate pre operative tests. The patient is counseled in the preoperative area. The preoperative interval history, note and exam are documented in the patient record. The integrity of the ocular surface is assessed, as well as eyelid height and levator function. Photographs are reviewed.

Description of Intra-Service Work: The correct surgical site is confirmed. A marking pen is used to delineate the planned 6 incisions in the eyelid and above the brow. Antibiotic ointment and a protective device (e.g., protective shell) are placed on the cornea. Lidocaine with epinephrine is infiltrated for hemostasis and for anesthesia. Five minutes are allowed to pass.

A traction suture is placed through the upper eyelid margin and clamped inferiorly. The eyelid incisions are made just above the lash line through skin and orbicularis oculi muscle. The suprabrow incisions are made to the level of periosteum. A superiorly-directed pocket is created at each suprabrow incision.

A fascia needle is used to thread the banked fascia between the incisions in the eyelids and brow forming two rectangles with two pieces of fascia. The eyelid incisions are closed with absorbable 7-0 suture. The upper eyelid traction suture is removed. The protective device is removed. Tension on the two fascia ends that finally exit the suprabrow incision is adjusted until optimal eyelid height and contour are obtained. Square knots are tied in the fascia, secured with suture, and buried deep in the suprabrow wounds.

The suprabrow incisions are closed in layers with 7-0 absorbable suture. The eyelid incisions may be closed according to surgeon's preference. Antibiotic ointment is placed on the wounds and in the conjunctival cul-de-sac. A traction suture is placed in the lower lid margin and taped to the brow with adhesive strips.

Description of Post-Service Work: The patient is seen in the post-operative area after the op note is dictated. Post op instructions are then given and arrangements for follow up the next day are confirmed.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	L. Neal Freeman, M.D., MBA and Stephen Kamenetzky, M.D.
<b>Specialty(s):</b>	ophthalmology

<b>CPT Code:</b> 67901					
<b>Sample Size:</b> 280	<b>Resp n:</b> 59		<b>Response:</b> %		
<b>Sample Type:</b> Random					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	5.00	7.50	8.48	9.50	16.50
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			10.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.0		
<b>Intra-Service Time:</b>	0.00	42.50	60.00	60.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>15.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>18.0</u>	99238x 0.50	99239x 0.00		
<b>Office time/visit(s):</b>	<u>60.0</u>	99211x 0.0	12x 4.0	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>
65105	090	8.48

CPT Descriptor Remove eye/attach implant

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 30.5 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 67901</b>	<b>Key Reference CPT Code: 65105</b>
Median Pre-Service Time	30.00	49.00
Median Intra-Service Time	60.00	77.00
Median Immediate Post-service Time	15.00	21.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	14.00
Median Office Visit Time	60.0	59.00
<b>Median Total Time</b>	<b>183.00</b>	<b>220.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.17	3.50
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.28	3.17
--	------	------

Urgency of medical decision making	2.78	3.06
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.11	3.89
--------------------------	------	------

Physical effort required	3.33	3.28
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.50	2.72
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Outcome depends on the skill and judgment of physician	3.78	3.33
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Estimated risk of malpractice suit with poor outcome	4.17	4.00
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.67	3.39
----------------------------------	------	------

Intra-Service intensity/complexity	4.00	3.72
------------------------------------	------	------

Post-Service intensity/complexity	3.50	3.17
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**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 revised descriptor of this service only adds a parenthetical to the existing descriptor. The parenthetical indicates that 67901 is the appropriate code when banked fascia is used as the suspension device. The revised version of 67901 is not fundamentally different in terms of preservice work or intraservice work compared to the existing version of 67901.



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 Ophthalmology Frequency 1660 Percentage 83.00 %

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

## Compelling evidence for the change in values for 67902 and 67901

Code 67902 requires more work than code 67901. That additional work is not captured in the current value. The basis for reaching this conclusion is the "building-block" method approved by the RUC as a valid approach for valuing codes.

In addition, the AAO is correcting the number of post-op visits associated with both codes, which have never been RUC valued, to reflect current ophthalmic practice. Newer techniques to allow suture/fascia adjustment and greater emphasis on the cosmetic portion of the functional correction have caused the number of post-op visits to increase as patient demands increase.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:67902 Tracking Number: AA2 Global Period: 090

**Recommended Work Relative Value**  
Specialty Society RVU: **9.35**

**RUC RVU: 9.35**

CPT Descriptor: Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An 8-year-old child with 3 mm left upper lid ptosis with poor levator function experiences visual obstruction due to the drooping of the lid. The surgical plan is to perform a frontalis suspension of the left upper lid using autologous fascia lata.

Percentage of Survey Respondents who found Vignette to be Typical: 52%

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: Prior history and physical exam are reviewed. The family is counseled in the preoperative area. The preoperative interval history, note and exam are documented in the patient record. The integrity of the ocular surface is assessed, as well as eyelid height and levator function. Photographs are reviewed. The source of autologous fascia, the patient's thigh is inspected.

Description of Intra-Service Work: The correct surgical site and the site for harvesting the fascia autograft are confirmed.

The thigh is positioned. An incision is made in the thigh approximately 2.5 inches above the knee joint. The incision is carried through skin and subcutaneous tissue until the fascia lata is identified. Three cuts in the fascia are made to create a U shape. The fascia is separated from the underlying muscle. A ligature is placed on the free end of fascia. The free end of fascia is threaded into the fascia stripper. The stripper is directed superiorly beneath the skin for about 20 cm in a line from the head of the fibula to the iliac crest. The fascia is cut superiorly by activating the cutting mechanism of the stripper. The fascia and stripper are removed. The skin wound is closed in layers and the thigh is dressed with a pressure dressing.

The fascia is cleaned of subcutaneous tissue and fat and cut to produce 2 strips of appropriate size.

A marking pen is used to delineate the planned 6 incisions in the eyelid and above the brow. Antibiotic ointment and a protective device (e.g., protective shell) are placed on the cornea. Lidocaine with epinephrine is infiltrated for hemostasis. Five minutes are allowed to pass. A traction suture is placed through the upper eyelid margin and clamped inferiorly. The 3 eyelid incisions are made just above the lash line through skin and orbicularis oculi muscle. The 3 suprabrow incisions are made to the level of periosteum. A superiorly-directed pocket is created above each suprabrow incision.

A fascia needle is used to thread the two pieces of fascia between the incisions in the eyelids and brow forming two rectangles. The eyelid incisions are closed with absorbable 7-0 suture. The upper eyelid traction suture is removed. The protective device is removed. Tension on the two fascia ends that exit two of the suprabrow incisions is adjusted until optimal eyelid height and contour are obtained. Square knots are tied in the fascia, secured with suture, and buried deep in the suprabrow wounds.

The suprabrow incisions are closed in layers with 7-0 absorbable sutures. Antibiotic ointment is placed on wounds and in the conjunctival cul-de-sac. A traction suture is placed in the lower lid margin and taped to the brow with adhesive strips.

Description of Post-Service Work: The patient is seen in the post-operative area after the op note is dictated. The family is counseled and post-op instructions are then given and arrangements for follow up the next day are confirmed.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	L. Neal Freeman, M.D., MBA and Stephen Kamenetzky, M.D.					
<b>Specialty(s):</b>	ophthalmology					
<b>CPT Code:</b>	67902					
<b>Sample Size:</b>	280	<b>Resp n:</b>	60	<b>Response:</b> 21.42 %		
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		4.00	8.50	10.25	13.50	20.79
<b>Pre-Service Evaluation Time:</b>				10.0		
<b>Pre-Service Positioning Time:</b>				10.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				13.0		
<b>Intra-Service Time:</b>		0.00	60.00	78.00	120.00	180.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>		<u>20.00</u>				
<b>Critical Care time/visit(s):</b>		<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>		<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>		<u>18.0</u>	99238x 0.50	99239x 0.00		
<b>Office time/visit(s):</b>		<u>68.0</u>	99211x 0.0	12x 3.0	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>
65105	090	8.48

CPT Descriptor Remove eye/attach implant

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 18      **% of respondents:** 30.0 %

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 67902</b>	<b>Key Reference CPT Code: 65105</b>
Median Pre-Service Time	33.00	49.00
Median Intra-Service Time	78.00	77.00
Median Immediate Post-service Time	20.00	21.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	14.00
Median Office Visit Time	68.0	59.00
Median Total Time	217.00	220.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.83	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.17	3.06
Urgency of medical decision making	2.56	2.72

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.22	3.67
Physical effort required	3.83	3.28

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.56	2.61
Outcome depends on the skill and judgment of physician	3.83	3.28
Estimated risk of malpractice suit with poor outcome	4.28	3.67

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.67	3.39
Intra-Service intensity/complexity	4.06	3.61
Post-Service intensity/complexity	3.44	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.*

Presently there is only 0.06 difference in work RVU between this code and 67901. This is despite the fact that the surgeon will be harvesting fascia lata from the thigh when this code is reported.

There are 5.30 work RVUs associated with 20920; fascia lata graft by stripper.

Harvard data lists 20920 preservice times as 21 minutes for preservice evaluation time and 25 minutes for dress, scrub, and wait time. Preservice RVUs are therefore  $(21 * 0.0224) + (25 * 0.0081) = 0.67$ . Harvard data also lists 20920 postop visits as three 99212, one half of a 99231, and one 99238. Postservice RVUs are therefore  $(3 * 0.43) + (0.5 * 0.64) + (1 * 1.28) = 2.89$ .

Therefore, intraservice RVUs for 20920 are  $5.30$  (total)  $- 0.67$  (preservice)  $- 2.89$  (postservice)  $= 1.74$ .

The three 99212 postop visits for 67902 listed as Harvard data do not accurately reflect the postoperative service. A more typical scenario would include three 99212 postop visits and one 99213 postop visit as supported by survey data. The typical series of visits is postop day 1 (including removal of the eyelid closure suture), postop day 7 (including removal of leg staples), postop day 30, and postop days 60 thru 90. day 60. This change adds an additional 99213 visit.

Although some of the preservice work of 20920 (prepping and draping of the leg) is indeed a component of the new 67902 procedure, we have chosen to be conservative and are adding only the intraservice component of 20920.

Adding a 99213 visit adds 0.65 work RVUs.

Adding 1.74 and 0.65 to the existing work RVUs of 7.02 for 67902 results in 9.41. We are being again more conservative and are recommending 9.35 work RVUs for 67902. This value lies between the 25th percentile and the median on the recently completed 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: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 165

How often do physicians 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? 3000  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Ophthalmology Frequency 2760 Percentage 92.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Ophthalmology Frequency 460 Percentage 92.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
010 or 090 Day Global Periods  
Facility Direct Inputs**

CPT Long Descriptor: Repair of blepharoptosis; frontalis muscle technique with suture or other material

Sample Size: N/A      Response Rate (%): N/A      Global Period: 90 days

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 American Academy of Ophthalmology used a consensus panel comprised of members of the association's RVS committee to develop the summary for this code. The panel members were convened via e-mail and telephone conference call. The panel members reached a consensus regarding practice expense valuation for this code. The members of the panel are well versed in the practice expense survey instrument and developed fair and correct inputs for this summary.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Necessary labs ordered and preoperative medications phoned in. Patient counseled re: preoperative logistics. Consent documents reviewed and signed. Patient advised re: anticipated postoperative visual limitations. Schedule time in facility. Phone call(s) made to answer last minute questions and confirm understanding. Confirm appropriate ordering of suspension device by facility.

Intra-Service Clinical Labor Activities: Discharge day management tasks including provision of home care instructions (brow, lid, and globe). Phone call(s) for analgesics, antibiotics, and ocular lubricants. Coordinate office visits.

Post-Service Clinical Labor Activities: Greet patient; escort to room; provide gowning, interval history and vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare diagnostic test, prescriptions forms; post-service education, instruction, counseling; clean room/equipment; check supplies; coordinate home or outpatient care.

Total Staff Time Out of Office: 178.0

Visits in Global Period: 4

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
010 or 090 Day Global Periods  
Non Facility Direct Inputs**

CPT Long Descriptor: Repair of blepharoptosis; frontalis muscle technique with suture or other material

Sample Size: N/A    Response Rate (%): N/A    Global Period: 90 days

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:

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Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Necessary labs ordered and preoperative medications phoned in. Patient counseled re: preoperative logistics. Consent documents reviewed and signed. Patient advised re: anticipated postoperative visual limitations. Phone call(s) made to answer last minute questions and confirm understanding.

Intra-Service Clinical Labor Activities: Greet and gown. Check vital signs (including visual acuity). Room prepared. Patient positioned. Assist doctor during procedure (including stabilization of protective plate to guard against globe injury during multiple passes of fascia needle through eyelid). Clean room and instruments. Check wound. Provide home care instructions (brow, lid, and globe). Phone call(s) for analgesics, antibiotics, and ocular lubricants.

Post-Service Clinical Labor Activities: Greet patient; escort to room; provide gowning, interval history and vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare diagnostic test, prescriptions forms; post-service education, instruction, counseling; clean room/equipment; check supplies; coordinate home or outpatient care.

Total Staff Time-Non Facility: 243.0

Visits in Global Period: 4

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
010 or 090 Day Global Periods  
Facility Direct Inputs**

CPT Long Descriptor: Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)

Sample Size: N/A    Response Rate (%): N/A    Global Period: 90 days

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 American Academy of Ophthalmology used a consensus panel comprised of members of the association's RVS committee to develop the summary for this code. The panel members were convened via e-mail and telephone conference call. The panel members reached a consensus regarding practice expense valuation for this code. The members of the panel are well versed in the practice expense survey instrument and developed fair and correct inputs for this summary.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Prior history and physical exam are reviewed. The family is counseled in the preoperative area. The preoperative interval history, note and exam are documented in the patient record. The integrity of the ocular surface is assessed, as well as eyelid height and levator function. Photographs are reviewed. The source of autologous fascia, the patient's thigh is inspected.

Intra-Service Clinical Labor Activities: The correct surgical site and the site for harvesting the fascia autograft are confirmed.

The thigh is positioned. An incision is made in the thigh approximately 2.5 inches above the knee joint. The incision is carried through skin and subcutaneous tissue until the fascia lata is identified. Three cuts in the fascia are made to create a U shape. The fascia is separated from the underlying muscle. A ligature is placed on the free end of fascia. The free end of fascia is threaded into the fascia stripper. The stripper is directed superiorly beneath the skin for about 20 cm in a line from the head of the fibula to the iliac crest. The fascia is cut superiorly by activating the cutting mechanism of the stripper. The fascia and stripper are removed. The skin wound is closed in layers and the thigh is dressed with a pressure dressing.

The fascia is cleaned of subcutaneous tissue and fat and cut to produce 2 strips of appropriate size.

A marking pen is used to delineate the planned 6 incisions in the eyelid and above the brow. Antibiotic ointment and a protective device (e.g., protective shell) are placed on the cornea. Lidocaine with epinephrine is infiltrated for hemostasis. Five minutes are allowed to pass. A traction suture is placed through the upper eyelid margin and clamped inferiorly. The 3 eyelid incisions are made just above the lash line through skin and orbicularis oculi muscle. The 3 suprabrow incisions are made to the level of periosteum. A superiorly-directed pocket is created above each suprabrow incision.

A traction suture is placed through the upper eyelid margin and clamped inferiorly. The eyelid incisions are made just above the lash line through skin and orbicularis oculi muscle. The suprabrow incisions are made to the level of periosteum. A superiorly-directed pocket is created at each suprabrow incision.

A fascia needle is used to thread the two pieces of fascia between the incisions in the eyelids and brow forming two rectangles. The eyelid incisions are closed with absorbable 7-0 suture. The upper eyelid traction suture is removed. The protective device is removed. Tension on the two fascia ends that exit two of the suprabrow incisions is adjusted until optimal eyelid height and contour are obtained. Square knots are tied in the fascia, secured with suture, and buried deep in the suprabrow wounds.

The suprabrow incisions are closed in layers with 7-0 absorbable sutures. Antibiotic ointment is placed on wounds and in the conjunctival cul-de-sac. A traction suture is placed in the lower lid margin and taped to the brow with adhesive strips.

Post-Service Clinical Labor Activities: The patient is seen in the post-operative area after the op note is dictated. The family is counseled and post-op instructions are then given and arrangements for follow up the next day are confirmed.

Total Staff Time Out of Office: 187.0

Visits in Global Period: 4

	A	B	C	D	E	F
1						
2			67901		67902	
3	Meeting: April, 2005	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g. banked fascia)		Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	
4	LOCATION		Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		90	90	N/A	90
6	TOTAL CLINICAL LABOR TIME	L038A COMT/COT/RN/CNT	237.0	174.0		183.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		35.0	60.0		60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		94.0	6.0		6.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		108.0	108.0		117.0
10	PRE-SERVICE					
11	Start: Following visit when decision for surgery or procedure made					
12	Complete pre-service diagnostic & referral forms		5	5		5
13	Coordinate pre-surgery services		10	20		20
14	Schedule space and equipment in facility		0	8		8
15	Provide pre-service education/obtain consent		10	20		20
16	Follow-up phone calls & prescriptions		10	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		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		2			
30	Intra-service					
31	Assist physician in performing procedure		60			
32	Post-Service					
33	Monitor pt. following service/check tubes, monitors, drains					
34	Clean room/equipment by physician staff		3			
35	Clean Scope					
36	Clean Surgical Instrument Package		15			
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		4			
40	Discharge day management 99238 -12 minutes 99239 -15 minutes			6		6
41	Other Clinical Activity (please specify)					
42	End: Patient leaves office					
43	POST-SERVICE PERIOD					
44	Start: Patient leaves office/facility					
45	Conduct phone calls/call in prescriptions					
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	4	4		3
50	99213 36 minutes	36				1
51	99214 53 minutes	53				
52	99215 63 minutes	63				
53	Other					
54						
55	Total Office Visit Time		108	108		117
56	Other Activity (please specify)					
57	End: with last office visit before end of global period					

	A	B	C	D	E	F
2			67901		67902	
3	Meeting: April, 2005	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g. banked fascia)		Repair of blepharoptosis; frontalis muscle technique with autologous fascial sliding (includes obtaining fascia)	
4	LOCATION		Non Facility	Facility	Non Facility	Facility
58	<b>MEDICAL SUPPLIES</b>					
59	pack, minimum multi-specialty visit	SA048	5	4		3
60	pack, post-op incision care (staple)	SA052				1
61	pack, cleaning, surgical instruments	SA043	1			
62	mask, surgical, with face shield	SB034	2			
63	gown, surgical, sterile	SB028	2			
64	shoe covers, surgical	SB039	2			
65	cap, surgical	SB001	2			
66	gloves, sterile	SB024	2			
67	Drape, Sterile, For Mayo Stand	SB012	1			
68	Drape, Sterile, U-shape	SB015	1			
69	Drape/Cover, Sterile, For O.R. Light Handle	SB016	1			
70	Betadine swabstick (3 pack uou)	SJ043	1			
71	skin marking pen, sterile (Skin Scribe)	SK075	1			
72	synnqe, 5-6 ml	SC057	1			
73	needle, 18-27g	SC029	1			
74	needle, 30g	SC031	1			
75	Lidocaine 2% with epi Inj (Xylocaine w/epi)	SH049	5			
76	Bupivacaine 0.5% inj	SH022	5			
77	water, sterile for irrigation (250-1000 ml uou)	SH074	1			
78	Scalpel w/blade, surgical (#10-20)	SF033	1			
79	Gauze, Sterile 4" X 4" (10 pack uou)	SG056	1			
80	applicator, cotton tipped, non ster 6"	SG008	20			
81	Suture, Silk, 2-0 to 5-0, x,fs, c	SF039	2			
82	Suture, Vicryl, 3-0 to 6-0, p, ps	SF040	1			
83	suture, vicryl, 7-0	SF052	1			
84	Hydrogen Peroxide	SJ028	30			
85	ice pack, instant	SJ029	1			
86	Erythromycin ophth oint (3.5 gm uou)	SH032	1			
87	Balanced Salt Solution (15 ml uou)	SH078	1			
88	tape	SG079	36			
89	Pad, sterile strabismus	SG046	2			
90	Eye Shield, fox	SG048	1			
91	cautery, monopolar, electrode tip	SF016	1			
92	cautery, patient ground pad w-cord	SF021	1			
93	cautery, monopolar, pencil-handpiece	SF020	1			
94						
95	<b>EQUIPMENT</b>					
96	Surgical loupes	E30018	1			
97	Electrocautery	E30005	1			
98	Blepharoplasty Tray	E72005	1			
99	Screening Lane	E71111	4	4		4
100	Surgical light	E30009	1			
101	Mayo stand	EF015	1			
102	Power table	E11003	1			
103	Suction machine (Gomco)	E30001	1			
104	Light , fiberoptic headlight with source	E13122	1			
105	Pulse oximeter	E55003	1			

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**3D Image Rendering**

The CPT Editorial Panel created two new codes to describe the new technology of volumetric acquisition of advanced cross-sectional imaging. This new technology will address complex renderings such as shaded surface rendering, volumetric rendering, maximum intensity projections, fusion imaging from multiple modalities and quantitative analysis.

**76376**

The RUC reviewed the survey results for *76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image post-processing on an independent workstation*. The specialty society recommended that the surveyed intra-service time was over-estimated by the survey respondents and felt that the total service time for the surveyed code and the reference code, *74160 Computed tomography, abdomen; with contrast material(s)* (Work RVU=1.27), should be the same, 15 minutes. The specialty society recommended that the intra-service time for the surveyed code be 5 minutes. In addition, the specialty society noted that the reference code was deemed far more intense and complex than the surveyed code. Therefore, because the reference code and surveyed code had the same amount of time but vastly different intensities, the specialty society recommended the 25th percentile survey work RVU of 0.20. **The RUC recommends 0.20 Work RVUs for 76376.**

**76377**

The RUC reviewed the survey results for *76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post-processing on an independent workstation*. When evaluating the RVW recommendations for 76376 and 76377, the RUC took into consideration that CPT *74170 Computed tomography, abdomen; without contrast material followed by contrast material(s) and further sections* (Work RVU=1.40) or other similar CT code will be reported in addition to 76376 or 76377. As an additional reference the RUC compared the combined use of *74170 and 76377 to 74175 Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing* (Work RVU=1.90) a service previously valued by the RUC that combines computed tomography and three-dimensional rendering techniques to evaluate the abdominal vasculature. The following table indicates

that at the recommended value of the 25th percentile, 0.79, the combined RVW recommendation is 0.29 RVU higher than CT angiography of the abdomen and is supported by additional intensity and complexity as well as 8 additional minutes of total time and 2 additional minutes of intra-service time:

	74170*	76377	74170 + 76377	74175**
Pre-service time		5	10	10
Intra-service time		17	32	30
Post-service time		8	16	10
Total Time	27	30	58	50
Work RVU	1.40 RVW	0.79 RVW	2.19 RVW	1.9 RVW

\* Total Harvard time

\*\* RUC time from 2001

The RUC agreed with the specialty society's recommendation. **The RUC recommends 0.79 Work RVU for 76377.**

### Work Neutrality

In addition to the work RVU recommendation, the specialty society acknowledged the fact that new physician work did not drive the creation of new codes. Since the original code descriptor was written, the work of three-dimensional imaging has become much more complex. The evolution of this process has occurred over a number of years and a need for establishing new codes has not arisen until now. The relative undervaluation of complex three-dimensional was mitigated by the preponderance of two-dimensional multiplanar reformatting also described by CPT code 76375. Of the 469,255 cases of CPT code 76375 reported in the 2003 Medicare utilization data, the RUC understands that 80 to 90 percent reflect two-dimensional multiplanar reformatting and only 10 to 20 percent reflect three-dimensional rendering described in codes 76376 and 76377. At the recommended work levels, there should be a net savings in rowk RVUs to CMS of approximately 38%.

Total 2003 cases of 76375	469,255	RVU for 76376	0.20
		RVU for 76377	0.79
Work RVU 76375	0.16	Total RVU for 76376	9,385
Total RVUs for 76375	75,081	Total RVU for 76377	37,071
		Total RVU for 76376 and 76377	46,456
Number of cases of 76376 (10%)	46,925		
Number of cases 76377 (10%)	46,925	Percent Savings in Work RVUs	38

**Practice Expense**

The RUC agreed with most of the PE inputs recommended by the specialty society as they conform to the PEAC standards. However, revisions were made to the clinical labor intra-service time and post service time of 76377 to reflect that this procedure would be performed with other procedures. The recommended practice expense inputs are attached to this recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 76375		<p><del>Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic, reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality</del></p> <p><del>(Use 76375 in addition to code for imaging procedure)</del></p> <p><del>(76375 has been deleted)</del></p> <p><del>(2D reformatting is no longer separately reported. To report 3D rendering, see 76376, 76377)</del></p> <p><del>(Codes 76376 or 76377 require concurrent physician supervision of image post-processing 3D manipulation of volumetric data set and image rendering)</del></p>	XXX	N/A
•76376	SS1	<p>3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image post-processing on an independent workstation</p> <p>(Use 76376 in conjunction with code for base imaging procedure(s))</p> <p>(Do not report 76376 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75635, 78814, 78815, 78816, 0066T, 0067T)</p>	XXX	0.20

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•76377	SS2	<p>requiring image post processing on an independent workstation</p> <p>(Use 76377 in conjunction with code for base imaging procedure(s))</p> <p>(Do not report 76377 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75635, 78814, 78815, 78816, 0066T, 0067T)</p>	XXX	0.79

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

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CPT Code:76376 Tracking Number: SS1 Global Period: XXX **Recommended Work Relative Value**  
Specialty Society RVU: **0.20**

**RUC RVU: 0.20**

CPT Descriptor: 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image post-processing on an independent workstation

(Use 76376 in conjunction with code for base imaging procedure(s))

(Do not report 76376 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75635, 78814, 78815, 0066T, 0067T)

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**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 27-year-old female patient G2P1 has previously delivered an infant with a cleft lip and palate. The obstetrician performs a pelvic exam and concludes that the uterine size appears consistent with a 20-22 weeks gestation. The patient is scheduled for a 2D ultrasound examination to confirm fetal dating of the pregnancy and to evaluate for possible fetal abnormalities including a possible facial cleft malformation.

An ultrasound technologist scans the patient in a conventional ultrasound unit that has 2D ultrasound capabilities. Sagittal and transverse images of the pregnant uterus are obtained in 2D ultrasound (coded separately). The attending physician evaluates the images and concludes that the images generated from the 2D ultrasound are not able to confidently exclude or identify a facial cleft anomaly. A 3D ultrasound is ordered to better visualize the facial structures in 3D shaded surface rendering.

Percentage of Survey Respondents who found Vignette to be Typical: 50%

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:**

- Discuss the need for 3D imaging with technologist to assure adequate source data
- Review any prior imaging studies
- Describe procedure to patient and obtain consent as needed
- Review source imaging data

**Description of Intra-Service Work:**

- Supervise technologist in creating three-dimensional images
- Interpret three-dimensional images
- Dictate report for medical record

**Description of Post-Service Work:**

- Review and sign report
- Discuss findings with referring physician

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>		Bibb Allen, Jr., M.D., Jonathan Berlin, M.D.				
<b>Specialty(s):</b>		American College of Radiology				
<b>CPT Code:</b>		76376				
<b>Sample Size:</b>	200	<b>Resp n:</b>	26	<b>Response:</b>	%	
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		0.10	0.20	0.60	1.00	2.60
<b>Pre-Service Evaluation Time:</b>				5.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		3.00	5.00	5.00	15.00	50.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>		<b>5.00</b>				
<b>Critical Care time/visit(s):</b>		<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>		<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>		<b>0.0</b>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>		<b>0.0</b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
74160	XXX	1.27

CPT Descriptor Computed tomography, abdomen; with contrast material(s)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4      % of respondents: 15.3 %

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 76376</b>	<b>Key Reference CPT Code: 74160</b>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	-15.00
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	-15.00
Other time if appropriate		-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	3.25	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	4.00
Urgency of medical decision making	3.25	4.25

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.25	3.00
Physical effort required	2.75	3.00
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	2.50	3.50
Outcome depends on the skill and judgment of physician	3.25	4.25
Estimated risk of malpractice suit with poor outcome	2.75	4.00

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.00	3.25
Intra-Service intensity/complexity	3.75	4.25
Post-Service intensity/complexity	2.25	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.*

After evaluating the survey data for 763XX1, the ACR RUC Committee believes that the appropriate work value for 763XX1 is 0.20 RWV, the 25th percentile. In contrast to 763XX2, this service will require little physician work for creating the three-dimensional data set and much of pre-service and post-service work is captured in the base code. Respondents may have included some technologist time in the intra-service work as well. We believe the actual intra-service time is between the median and 25th percentile.

### Rationale For Code Development

Advances in multidetector computed tomography (MDCT) and computer processing have simplified the ability to obtain two-dimensional reformatted images in addition to the standard projections. Furthermore, MDCT has further accentuated the differences in physician work and practice expense between the much more complex three-dimensional rendering and the less complex two-dimensional reformatting. The ACR believes it is no longer appropriate to code separately for two dimensional post-processing and proposed elimination of CPT code 76375 (Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computerized axial tomography, magnetic resonance imaging, or other tomographic modality), which described both two-dimensional reformatting and three-dimensional imaging. CPT code 76375 has been replaced with two new codes describing two levels of three-dimensional rendering. 763XX1 describes three-dimensional performed at the modality console. This rendering is typically performed by a technologist and then interpreted by the physician along with the base CT, MRI or US examination. This typically adds two or three imaging series to the base examination, and their interpretation is typically more complex than two-dimensional reformations. CPT code 763XX2 describes three-dimensional rendering that requires an independent workstation for creating the three-dimensional series of images. Physician involvement is typically required to provide the anatomic and pathological skill required to obtain meaningful three-dimensional information. The final result is typically four or five three-dimensional imaging series with physician work required both for the creation of the series and their subsequent interpretation and review with the referring physician.

### Budget Neutrality Issues

The ACR recognizes that new physician work did not drive the creation of the new codes. Since the original code descriptor was written, the work of three-dimensional imaging has become much more complex. The evolution of this process has occurred over a number of years and a need for establishing new codes has not arisen until now. The relative undervaluation of complex three-dimensional was mitigated by the preponderance of two-dimensional multiplanar reformatting also described by CPT code 76375. Of the 469,255 cases of CPT code 76375 reported in the 2004 RUC Database, our belief is that 80 to 90 percent reflect two-dimensional multiplanar reformatting and only 10 to 20 percent reflect three-dimensional rendering described in codes 763XX1 and 763XX2. At the recommended work levels, there should be a net cost savings to CMS of approximately 38%.

TTotal 2003 cases of 76375	469,255
Work RVU 76375	0.16
Total RVUs for 76375	75,081
Number of cases of 763XX1 (10%)	46,925
Number of cases 763XX2 (10%)	46,925
RVU for 763XX1	0.20
RVU for 763XX2	0.79
Total RVU for 763XX1	9,385
Total RVU for 763XX2	37,071
Total RVU for 763XX1 and 763XX2	46,456
Percent Savings in Work RVUs	388

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### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.



**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 71020

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: 76377 Tracking Number: SS2 Global Period: XXX	<b>Recommended Work Relative Value</b> Specialty Society RVU: <b>0.79</b> RUC RVU: <b>0.79</b>
CPT Descriptor: 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation	

( Use 76377 in conjunction with code for base imaging procedure(s))

(Do not report 76377 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75635, 78814, 78815, 78816, 0066T, 0067T)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 50-year-old male presented to his physician with hematuria. Renal ultrasound (coded separately) identified a 3 cm lower pole right renal mass consistent with renal cell carcinoma, previously diagnosed with ultrasound. The patient is a possible candidate for nephron-sparing partial nephrectomy and a computerized tomographic (CT) scan of the abdomen is ordered by the patient's urologist. Three-dimensional rendering is requested for further evaluation.

A CT examination of the abdomen, both before and after the use of contrast media, is performed (coded separately). Subsequent post-processing and 3D reconstruction is performed demonstrating the patient is a candidate for partial nephrectomy.

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:**

- Review protocol with technologist
- Review any prior imaging studies
- Describe procedure to patient and obtain consent as needed
- Review source imaging data

**Description of Intra-Service Work:**

- Supervise and/or create three-dimensional reconstructions of the organs of interest using an independent workstation
- Adjust the projection of the three-dimensional reconstructions to optimize visualization of anatomy or pathology
- Interpret the three-dimensional reformatted images resulting from the study, typically including cine review
- Compare to all pertinent available prior studies
- Dictate report for medical record

**Description of Post-Service Work:**

- Review and sign report
- Discuss findings with referring physician

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Bibb Allen, Jr., M.D., Jonathan Berlin, M. D.					
<b>Specialty(s):</b>	American College of Radiology					
<b>CPT Code:</b>	763XX2					
<b>Sample Size:</b>	200	<b>Resp n:</b>	30	<b>Response:</b>	%	
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>		0.15	0.79	1.13	1.99	6.25
<b>Pre-Service Evaluation Time:</b>				5.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		5.00	10.00	17.00	26.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>8.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
74160	XXX	1.27

CPT Descriptor Computed tomography, abdomen; with contrast material(s)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 33.0 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 763XX2</u>	<u>Key Reference CPT Code: 74160</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	17.00	-15.00
Median Immediate Post-service Time	8.00	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	15.00
Other time if appropriate		-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	3.30	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	3.50
Urgency of medical decision making	3.20	3.90

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	2.80
Physical effort required	3.20	2.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.50	3.10
Outcome depends on the skill and judgment of physician	3.80	4.20
Estimated risk of malpractice suit with poor outcome	3.10	3.70

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.20	2.30
Intra-Service intensity/complexity	3.90	3.80
Post-Service intensity/complexity	2.50	2.70

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR recognizes that the typical patient undergoing three-dimensional rendering will also have undergone a base CT, MR or US examination. For the vignettes we chose computed tomography for 763XX2 which respondents considered typical. By far the majority of complex three-dimensional rendering will be performed in conjunction with computed tomography. There was no one typical vignette for 763XX1, our respondents noted that in addition to the vignette chosen for the CPT application CT can also be used for the base modality for this service as well.

When evaluating the RVW recommendations for 763XX1 and 763XX2, we took into consideration that CPT 74170 or other similar CT code will be reported in addition to 763XX1 or 763XX2. As an additional reference we compared the combined use of 74170 and 763XX2 to 74175 (computed tomography angiography of the abdomen), a service previously valued by the RUC that combines computed tomography and three-dimensional rendering techniques to evaluate the abdominal vasculature. We conducted a time survey for 74170 along with the surveys for 763XX1 and 76XX2 since CPT code 74170 does not have RUC surveyed time. The table indicates that at the recommended value of the 25th percentile, the combined RVW recommendation is 0.29 RVU higher than CT angiography of the abdomen and is supported by 8 additional minutes of total time and 2 additional minutes of intra-service time.

	74170*	763XX2	74170 + 763XX2	74175**
Pre-service time	5	5	10	10
Intra-service time	15	17	32	30
Post-service time	8	8	16	10
Total Time	28	30	58	50
Work RVU	1.4 RVW	0.79 RVW	2.19 RVW	1.9
RVW				

\* These data are from a separate time survey for this code conducted by the ACR (Total Harvard time is 27 min)

\*\* RUC time from 2001

#### Rationale For Code Development

Advances in multidetector computed tomography (MDCT) and computer processing have simplified the ability to obtain two-dimensional reformatted images in addition to the standard projections. Furthermore, MDCT has further accentuated the differences in physician work and practice expense between the much more complex three-dimensional rendering and the less complex two-dimensional reformatting. The ACR believes it is no longer appropriate to code separately for two dimensional post-processing and proposed elimination of CPT code 76375 (Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computerized axial tomography, magnetic resonance imaging, or other tomographic modality), which described both two-dimensional reformatting and three-dimensional imaging. CPT code 76375 has been replaced with two new codes describing two levels of three-dimensional rendering. 763XX1 describes three-dimensional performed at the modality console. This rendering is typically performed by a technologist and then interpreted by the physician along with the base CT, MRI or US examination. This typically adds two or three imaging series to the base examination, and their interpretation is typically more complex than two-dimensional reformations. CPT code 76XX2 describes three-dimensional rendering that requires an independent workstation for creating the three-dimensional series of images. Physician involvement is typically required to provide the anatomic and pathological skill required to obtain meaningful three-dimensional information. The final result is typically four or five three-dimensional imaging series with physician work required both for the creation of the series and their subsequent interpretation and review with the referring physician.

#### Budget Neutrality Issues

The ACR recognizes that new physician work did not drive the creation of the new codes. Since the original code descriptor was written, the work of three-dimensional imaging has become much more complex. The evolution of this process has occurred over a number of years and a need for establishing new codes has not arisen until now. The relative undervaluation of complex three-dimensional was mitigated by the preponderance of two-dimensional multiplanar reformatting also described by CPT code 76375. Of the 469,255 cases of CPT code 76375 reported in the 2004 RUC Database, our belief is that 80 to 90 percent reflect two-dimensional multiplanar reformatting and only 10 to 20 percent reflect three-dimensional rendering described in codes 763XX1 and 763XX2. At the recommended work levels, there should be a net cost savings to CMS of approximately 38%.

Total 2003 cases of 76375                      469,255

Work RVU 76375                                      0.16

Total RVUs for 76375                            75,081





CPT Codes: 76376 and 76377

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

Family: **3D image rendering**

Sample Size: \_\_\_\_\_ Response Rate (%): \_\_\_\_\_ Global Period: XXX

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The ACR conducted practice expense surveys and utilized a consensus panel process to develop recommended inputs.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

76376: The technologist performs the three-dimensional renderings with supervision from the physician. The technologist reviews final output with physician. The technologist archives the three-dimensional renderings for final interpretation by the physician.

76377: The technologist transfers data to the workstation. The technologist assists the physician in creating three-dimensional renderings. The technologist reviews final output with physician. The technologist archives the three-dimensional renderings for final interpretation by the physician.

Post-Service Clinical Labor Activities:

		76376	76377
1	April 2005 RUC Meeting Practice Expense 3D		
2		CMS STAFF TYPE: MED SUPPLY, OR EQUIP CODE	
		3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image post- processing on an independent workstation	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation
3	LOCATION	In Office	In Office
4	GLOBAL PERIOD	XXX	XXX
5	TOTAL CLINICAL LABOR TIME	20	38
6	TOTAL PRE-SERV CLINICAL LABOR TIME		
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	20	38
8	TOTAL POST-SERV CLINICAL LABOR TIME		
9	PRE-SERVICE PERIOD		
10	Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD	L046A	
11	SERVICE PERIOD		
12	Start: When patient enters office/facility for surgery/procedure		
13	Pre-service		
14	Greet patient and provide gowning	L046A	
15	Provide pre-service education/obtain consent	L046A	
16	Prepare room, equipment, supplies	L046A	
17	Prepare and position patient (7 min)/ monitor patient/ set up IV (5 min)	L046A	
18	Intra-service		
19	Assist physician in performing procedure/ Computer post processing	L046A	15
20	Perform CT examination to obtain source images	L046A	33
21	Post-Service		
22	Clean room/equipment by physician staff	L046A	
23	Other Clinical Activity: follow up phone call		
24	- Process films, hang films and review study with interpreting MD prior to patient discharge	L046A	5
25	End: Patient leaves office		
26	POST-SERVICE PERIOD		

	A	B	F	G
1			76376	76377
2	April 2005 RUC Meeting Practice Expense 3D	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image post- processing on an independent workstation	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation
3	LOCATION		In Office	In Office
4	GLOBAL PERIOD		XXX	XXX
27	MEDICAL SUPPLIES			
28	Film developer/ cost per exposure	SK089	4	8
29	Film, 14x17	SK034	4	8
30	Film fixer	SK092	4	8
31	Alcohol swab	31101		
32	Angiocatheter	91106		
33	Band aid	31502		
34	Betadine swab	52305		
35	Contrast			
36	Drape, sheet	11106		
37	Extension tubing			
38	Film 14x17, Laser			
39	Film jacket or jacket insert	73405		
40	Gauze 2x2	31506		
41	Gloves, non-sterile	11302		
42	Gloves, sterile			
43	Heplock	53009		
44	IV start kit	91114		
45	Needle, 20G	91402		
46	stop cock, 4-way			
47	Cdrom			
48	Patient gown, disposable	11107		
49	Saline			
50	Syringe, 20 cc	91409		
51	Table paper	11111		
52	Tape	31514		
53	sodium chloride .9% inj bacteriostatic (30 ml uou)			
54	Equipment			
55	3D reconstruction workstation	ED014		1
56	Film alternator	ER029	1	1
57	Film processor		1	1
58	CT Room			
59	Laser printer			
60	Power injector			
61	Ultrasound room		15 min	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Neutron Therapy**

The CPT Editorial Panel created two new codes and revised one code to allow for more specificity in CPT for radiation treatment delivery, and to recognize high energy neutron therapy that is greater than 45MeV. The new codes now reflect the actual resources used in delivering neutron therapy and enable tracking and monitoring of this modality. Neutron therapy facilities require a high capital investment, and therefore only three neutron therapy facilities exist in the United States for this non-physician service. These facilities continue to draw patients from all over the United States, and many countries throughout the world.

The RUC then carefully reviewed the practice expense inputs for the two new codes. The RUC had minor changes regarding the clinical staff type and medical supplies in the non-facility setting. **The RUC recommends a total of 46 minutes of clinical labor time for code 77422 and 76 minutes for 77423. The RUC recommends no facility practice expense inputs for the codes, only non-facility practice expense inputs are recommended. The full revised practice expense recommendations from the RUC are attached.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 77412		Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, <del>special particle electron</del> beam (eg, <del>electron or neutrons</del> ); up to 5MeV	XXX	0.00
77413		6-10 MeV	XXX	0.00
77414		11-19 MeV	XXX	0.00
77416		20 MeV or greater	XXX	0.00
● 77422	BB1	High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking	XXX	0.00 (PE Inputs Only)
● 77423	BB2	one or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)	XXX	0.00 (PE Inputs Only)

	A	B	C	D	E	F	G
1							
2				CPT Code 77422		CPT Code 77423	
3	Meeting Date: February 2005 RUC Recommendation			High energy neutron radiation treatment delivery to a single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking		High energy neutron radiation treatment to one or more isocenter(s) with coplanar or non-coplanar geometry with simple or complex blocking and/or wedge, and/or compensator(s).	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD						
6	TOTAL CLINICAL LABOR TIME			46.0		76.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L121A	MP	5.0		5.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L042A	RN/LPN	3.0		3.0	
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L050C	RT	12.0		25.0	
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L050C	RT	26.0		43.0	
11	TOTAL POST-SERV CLINICAL LABOR TIME						
12							
13	Start: Following visit when decision for surgery or procedure made						
14	Complete pre-service diagnostic & referral forms						
15	*Coordinate pre-treatment 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	Daily Calibration per patient	L121A	MP	5		5	
21	End:When patient enters office/facility for surgery/procedure						
22							
23	Start: When patient enters office/facility for surgery/procedure						
24	Pre-service services						
25	Review charts	L050C	RT	1		1	
26	Greet patient and provide gowning	L050C	RT	3		3	
27	Obtain vital signs	L042A	RN/LPN	3		3	
28	Provide pre-service education/obtain consent						
29	Prepare room, equipment, supplies	L050C	RT	5		7	
30	Setup scope (non facility setting only)						
31	Prepare and position patient/ monitor patient/ set up IV	L050C	RT	2		4	
32	Sedate/apply anesthesia						
33	Intra-service						
34	Performing procedure	L050C	RT	12		25	
35	Performing procedure	L050C	RT	12		25	
36	assess cum						
37	-Field 1: rotate gantry, adjust field size, rotate collimators, align lasers with tattoos, verify and double check field position, verify ODI and SSD, pull wedge plug, place wedge, double check wedge orientation, final position check, leave room, close vault door, double check parameters with RVS, verify interlocks, program dose and confirm, beam on, monitor patient						
38	-Field 2: open vault, enter room, recheck patient position and isocenter, pull wedge, rotate gantry to reciprocal field align with tattoos, verify ODI and SSD, double check field position and field geometry, place wedge and double check wedge orientation, final position check, leave room, close vault						
39	-Field 3: open vault, enter room, recheck patient position and isocenter, pull wedge, rotate gantry, place wedge plug, set up AP field on tattoos, adjust field size, rotate collimator, verify ODI and SSD, place block, check field position and double check geometry, leave room and close vault						
40	chart data						
41	Post-Service						
42	Monitor pt. following service/check tubes, monitors, drains						
43	Clean room/equipment by physician staff	L050C	RT	3		3	
44	Clean Scope						
45	Clean and decontaminate Control Package						
46	Complete diagnostic forms, lab & X-ray requisitions						
47	Review/read X-ray, lab, and pathology reports						

	A	B	C	D	E	F	G
2				CPT Code 77422		CPT Code 77423	
3	Meeting Date: February 2005 CIC Recommendation			High energy neutron radiation treatment delivery to a single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking.		High energy neutron radiation treatment delivery to one or more isocenter(s) with coplanar or non-coplanar geometry with simple or complex blocking and/or wedge, and/or compensator(s).	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
48	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
49	Discharge day management 99238 –12 minutes						
50	Other Clinical Activity (please specify)						
51	End: Patient leaves office						
52							
53	Start: Patient leaves office/facility						
54	Conduct phone calls/call in prescriptions						
55	Office visits:						
56	List Number and Level of Office Visits						
57	99211 16 minutes		16				
58	99212 27 minutes		27				
59	99213 36 minutes		36				
60	99214 53 minutes		53				
61	99215 63 minutes		63				
62	Other						
63	Total Office Visit Time						
64	Other Activity (please specify)						
65	End: with last office visit before end of global period						
66							
67	Table Paper	11111	7 feet	2 feet		2 feet	
68	Gloves, non-sterile	11302	pair	2 pair		2 pair	
69	Patient Gown, Disposable	11107	item	1 item		1 item	
70	Gauze, sterile 4 x 4	31505	2 items	1.33 items		1.33 items	
71	Tongue Depressor	11511	1 item	0.33 item		0.33 item	
72	Usage fee for use of cyclotron/accelerator *documentation to be provided to CMS			\$ 124.10		\$ 186.15	
73				34 minutes		51 minutes	
74							
75	TV monitor with sound			x		x	
76	Laser targeting system			x		x	
77	RVS system			x		x	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Stereoscopic X-Ray Guidance**

The CPT Editorial Panel created a new code to more accurately report stereoscopic x-ray guidance. Stereoscopic x-ray guidance is a relatively new technology that allows physicians to calculate beam attenuation using precise source-to patient distance data and confirm and position patients for treatment so a more homogenous dose of radiation is delivered to the target volume.

The RUC discussed the physician work valuation of code 77421 *Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy*.

Representatives from the specialty society began by providing a clear description of this new procedure and the physician work involved. Much of the physician work involves reviewing stereoscopic x-ray images with other images from a treatment planning system or stored CT treatment planning scan data. Other work may involve supervision of patient preparation and providing instructions to the therapists concerning treatment.

The RUC reviewed the survey results carefully and heard statements concerning site visits by CMS. The committee believed that the survey results provided more validity at the 25<sup>th</sup> percentile as a starting point for obtaining a physician work relative value. The committee believed that the 25<sup>th</sup> percentile work relative value of 0.60 should be reduced by the work and time of code 72190 *Radiologic examination, pelvis; complete, minimum of three views* (Work RVU = 0.21) as the time and intensity of 72190 serves as a reasonable proxy for the port films currently performed and work bundled into the weekly radiation therapy service (77427 *Radiation treatment management, five treatments* (Work RVU=3.31)). The physician time for the new code is also recommended by the RUC to be decreased by 6 minutes from the 25<sup>th</sup> percentile of 15 minutes resulting in 9 minutes.

The RUC agreed there is a variable effect on physician work between the radiotherapy code 77427 and stereoscopic X-ray guidance code that requires resolution. This variability is based on the fact that radiation management therapy consists of 5 treatments, whereas the new code can be reported a number of times, typically 3 times. The development of other modalities may have a different relationship, thus being able to account for physician work changes in the radiation management code. The RUC questions whether

this new technology will eventually replace port films and whether CPT/CMS should have considered this as an increase in work within the radiation therapy codes rather than coded separately. This issue requires further evaluation by CPT, CMS and the specialties. **The RUC recommends an analysis of this issue by CMS, CPT, and the specialties.**

**The RUC recommends the following physician work relative value and physician time for code 77421:**

25 <sup>th</sup> Percentile Time	Recommended Time intra and total time	25 <sup>th</sup> percentile RVU	Recommended RVU
15 minutes	<b>9 minutes</b>	0.60	<b>0.39</b>

This issue was referred to CPT Editorial Panel Executive Committee to convene a workgroup to review the best manner to address the potential overlap or unbundling of services with the establishment and increased use of this procedure.

**Practice Expense:**

The RUC recommends that the three minutes associated with the clean room/equipment be removed because there is not any additional time needed for this service as it is billed with other procedures on the same day. The adjustment in physician time has no impact on the clinical staff time as it is not related.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•77421	TT1	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy  (Do not report 77421 with 77432 and 0083T)	XXX	0.39

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

**Percutaneous Radiofrequency Ablation of Renal Tumors**

In February 2005, the CPT Editorial Panel added one code to adequately describe percutaneous cryotherapy ablation of renal tumors which is an expansion of existing technology to a new anatomic site and tumor type that was not currently described in CPT.

The RUC first reviewed the specialty society's survey results for code 50592 *Ablation one or more renal tumor(s), percutaneous, unilateral; radiofrequency*. The RUC and the presenters believed that the survey results demonstrated that the new service required physician work than liver radiofrequency ablation, code 47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency* (Work RVU = 15.17). This belief was inaccurate as liver tumor RFA requires a significant more time and physician work than 50592. The RUC agreed that a better key reference code is code 20982 *Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance* (Work RVU = 7.27), although slightly more intense. Since the RUC believed key reference code should have been different, the RUC and the specialty thought it would be appropriate to change two components of the surveyed physician time. **The RUC recommends the total pre-service time to equal 30 minutes from 75 minutes, and eliminate the physician work of a level one hospital visit.**

The RUC, based on these physician time changes, a comparison the work and time of 20982, and a building block approach, determined the relative value for 50592.

**Building Block Approach**

20 minutes of pre-service evaluation and positioning at an intensity of 0.0224 = 0.45

10 minutes of pre-service scrub and dress at an intensity of 0.0081 = 0.08

60 minutes of intra-service work at an intensity of 0.075 = 4.48

30 minutes of immediate post service work with an intensity of 0.0224 = 0.67

½ of a discharge day management service with a RVU = 0.64

1 level two post-operative office follow-up visit with an RVU = 0.43

**RUC recommends a relative work value of 6.75, for code 50592. In addition, conscious sedation was determined to be inherent in this code.**

**Practice Expense**

The RUC reviewed the practice expense inputs for code 50592 in relation with bone ablation code 20982 and made minor changes in clinical labor time and medical equipment.

<b>CPT Code (•New)</b>	<b>Tracking Number</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
•50592	OO1	<p data-bbox="587 289 1325 354">Ablation one or more renal tumor(s), percutaneous, unilateral; radiofrequency</p> <p data-bbox="587 396 1325 461">(For bilateral procedure, use modifier 50) (For percutaneous cryotherapy ablation of renal tumors use 0135T).</p>	010	6.75

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 77421 Tracking Number: TT1 Global Period: XXX **Recommended Work Relative Value**  
Specialty Society RVU: **0.70**

**RUC RVU: 0.39**

CPT Descriptor: Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 60 year-old-male presented with prostate cancer. The patient opted for external beam radiotherapy and the plan is to deliver 78 Gy at 2 Gy per fraction to the prostate and seminal vesicles using highly conformal radiotherapy. Service includes acquisition and review of positioning X-rays and physician-directed repositioning as necessary.

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:

Description of Intra-Service Work:

Intra Procedure Work:

\* Radiation oncologist oversees patient preparation, including placement of infrared markers where used. The infrared markers are placed either on the patient to monitor patient position or on the treatment couch to localize the position of the couch.

\* Two sets of x-rays are acquired to visualize internal anatomy or implanted marker positions immediately prior to treatment. This is done using kV or MV x-ray units which may be a combination of two kV x-ray units and two amorphous silicon Flat Panel detectors or an x-ray unit attached to the gantry or MV x-rays with Electronic Portal Imaging Device (EPID) which takes two orthogonal images. These two high resolution x-rays are acquired prior to treatment delivery, in order to visualize the internal anatomy or implanted markers.

\* The stereoscopic x-ray images are compared with the imported DRR's from the treatment planning system or generated DRR's from the stored CT treatment planning scan data which are in the same plane as the Xrays taken. The DRRs serve as a reference for identifying rotational / movement discrepancies, positioning, and guidance for the delivery of radiation and enables real-time analysis of the targeted area.

\* Alignment, registration and fusion of the two images are done manually or automatically using previously implanted markers, direct visualization of the target volume or surrounding bony anatomy. These procedures are done under the supervision of the radiation oncologist.

\* The rotational errors of the patient set-up and the table movement necessary to optimally align the patient's target volume at the isocenter in longitudinal, lateral and vertical directions are calculated.

\* The deviations, if present, are determined and corrected by adjusting the patient's treatment position to the treatment target volume isocenter. This is performed by applying the required translational shifts to the treatment couch performed by the therapist and done under physician supervision.

\* The radiation oncologist reviews the images daily and compares with previous shifts. Feed back by the physician is given to the therapists about the adequacy of registrations and, if necessary, about the steps necessary to take to improve future registrations as well as for required treatment modifications.

## Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Louis Potters, MD ASTRO RUC Advisor					
	Najeeb Mohideen, MD ASTRO RUC Advisor Alternate					
<b>Specialty(s):</b>	The American Society For Therapeutic Radiology and Oncology					
<b>CPT Code:</b>	77421					
<b>Sample Size:</b>	179	<b>Resp n:</b>	41	<b>Response:</b> 22.90 %		
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>		0.40	0.60	0.70	0.80	1.16
<b>Pre-Service Evaluation Time:</b>				0.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		4.00	9.00	9.00	25.00	55.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>0.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
77280	XXX	0.70

CPT Descriptor Therapeutic radiology simulation-aided field setting; simple

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
76950	XXX	0.58

CPT Descriptor Ultrasonic guidance for placement of radiation therapy

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time 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: 46.3 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 77421</u>	<u>Key Reference CPT Code: 77280</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	9.00	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	9.00	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	2.98	2.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	3.00
Urgency of medical decision making	3.80	3.16

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.68	3.22
Physical effort required	2.58	2.50

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.93	3.42
Outcome depends on the skill and judgment of physician	3.83	3.26
Estimated risk of malpractice suit with poor outcome	3.32	2.95

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.36	1.61
Intra-Service intensity/complexity	3.67	3.31
Post-Service intensity/complexity	2.07	1.44

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

ASTRO's RVS Committee reviewed the survey data submitted to the specialty society for the new CPT code. Upon review, the members of the ASTRO RVS Committee concluded that the reference service code selected by the majority of the survey sample was appropriate, and the submitted data supported a specialty society recommendation for the median RVU.



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 Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor:

Sample Size: 179      Response Rate: (%): 41 (23%)      Global Period: XXX

Geographic Practice Setting %: Rural 2%      Suburban 29%      Urban 68%

Type of Practice %:      2%      Solo Practice  
                                 27%      Single Specialty Group  
                                 24%      Multispecialty Group  
                                 46%      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 Society for Therapeutic Radiology and Oncology (ASTRO) prepared these practice expense recommendations using the ASTRO RVS committee, and an ad hoc committee of physicians who perform stereoscopic x-ray image guided radiation therapy. The group used the submitted practice expense data as the basis to start the consensus process. These recommendations reflect a consensus opinion of the ASTRO RVS committee and the physician experts in stereoscopic x-ray IGRT.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The procedure is explained to the patient and an informed consent is signed. The tracking system (camera, video, isocenter, and flat panel) are calibrated daily.

Intra-Service Clinical Labor Activities:

The patient is set up on the treatment table in the treatment position. Two sets of x-ray images are acquired to visualize the internal anatomy or previously placed, surface-mounted or implanted fiducial markers. Two KV x-ray units and two amorphous silicon flat panel detectors are used to acquire the images. The images are then compared with the imported digital reconstructive radiograph (DRR's) from the treatment planning system to determine organ motion or rotational errors in the patient's treatment position. The patient is re-aligned accordingly and a new set of x-ray images are taken to verify that all points of concern and interest are now in the correct position for the treatment. Frequently, another set of x-ray images are taken mid-treatment to ensure further accuracy.

Post-Service Clinical Labor Activities:

The images are printed out in hard copy for the treatment record and reviewed by the physician. Summary reports are also printed out for review. All steps in the process are appropriately documented.

	A	B	C	F	G
1					
2					
3	Meeting Date: April 2005			CPT Code: 77421 Code Descriptor: Stereoscopic x-ray guidance for localization of target volume for the delivery of	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
5	GLOBAL PERIOD			XXX	XXX
6	TOTAL CLINICAL LABOR TIME			34.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			34.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0
10	<b>Start: Following visit when decision for surgery or procedure made</b>				
11					
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) -simulator QA				
18	<b>End:When patient enters office/facility for surgery/procedure</b>				
19	<b>Start: When patient enters office/facility for surgery/procedure</b>				
20					
21	Pre-service services				
22	Review charts	L050C	Radiation Therapist		
23	Greet patient and provide gowning	L050C	Radiation Therapist		
24	Obtain vital signs	L050C	Radiation Therapist		
25	Provide pre-service education/obtain consent	L050C	Radiation Therapist		
26	Prepare room, equipment, supplies	L050C	Radiation Therapist	2	
27	Setup scope (non facility setting only)				
28	Prepare and position patient/ monitor patient/ set up IV	L050C	Radiation Therapist	2	
29	Sedate/apply anesthesia				
30	Intra-service				
31	Perform Procedure	L050C	Radiation Therapist	30	
32					
33	Post-Service				
34	Monitor pt. following service/check tubes, monitors, drains				
35	Clean room/equipment by physician staff	L050C	Radiation Therapist		
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	<b>End: Patient leaves office</b>				
44	<b>Start: Patient leaves office/facility</b>				
45					
46	Conduct phone calls/call in prescriptions				
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	Other				
55					

	A	B	C	F	G
2				<b>CPT Code: 77421</b>	
3	Meeting Date: April 2005			<b>Code Descriptor:</b> Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy	
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>
56	<i>Total Office Visit Time</i>			0	0
57	<i>Other Activity (please specify)</i>				
58	<b>End: with last office visit before end of global period</b>				

	A	B	C	F	G
2				CPT Code: 77421	
3	Meeting Date: April 2005			Code Descriptor: Stereoscopic x-ray guidance for localization of target volume for the delivery of	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
59					
60	swab-pad, alcohol	SJ053	item	2	
61	guaze, sterile (4in x 4in) (10 pack uou)	SG056	10 pk uou	2	
62					
63	gown, patient	SB026	item		
64	Minimum supply package	SA058	pkg		
65	paper, exam table (ft)	SB036	feet		
66	Foley Catheter	SD024	item		
67	underpad - chux (2ft x 3ft)	SB044	item		
68	drape, sterile, for mayo stand	SB012	item		
69	drape-towel, sterile (18in x 26in)	SB019	item		
70	syringe 10-12ml	SC051	item		
71	lubncating jelly (K-Y) (5gm uou)	SJ032	5gm uou		
72	tray, catheter insertion (w-o catheter)	SA063	item		
73	cidex (1 Liter)	52302	1 Liter		
74					
75					
76					
77	Portal Imaging System for fast acquisition capture for real time modification		item	\$ 377,319.00	
78	PC Work station for Portal Imaging System		item		
79	Interface software		item		
80					
81	Exam Table	E11001	item		
82	Exam lamp	E30006	item		
83	Ultrasound machine with probe		item		

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Intraoperative Consult and Touch Prep**

The CPT Editorial Panel created two new codes to accurately report an intra-operative cytologic evaluation as a single service. Currently, 88161 *Cytopathology, smears, and other source; preparation, screening and interpretation* (Work RVU=0.50) is how this service is being captured. However, 88161 does not take into consideration the increased intensity of effort evaluating cytologies intra-operatively.

**88333**

The RUC reviewed the specialty society's survey data and noted that the surveyed code, 88333, when compared to the reference code, 88331 *Cytopathology, evaluation of fine needle aspirate; first tissue block, with frozen section(s), single specimen* (Work RVU=1.19) has slightly higher intensity/complexity measures and an additional two minutes of intra-service time, 25 minutes and 23 minutes, respectively. Therefore, the specialty society recommended that the median value of their survey, 1.20 wRVUs, be the work RVU recommendation for 88333 as this value properly ranks the surveyed code in comparison to the reference code. **The RUC agreed with the specialty society and recommends 1.20 work RVUs for 88333.**

**88334**

The RUC reviewed the specialty society's survey data and noted that the surveyed code 88334, when compared to the reference code 88332 *Cytopathology, evaluation of fine needle aspirate; each additional tissue block with frozen section(s)* (Work RVU=0.59) has higher intensity/complexity measures and an additional five minutes of intra-service time, 20 minutes and 15 minutes, respectively. Therefore, the specialty society recommended that the median value of their survey, 0.80 wRVUs be the work RVU recommendation for 88334 as this value properly ranks the surveyed code in comparison to the reference code. **The RUC agreed with the specialty society and recommends 0.80 RVUs for 88334.**

**Practice Expense**

The RUC reviewed the practice expense inputs recommended for 88333 and 88334. When reviewing the recommendations for 88334, the RUC requested that the 5 minutes attributed to cleaning the room following the procedure should be removed as 88333 and 88334 are performed in conjunction and this activity is already accounted for in 88333.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
88172		<i>Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)</i>	XXX	0.60  (No Change)
88329		<i>Pathology consultation during surgery;</i>	XXX	0.67  (No Change)
88331		<i>first tissue block, with frozen section(s), single specimen</i>	XXX	1.19  (No Change)
88332		<i>each additional tissue block with frozen section(s)</i>	XXX	0.59  (No Change)
● 88333	UU1	cytologic examination (eg, touch prep, squash prep), initial site	XXX	1.20
● 88334	UU2	cytologic examination (eg, touch prep, squash prep), each additional site  (For intra-operative consultation on a specimen requiring both frozen section and cytologic evaluation, use 88331 and 88334)  (For percutaneous needle biopsy requiring intra-procedural cytologic examination, use 88333)  (Do not report 88333 and 88334 for non-intraoperative cytologic examination, see 88160-88162)  (Do not report 88333 and 88334 for intra-procedural cytologic evaluation of fine needle aspirate, see 88172)	XXX	0.80

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:88333 Tracking Number: Global Period: XXX

Recommended Work Relative Value

Specialty Society RVU: 1.20

RUC RVU: 1.20

CPT Descriptor: Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45 year-old woman with a mammary carcinoma previously diagnosed by needle biopsy presents for sentinel lymph node biopsy with possible axillary dissection. Following radioisotopic and methylene blue injection around the tumor, the surgeon performs an axillary lymph node biopsy guided by the tracers and methylene blue staining. The surgeon then requests an intra-operative pathology consultation. The pathologist performs an intra-operative touch prep examination on the sentinel lymph node. As the pathologist does not identify malignant cells, the surgeon elects not to proceed with the axillary lymph node dissection.

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:

Description of Intra-Service Work: The pathologist comes to the OR and reviews the pertinent clinical information with the surgeon. The pathologist then takes the biopsy to the intra-operative pathology suite where the patient's original diagnosis is confirmed by a query into the anatomic pathology computer system. The specimen is dissected and grossly examined, and multiple cross sections are made and evaluated for macroscopic tumor involvement. A glass slide is then labeled with the patients name and other slide specific identifier. The tissue is then prepared and arranged for the cell transfer. A slide is carefully touched to the tissue and immediately fixed. It is stained by hematoxylin & eosin and coverslipped by the pathologist. The pathologist then screens and evaluates the entire slide for evidence of malignant cells. Following this the pathologist presents a verbal report to the surgeon intra-operatively and then records a written confirmation of this report in the patients medical record.

## Description of Post-Service Work:

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	Susan Spires, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	88333				
Sample Size:	47	Resp n:	37	Response: 78.72 %	
Sample Type:	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
Survey RVW:	1.05	1.19	1.20	1.30	1.80
Pre-Service Evaluation Time:			0.0		
Pre-Service Positioning Time:			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		15.00	20.00	<b>25.00</b>	30.00	40.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b>0.00</b>					
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b>0.0</b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b>0.0</b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88331	XXX	1.19

CPT Descriptor Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
78494	XXX	1.19

CPT Descriptor 1 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
74160	XXX	1.27

CPT Descriptor 2 Computed tomography, abdomen; with contrast material(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
85097	XXX	0.94

CPT Descriptor Bone marrow, smear interpretation

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 36      % of respondents: 97.2 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 88333</u>	<u>Key Reference CPT Code: 88331</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	25.00	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	25.00	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	4.11	4.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.52
Urgency of medical decision making	4.97	4.86

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.22	4.16
Physical effort required	2.94	3.11

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.69	4.63
Outcome depends on the skill and judgment of physician	4.94	4.83
Estimated risk of malpractice suit with poor outcome	4.61	4.55

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.69	4.52
Post-Service intensity/complexity	0.00	0.00

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives from the general pathology community, and members who perform this service. The workgroup chose to recommend the median survey RVW of 1.20. This recommendation was further reviewed by 10 additional members of CAP's Economic Affairs Committee. This recommended RVW of 1.20 represents an increase of 0.8% above the reference code RVW of 1.19. The survey results support this recommendation as the surveyed time represents an increase of 8.7% above the reference code, and the time intensity/complexity

measure is 3.8% greater. In addition, the majority of the remaining intensity/complexity measures were higher in comparison to 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: 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) 88329 plus 88161

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 48800  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Frequency 0 Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 40,800 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical



<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		12.00	18.00	<b>20.00</b>	25.00	25.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b>0.00</b>					
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b>0.0</b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b>0.0</b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88332	XXX	0.59

CPT Descriptor Pathology consultation during surgery; each additional tissue block with frozen section(s)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
92012	XXX	0.67

CPT Descriptor 1 Ophthalmological services; medical evaluation and examination, with initiation or continuation of diagnostic and treatment programs; intermediate, established patient

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
76700	XXX	0.81

CPT Descriptor 2 Ultrasound, abdominal, B-scan and/or real time with image documentation; complete

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88331	XXX	1.19

CPT Descriptor Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24      % of respondents: 64.8 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 88334</u>	<u>Key Reference CPT Code: 88332</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	20.00	15.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	20.00	15.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.87	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.16	3.16
Urgency of medical decision making	4.96	4.83

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.08	3.95
Physical effort required	2.96	3.04

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.58	4.41
Outcome depends on the skill and judgment of physician	4.88	4.62
Estimated risk of malpractice suit with poor outcome	4.54	4.33

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.61	4.35
Post-Service intensity/complexity	0.00	0.00

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives from the general pathology community, and members who perform this service. The workgroup chose to recommend the median survey RVW of 0.80. This recommendation was further reviewed and supported by 10 additional members of CAP's Economic Affairs Committee. The survey results support this recommendation as both the time and RVW of the surveyed code represents a one-third increase above the



Specialty Pathology                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

Sample Size: No survey      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

**CPT Long Descriptor:**

88333      Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site

88334      Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

Data were developed by an 8-member CAP practice expense review committee with representation of the American Society of Cytopathology. The committee recommended that the new codes be cross walked to the practice expense inputs approved by the RUC's Practice Expense Review Committee in August of 2001 for CPT code 88161 (Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen) with the appropriate reductions in clinical staff time, equipment and revisions to the supply list for each of the new codes. The data were subjected to additional review by another committee of 10 pathologists.

**See Excel spreadsheet for labor, supplies and equipment detail.**

	A	B	C	D	E	F	G
1							
2							
3	Meeting Date: April 2005			CPT Code: 88333 Code Descriptor: Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site		CPT Code: 88334 Code Descriptor: Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			XXX		XXX	
6	TOTAL CLINICAL LABOR TIME	LO33A & LO37B	Labtech & Histotech	30		13	
7	SUBTOTAL CLINICAL LABOR PER STAFF TYPE	LO33A	Labtech	10		0	
8	SUBTOTAL CLINICAL LABOR PER STAFF TYPE	LO37B	Histotech	20		13	
9	TOTAL PRE-SERV CLINICAL LABOR TIME	LO33A	Labtech	10		0	
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	LO37B	Histotech	15		13	
11	TOTAL POST-SERV CLINICAL LABOR TIME	LO37B	Histotech	5		0	
12	PRE-SERVICE PERIOD						
13	Start: When containers/requisitions prepared for physician						
14	Prepare specimen containers/preload fixative/label containers/distribute requisition form(s) to physician						
15	Accession specimen/prepare for examination						
16	Perform screening function (where applicable)						
17	Prepare room. Filter and replenish stains and supplies.	LO33A	Labtech	10		0	
18	End: When specimen is ready for examination by pathologist						
19	SERVICE PERIOD						
20	Start: When specimen is ready for examination by pathologist						
21	Assist pathologist with gross specimen examination (including performance of intraoperative frozen sections)	L037B	Histotech	7		5	
22	Prepare specimen for automated processing						
23	Process specimen for slide preparation (includes staining, coverslipping, quality control function, maintaining specimen tracking, logs and labeling)	L037B	Histotech	6		6	
24	Assemble and deliver slides with paperwork to pathologists	L037B	Histotech	2		2	
25	Clean room/equipment while performing service						
26	Coordinate care						
27	Other Activity (please specify)						
28	End: When specimen examination by pathologist is complete						
29	POST-SERVICE PERIOD						
30	Start: When specimen examination by pathologist is complete						
31	Prepare, pack and transport specimens and records for in-house storage and external storage (where applicable)						
32	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste						
33	Clean room/equipment following procedure (including any equipment maintenance that must be done after the procedure)	L037B	Histotech	5		0	
34	Manage any relevant utilization review/quality assurance activities and regulatory compliance documentation						
35	Submit/receive material for consultation (where applicable)						

	A	B	C	D	E	F	G
2				<b>CPT Code: 88333</b>		<b>CPT Code: 88334</b>	
3	Meeting Date: April 2005			<b>Code Descriptor:</b> Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep); initial site		<b>Code Descriptor:</b> Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep); each additional site	
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
36	Other Activity (please specify)						
37	End: When specimen, chemical waste and record handling is complete						
38							
39	gloves, non-sterile, nitrile	SB023	pair	2		2	
40	lab coat, staff	SB030	item	1		1	
41	mask, surgical	SB033	item	2		2	
42	scalpel with blade, surgical (#10-20)	SF033	item	1		1	
43	eye shield, non-fox	SG049	item	2		2	
44	bleach	SL020	ml	50		50	
45	cover slip, glass	SL030	item	1		1	
46	label for microscope slides	SL085	item	1		1	
47	mounting media (Histomount)	SL095	ml	0.2		0.2	
48	slide, microscope	SL122	item	1		1	
49	wipes, lens cleaning (per wipe) (Kimwipe)	SM027	item	1		1	
50	stain kit, H&E *		kit	0.1		0.1	
51							
52	grossing station w-heavy duty disposal	EL015		1		1	
53	microscope, compound	EL024		1		1	
54							
55	* stain kit, H&E. VWR Catalog # 84000-158, price: \$98.02. www.vwr.com						
56							
57							

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Multiple Molecular Marker Array-Based Evaluation**

With the role of inherited mutations in common diseases, such as multiple myeloma breast cancer and colon cancer, the advent of micro array technology has revolutionized the study of genetic abnormalities associated with disease pathogenesis and clinical implications. This type of testing may also be used to interpret, diagnose and monitor disease states, and in screening and preventative medicine to detect carriers or those predisposed to specific diseases. The CPT Editorial Panel created three new CPT codes to quantify the physician effort in the pre-analytic and post-analytic phases of testing, microdissection of lesion for testing, interpretation of test results, integration of multiple test results, and integration with clinicopathologic information (eg clinical history and results from laboratories/histology).

**88384**

The three tiered codes were developed to describe the physician work and technical costs for array based assays currently available when the code change request was submitted. Subsequent to the development of these codes, the vendor using the technology that the specialty society felt best represented 88384 *Array-based evaluation of multiple molecular probes; 11 through 50 probes* informed the specialty society that their test does not meet the requirements to be considered as an array by the Food and Drug Administration. Although it appears that array-based assays for 11 to 50 probes will soon be forthcoming, the specialty society recommends that it is not appropriate for the RUC to make recommendations regarding 88384 at this time and request this procedure to be carrier priced. The RUC reviewed and agrees with the specialty society's recommendation. **The RUC recommends that 88384 be carrier priced for 2006.**

**88385**

The RUC reviewed the survey results for 88385 *Array-based evaluation of multiple molecular probes; 51 through 250 probes*. The RUC noted that 88385 when compared to its reference service 88368 *Morphametric analysis, in situ hybridization (quantitative or semi-quantitative), each probe; manual* (Work RVU=1.40), takes more total physician time (59 and 45 minutes, respectively with similar intensity/complexity measures. Because of the additional time associated with this code, the specialty society recommends 1.50 for 88385. The RUC reviewed this recommendation and felt that this value properly places this service in comparison to the reference code as well as the other pathology services. **The RUC recommends 1.50 work RVUs for 88385.**

**88386**

The RUC reviewed the survey results for 88386 *Array-based evaluation of multiple molecular probes; 251 through 500 probes*. The RUC was concerned about the low number of survey responses, however, the specialty society explained that the frequency for these procedures is very low, 300 times per year. However, due to the low number of responses the specialty societies felt that the survey results were not reflective of the work associated with this procedure. Therefore, the specialty society's expert panel compared this code to 88385 and felt that 88386 required 25% more work than 88385 which represents a work RVU of 1.88 for this procedure. The RUC reviewed this recommendation and felt that this value properly places this service in comparison to 88385 as well as other pathology services. **The RUC recommends 1.88 work RVUs for 88386.**

**RUC Re-Review**

The specialty society requests that these codes be reviewed for changes in work or practice expense once this new technology become widely dispersed. **The RUC requests that these codes be re-reviewed in time certain of 2 years.**

**Practice Expense**

The RUC reviewed the practice expense inputs recommended by the specialty society. The RUC agreed with the recommended values.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•88384	VV1	Array-based evaluation of multiple molecular probes; 11 through 50 probes	XXX	Carrier Priced
•88385	VV2	51 through 250 probes	XXX	1.50
•88386	VV3	251 through 500 probes  (For preparation of array-based evaluation, see 83890-83892, 83898-83901)  (For preparation and analyses of less than 11 probes use 83890-83912)	XXX	1.88



<b>Survey RVW:</b>	1.50	1.50	1.50	2.25	3.00
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	20.00	25.00	59.00	37.50	45.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>0.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u> 88368	<u>Global</u> XXX	<u>Work RVU</u> 1.40
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CPT Descriptor Morphametric analysis, in situ hybridization, (quantitative or semi-quantitative), each probe; manual

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u> 74160	<u>Global</u> XXX	<u>Work RVU</u> 1.27
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CPT Descriptor 1 Computed tomography, abdomen; with contrast material(s)

<u>MPC CPT Code 2</u> 73721	<u>Global</u> XXX	<u>Work RVU</u> 1.35
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CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

<u>Other Reference CPT Code</u> 88325	<u>Global</u> XXX	<u>Work RVU</u> 2.22
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CPT Descriptor Consultation, comprehensive, with review of records and specimens, with report on referred material

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.

Number of respondents who choose Key Reference Code: 2      % of respondents: 66.6 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 88385</u>	<u>Key Reference CPT Code: 88368</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	59.00	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	59.00	45.00
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	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	2.50	3.50

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.50	4.50
Physical effort required	3.50	3.50
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	3.50	3.50
Outcome depends on the skill and judgment of physician	5.00	5.00
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	4.00	3.50
Intra-Service intensity/complexity	4.50	4.50
Post-Service intensity/complexity	4.00	3.50

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives from the general pathology community, and members with molecular pathology experience. The relative value workgroup felt due to the low response rate and results an Expert Panel would be held to review results and make recommendations on the array-based evaluation codes. The Expert Panel included members of CAP's relative value workgroup and the Molecular Pathology Committee, as well as individuals who perform the surveyed service. The panel did not support the survey's median RVU of 1.50 and agreed



Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 50  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? No

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### Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? 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:88386 Tracking Number:      Global Period: XXX      **Recommended Work Relative Value**  
Specialty Society RVU: **1.88**

**RUC RVU: 1.88**

CPT Descriptor: Array-based evaluation of multiple molecular probes; 251 through 500 probes

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 48-year-old male patient is evaluated by an oncologist for recently diagnosed plasma cell myeloma. To aid in clarifying the patient's prognosis and treatment options and to serve as a marker for residual disease, the clinician orders comparative genomic hybridization (CGH) array on the marrow. Anticoagulated marrow aspirate is submitted to the laboratory for gene dosage testing at 300 different chromosomal loci using commercial reagents that have been previously analytically validated in the clinical laboratory.

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:**

Description of Intra-Service Work: Discussion of the potential service with the technologist or referring pathologist/clinician prior to the receipt of the specimen; ensures that the patient is an appropriate candidate for the diagnostic evaluation; and clarifies the necessity of referral of clinical history, tumor blocks, routine slides from biopsy and/or resection(s), and additional data (e.g. immunostains, immunophenotyping, cytogenetics, as appropriate). A pathologist reviews a Wright's stained aspirate smear to determine whether the proportion of plasma cells is sufficient to warrant gene dosage testing. The marrow differential count reveals 30% plasma cells, which the pathologist determines is sufficient. Following the extraction, isolation and purification of the sample by the technologist along with controls, the pathologist assesses the gene dosage assay performance, including the examination of the positive and negative control samples, and then analytically interprets the findings in the patient and assesses the significance of the results for this patient by correlating the analysis with clinical and morphologic data. The analytic results in this patient included monosomy for chromosomes 13 and 22, monosomy for 17p13 (the TP53 locus), and partial monosomy of chromosomes 14. The pathologists analyses the computer findings. The pathologists prepares the report, describing the patient's allelotype and the clinical implications of this result, including the clinical interpretation that the patient is at increased risk of progression and relapse following a standardized chemotherapy regimen. The pathologist verbally communicates the results of the profile with the referring pathologist and/or clinician providing him/her with overall results and additional information regarding statistical data and limitations of the predictive value of the recurrence score, and answers any questions specific to that clinical circumstance.

**Description of Post-Service Work:**

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	Susan Spires, MD, Jeffrey Kant, MD, Raymond Tubbs, DO		
<b>Specialty(s):</b>	College of American Pathologists		
<b>CPT Code:</b>	88386		
<b>Sample Size:</b>	16	<b>Resp n:</b>	3 <b>Response:</b> %

Sample Type: Panel					
	Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Survey RVW:	1.50	2.00	2.50	3.00	3.50
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	40.00	95.00	60.00	60.00
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>
88325	XXX	2.22

CPT Descriptor Consultation, comprehensive, with review of records and specimens, with report on referred material

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
78465	XXX	1.46

CPT Descriptor 1 Myocardial perfusion imaging; tomographic (SPECT), multiple studies, at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
92004	XXX	1.67

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88368	XXX	1.40

CPT Descriptor Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative), each probe; manual

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 2      % of respondents: 66.6 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 88386</u>	<u>Key Reference CPT Code: 88325</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	95.00	69.00
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	95.00	69.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	5.00	4.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.50
Urgency of medical decision making	4.00	4.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.50	4.50
Physical effort required	3.50	3.00
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.00	4.00
Outcome depends on the skill and judgment of physician	5.00	4.50
Estimated risk of malpractice suit with poor outcome	3.50	3.50

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	4.00
Intra-Service intensity/complexity	5.00	5.00
Post-Service intensity/complexity	4.00	3.50

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives from the general pathology community, and members with molecular pathology experience. The relative value workgroup felt that due to the low response rate and results an Expert Panel would be necessary to review results and make recommendations on the array-based evaluation codes. The Expert Panel included members of CAP's relative value workgroup and the Molecular Pathology Committee, as well as individuals who perform the surveyed service. The panel did not support the survey's median RVU of 2.50.





**AMA/Specialty Society Update Process**  
**PEAC Summary of Recommendation**  
**XXX Global Period**  
**Non Facility Direct Inputs**

Sample Size:   No survey        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

**CPT Long Descriptor:**

88385    Array-based evaluation of multiple molecular probes; 51 through 250 probes

88386    Array-based evaluation of multiple molecular probes; 251 through 500 probes

**Please provide a brief description of the process used to develop your recommendation:** Data were developed by an 8-member CAP practice expense review committee with representation of the American Society of Cytopathology. Additional members of the CAP Molecular Pathology Committee also participated in this review for a total of 14 pathologists. The data development also included technologists who are involved in the clinical labor activities associated with these services. The data were subjected to review by another committee of 10 pathologists.

**See Excel spreadsheet for labor, supplies and equipment detail.**

**Cost Information for Supplies Not on CMS' Supply List**

Description	Cost
15 mL conical tube	\$173.10/case of 500 VWR #21008-935
0.2 micron filter flasks (1L) <sup>2</sup>	\$172.75/case of 12 VWR #28196-254
1% Agarose mini gel in 1X TAE buffer	\$110.00/pack of 20 gels VWR #12001-426
1-Kb DNA ladder	\$77.00/unit Invitrogen #10511-012 <sup>1</sup>
1mM Cyanine 5 dCTP (1mM)	\$286.00/vial (25ul) Perkin Elmer/NEN #NEL577 <sup>1</sup>
2% Agarose mini gel in 1X TAE buffer	\$120.00/pack of 6 gels VWR #12001-142
250 µL wide-orifice pipette tips	\$58.00/pack of 960 Rainin# HR-250WS <sup>1</sup>
50-bp DNA Ladder	\$102.00/each (50-bp ladder) Life Technologies #10416-014 <sup>1</sup>
3X Gel-Loading Buffer: 0.25% bromophenol blue, 0.25% xylene cyanol, 30% glycerol in H <sub>2</sub> O.	\$30.00 (5ml) VWR #80030-946
Absolute Ethanol (200 proof Ethyl Alcohol)	\$23.20/each (500mL) VWR #MK701904
Aerosol-Resistant pipette tips	\$85.00/pack of 960 Rainin #RT-10GF <sup>1</sup>

Beveled aerosol barrier tips	\$45.10/pack of 960 VWR #53502-903
Compressed filtered air	\$8.79 Falcon Safety Products, Inc. # DPSXL <sup>1</sup>
Covalent binding cover slips	\$575.00 per 100 Xenopore catalog number VXB 001 00
de-ionized water	\$100.12/pack of 6 (1L) VWR #45001-042
DNase free snap lock 1.5mL microcentrifuge tubes	\$72.14/pack of 1000 (1mL) VWR #20170-293
DNase free sterile pipette tips	\$52.50/case of 960 VWR #47745-118
Formamide, ultra-pure grade	\$0.22/mL MFS 2005 database
GenoSensor Array 300 Kit	\$2121.00/kit Vysis #32-801040
Glass slides (plain blank slides)	\$26.00/slide Gold Seal Products #3010 <sup>1</sup>
Hematology tube (10mL)	\$28.50/pack of 100 VWR #VT6457
Hoechst 33258 fluorescent dye	\$65.00/unit (100mg) Amersham #80-6226-87
MicroSpin S-200 HR Columns	\$157.00/50 columns Amersham #27-5120-01
MLL Fusion Gene Kit	\$1395 InVivoScribe Technologies Cat No. 1-813-0018 (MLFC-01)
Nucleic acid gel stain (10,000X in DMSO) (Ethidium bromide)	\$99.00/vial (500ul) Molecular Probes #S-11494 <sup>1</sup>
Random Priming Kit	\$463.00/kit Vysis #30-801410
Tween 20	\$38.00/250mL bottle VWR# 80058-796
Ultra-High Purity Nitrogen Gas (compressed), Grade 5.0	\$189.27/day BOC Gas
Versagene DNA Blood Kit (0.05-10mL)	\$207.03/50 samples VWR #82021-140

<sup>1</sup> Catalog number referenced in Karyoscan Assay Clinical Brochure

**Cost Information for Equipment Not on CMS' Supply List**

Description	PRICE REFERENCE
Spectrophotometer	\$6,600.00 VWR #BK517940
Fluorometer + 2 Cuvettes	\$3826.00 Amersham #80-6406-8026 and #80-6227-06
4-°C microcentrifuge	\$1,975.00 VWR #58922-850
Room temperature microcentrifuge	\$1,975.00 VWR #58922-850
Eppendorf model 5415C centrifuge	\$832.00 VWR #20901-055
Pipet set: P20, P200, P1000, ACC	\$740.00 Rainin #P-START
Tecan HS 4800 Hybridization Station	\$65,000.00 Tecan
Dell Latitude D600 Notebook	\$1,506.40 Dell Inc.
GenoSensor II Reader System	\$75,000.00 Abbott
Agarose Gel System Power supply	\$1070.00 Model 500 VWR#13272-264
Mini Gel, Multi load system	\$748.00 VWR #27372-238 and #27373-250

As with the other pathology codes, 88361 and 8836X0 should not be placed in the zero work pool.

	A	B	C	D	E	F	G
1							
2				CPT Code: 88385		CPT Code: 88386	
3				Code Descriptor: Array-based evaluation of multiple molecular probes; 51 through 250 probes		Code Descriptor: Array-based evaluation of multiple molecular probes; 251 through 500 probes	
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			XXX		XXX	
6	<b>TOTAL CLINICAL LABOR TIME</b>	<b>LO33A &amp; LO45B</b>	<b>Labtech &amp; EM Tech</b>	<b>170</b>		<b>170</b>	
7	<b>SUBTOTAL CLINICAL LABOR PER STAFF TYPE</b>	<b>LO33A</b>	<b>Labtech</b>	<b>21</b>		<b>21</b>	
8	<b>SUBTOTAL CLINICAL LABOR PER STAFF TYPE</b>	<b>LO45B</b>	<b>EM Tech</b>	<b>149</b>		<b>149</b>	
9	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	<b>LO33A</b>	<b>Labtech &amp; EM Tech</b>	<b>155</b>		<b>155</b>	
10	<b>SUBTOTAL PRE-SERV CLINICAL LABOR PER STAFF TYPE</b>	<b>LO33A</b>	<b>Lab Tech</b>	<b>6</b>		<b>6</b>	
11	<b>SUBTOTAL PRE-SERV CLINICAL LABOR PER STAFF TYPE</b>	<b>LO45B</b>	<b>EM Tech</b>	<b>149</b>		<b>149</b>	
12	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>						
13	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	<b>LO33A</b>	<b>Lab Tech</b>	<b>15</b>		<b>15</b>	
14	<b>PRE-SERVICE</b>						
15	<b>Start: When containers/requisitions prepared for physician</b>						
16	<b>DNA Extraction</b>						
17	Accession specimen, label and prepare specimen for storage until schedule processing date	LO33A	Lab Tech	6.00		6.00	
18	Prepare bone marrow smear, perform Wright stain, evaluate stain for quality	LO45B	EM Tech	10.0		10.0	
19	<b>Unlabeled DNA Quantification and Quality Assessment</b>						
20	Check DNA purity with A260/280 by measuring absorbance	LO45B	EM Tech	12.0		12.0	
21	Check concentration by fluorometry	LO45B	EM Tech	9.0		9.0	
22	Prepare agarose gel and check for degradation unlabeled specimen	LO45B	EM Tech	3.0		3.0	
23	Mix sample with buffers for each probe	LO45B	EM Tech	3.0		3.0	
24	Load and run samples and size marker on gel; visualize in UV light	LO45B	EM Tech	4.00		4.00	
25	<b>Preparation of Random Priming Reactions</b>						
26	Thaw, vortex, spin DNA labeling reagents, and prepare heat bath	LO45B	EM Tech	5.0		5.0	
27	Add denaturing reagents (TE Buffer and random primers) to test and reference samples; vortex, spin and place tubes on ice	LO45B	EM Tech	6.0		6.0	
28	Add remaining labeling reagents (nucleotide mix and probes) to both samples; vortex, spin and incubate	LO45B	EM Tech	5.0		5.0	
29	<b>DNase Digestion and Labeled Probe Purification</b>						
30	Treat both samples with stop buffer, vortex and incubate	LO45B	EM Tech	5.0		5.0	
31	Prepare MicroSpin S-200 HR Columns for probe purification (vortex and pre-spin columns, remove resin from columns, and place columns in new tube)	LO45B	EM Tech	5.0		5.0	
32	Add labeled probe and spin. Add sodium acetate, and ethanol to both samples, vortex and incubate	LO45B	EM Tech	5.0		5.0	
33	Spin samples, aspirate supernatant, resuspend pellets, vortex, incubate and collect sample	LO45B	EM Tech	10.0		10.0	
34	<b>Labeled DNA Verification</b>						

	A	B	C	D	E	F	G
2				<b>CPT Code: 88385</b>		<b>CPT Code: 88386</b>	
3				<b>Code Descriptor: Array-based evaluation of multiple molecular probes; 51 through 250 probes</b>		<b>Code Descriptor: Array-based evaluation of multiple molecular probes; 251 through 500 probes</b>	
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
35	Prepare agarose gel in buffer for labeled DNA verification	LO45B	EM Tech	3.0		3.0	
36	Mix sample with buffers for each probe	LO45B	EM Tech	3.0		3.0	
37	Load and run samples and size marker on gel; visualize in UV light	LO45B	EM Tech	4.0		4.0	
38	<b>Overnight hybridization on Tecan System</b>						
39	Prepare hybridization reagents (4 unique solutions), pour into Tecan solution holder. Pre-warm solution to eliminate precipitate and filter.	LO45B	EM Tech	4.0		4.0	
40	Warm, vortex, and spin hybridization buffer. Thaw and mix test/reference samples	LO45B	EM Tech	5.0		5.0	
41	Prepare hybridization probe mixture by combining reagents and test/reference samples	LO45B	EM Tech	2.0		2.0	
42	Prepare hybridization station and chambers (insert micorarrays)	LO45B	EM Tech	3.0		3.0	
43	Load hybridization program	LO45B	EM Tech	3.0		3.0	
44	Inject hybridization mix into hybridization chambers	LO45B	EM Tech	1.0		1.0	
45	Initiate hybridization program	LO45B	EM Tech	2.0		2.0	
46	Prepare coplin jars for extension unit	LO45B	EM Tech	3.0		3.0	
47	Immerse slides into 1X SSC buffer in deionized water	LO45B	EM Tech	3.0		3.0	
48	Mount coverslip on microarrays with DAPI utilizing coverslipping template	LO45B	EM Tech	3.0		3.0	
49	Store slides (45m - 1hr) in airtight, light-protected environment	LO45B	EM Tech	1.0		1.0	
50	Insert microarray into system reader	LO45B	EM Tech	1.0		1.0	
51	Initiate reader system software	LO45B	EM Tech	1.0		1.0	
52	Enter patient identifiers and demographics	LO45B	EM Tech	3.0		3.0	
53	Data capture using reader system software and generate printed data	LO45B	EM Tech	2.0		2.0	
54	Examine array integrity on reader system monitor, examine quality parameters on reader system monitor, verify and record suitability of data for interpretation	LO45B	EM Tech	12.0		12.0	
55	Aggregate data, store data and quality parameter results, release all to pathologist for interpretation	LO45B	EM Tech	8.0		8.0	
56	<b>End: When specimen is ready for examination by pathologist</b>						
57	<b>SERVICE PERIOD</b>						
58	<b>Start: When specimen is ready for examination by pathologist</b>						
59	<b>POST-SERVICE Period</b>						
60	<b>Start: When specimen examination by pathologist is complete</b>						
61	<b>Rinse</b>						
62	Prepare, pack and transport specimens and records for in-house storage and external storage (where applicable)	L033A	Lab Tech	1.0		1.0	
63	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	1.0		1.0	
64	Clean room	L033A	Lab Tech	2.0		2.0	
65	Perform hybridization station maintenance including system rinse and dry	L033A	Lab Tech	5.0		5.0	

	A	B	C	D	E	F	G
2				<b>CPT Code: 88385</b>		<b>CPT Code: 88386</b>	
3				<b>Code Descriptor: Array-based evaluation of multiple molecular probes; 51 through 250 probes</b>		<b>Code Descriptor: Array-based evaluation of multiple molecular probes; 251 through 500 probes</b>	
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
66	Manage any relevant utilization review/quality assurance activities and regulatory compliance documentation	L033A	Lab Tech	3.0		3.0	
67	Perform scheduled data management back-up	L033A	Lab Tech	3.0		3.0	
68	<b>End: When specimen, chemical waste and record handling is complete</b>						
69	<b>MEDICAL SUPPLIES</b>	<b>CMS Code</b>	<b>Unit</b>				
70	gloves, non-sterile, nitrile	SB023	pair	3		3	
71	mounting media (Histomount)	SL095	ml	0.2		0.2	
72	slide, microscope	SL122	item	1		1	
73	stain, Wright's Pack (per slide)	SL140	ml	0.3 ml		0.3 ml	
74	eye shield, splash protection	SM016	item	1		1	
75	0.2 micron filter flasks (1L) <sup>2</sup>		case	0.5		0.5	
76	1% Agarose mini gel in 1X TAE buffer		item	1		1	
77	15 mL conical tube		item	1		1	
78	1-Kb DNA ladder		item	1		1	
79	1mM Cyanine 5 dCTP (1mM)		ul	2.5 ul		2.5 ul	
80	2% Agarose mini gel in 1X TAE buffer		item	1		1	
81	250 µL wide-orifice pipette tips		item	1		1	
82	50-bp DNA Ladder		item	0.16		0.16	
83	6X Gel-Loading Buffer: 0.25% bromophenol blue, 0.25% xylene cyanol, 30% glycerol in H2O.		ml	0.5		0.5	
84	Absolute Ethanol (200 proof Ethyl Alcohol)		ul	700 ul		700 ul	
85	Aerosol-Resistant pipette tips		item	4		4	
86	Beveled aerosol barrier tips		item	1		1	
87	Compressed filtered air		can	0.016		0.016	
88	Covalent binding cover slips		item	1		1	
89	de-ionized water		ml	400 ml		400 ml	
90	DNase free snap lock 1.5mL microcentrifuge tubes		item	6		6	
91	DNase free sterile pipette tips		item	15		15	
92	Formamide, ultra-pure grade		mL	40 ml		40 ml	
93	GenoSensor Array 300 Kit		item	NA		0.16	
94	Glass slides (plain blank slides)		item	12		12	
95	Hematology tube (10mL)		item	1		1	
96	Hoechst 33258 fluorescent dye		ug/ml	1.2 ug/ml		1.2 ug/ml	
97	MicroSpin S-200 HR Columns		ul	2		2	
98	MLL Fusion Gene Kit		item	0.25		NA	
99	Nucleic acid gel stain (10,000X in DMSO) (Ethidium bromide)		ul	26ul		26ul	
100	Random Priming Kit		item	0.16		0.16	
101	Tween 20		ul	10 ul		10 ul	
102	Ultra-High Purity Nitrogen Gas (compressed), Grade 5.0		item	0.03		0.03	
103	Versagene DNA Blood Kit (0.05-10mL)		item	0.1		0.1	
104							
105	<b>Equipment</b>	<b>CMS Code</b>	<b>Unit</b>				
106	37-°C incubator	EL021		1		1	
107	37-°C water bath	EL043		1		1	
108	15-°C water bath	EL043		1		1	
109	100-°C water bath	EL043		1		1	
110	4-°C microcentrifuge			1		1	
111	Agarose Gel System Power supply			1		1	
112	Dell Latitude D600 Notebook			1		1	

	A	B	C	D	E	F	G
2				<b>CPT Code: 88385</b>		<b>CPT Code: 88386</b>	
3				<b>Code Descriptor: Array-based evaluation of multiple molecular probes; 51 through 250 probes</b>		<b>Code Descriptor: Array-based evaluation of multiple molecular probes; 251 through 500 probes</b>	
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
113	Eppendorf model 5415C centrifuge			1		1	
114	Fluorometer + 2 Cuvettes			1		1	
115	GenoSensor II Reader System			1		1	
116	Mini Gel, Multi load system			1		1	
117	Pipet set: P20, P200, P1000, ACC			1		1	
118	Spectrophotometer			1		1	
119	Room temperature microcentrifuge			1		1	
120	Tecan HS 4800 Hybridization Station			1		1	
121							

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Caffeine Halothane Contracture Test**

The CPT Editorial Panel created a new code under its Pathology and Laboratory procedures section, to identify individuals who are susceptible to malignant hyperthermia. Exposure to some common anesthetic agents can cause patients to develop an extremely high metabolic rate resulting in symptoms such as muscular rigidity and hyperthermia in excess of 110 degrees. Susceptibility to malignant hyperthermia is inherited, and the Caffeine Halothane Contracture Test is performed on patients who have a family history or past medical history that indicates susceptibility to this condition.

The RUC reviewed the physician work associated with the new code 89049 *Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report*. The RUC and the specialty society believed that the survey responses included technical clinical time (60 minutes of pre-service time, 90 minutes of intra-service time and 60 minutes post service for a total of 210 minutes). The RUC and the specialty society agreed that the physician work reflected a much lower total time of 45 minutes (5 minutes pre-service and 40 minutes of post-service time). The RUC and the specialty society believed the revised physician time should be used in a building block approach resulting in a physician work relative value of 1.40.

The RUC also assimilated the work intensity of 89049 to code 80502 *Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records* (Work RVU = 1.33) and RUC approved code 88361 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual using computer assisted technology* (Work RVU = 1.18). In addition, the work intensity of new code 89049 was understood to be similar to that of an E/M service for 45 minutes (.031 \* 45 minutes = 1.40 RVUs). Considering the building block approach, and the comparison of codes with similar physician work intensity, **the RUC recommends a relative value of 1.40 for code 89049.**

**The RUC recommends the following physician time for code 89049:**

- **Total Pre-Service Time = 5 minutes**
- **Total Intra-Service Time = 0 minutes**
- **Immediate Post Service time = 40 minutes**

**Practice Expense:**

The RUC examined the direct practice expense inputs for code 89049 with the understanding that the test requires significant clinical labor time to perform. This service is performed so rarely that a technologist may be required to dedicate as many as 5 hours per patient when the service is performed. The RUC recommends the attached non-facility direct practice expense inputs, and zero facility direct inputs for code 89049.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 89049	CC1	Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report	XXX	1.40

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:89049 Tracking Number: CC1 Global Period: XXX

Recommended Work Relative Value

Specialty Society RVU: 1.40

RUC RVU: 1.40

CPT Descriptor: Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient with a previous adverse reaction to anesthesia requires a caffeine halothane contracture test (CHCT) performed on freshly biopsied muscle for definitive diagnosis prior to further anesthesia exposure.

NOTE: Any work associated with obtaining the muscle specimen itself is separately reportable and should NOT be considered when evaluating the work of the caffeine halothane contracture test.

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? 20%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician performing the CHCT obtains a thorough patient history and a family history (separately reported) to assess suitability for the test. The physician performing the CHCT discusses with the surgeon the indications for the biopsy, the preferred technique for obtaining the muscle (including the site and size of the muscle sample), the time of the procedure to ensure the laboratory is prepared, and the process of preserving and transporting the muscle sample.

Description of Intra-Service Work: The technician will prepare fresh Krebs-Ringer solution and the apparatus required to perform the test and confirm quality control. As part of the separately reported muscle biopsy procedure, muscle is obtained - preferably from the vastus group of the lower extremity. The muscle sample is placed on a tongue depressor and secured and placed in a Krebs-Ringer solution and maintained at room temperature. The muscle is promptly transported to the anesthesia testing laboratory. All caffeine contracture testing must be performed within 5 hours. The muscle is grossly inspected by the technician to ensure the specimen is not stretched, distorted or otherwise injured. The muscle sample is then dissected to achieve a fascicle size of 1-2 cm length and 0.1-0.5 cm in width. The specimen is then inspected under magnification to ensure the muscle fascicles are not nicked or otherwise injured. During this process, the muscle is not manually handled, and is placed in a carbogenated Krebs-Ringer solution (95% Oxygen/5% carbon dioxide).

Some of the testing components include a force transducer, glass chambers for exposure to testing solutions, a muscle twitch stimulator preferably made of platinum to allow twitch stimulation of 0.1-0.2 Hz every 5-10 seconds with a pulse duration up to 5 msec, ventilation hood to scavenge vapors and a multi-channel electrophysiologic recorder.

A technician mounts the muscle to the force transducer in the presence of the Krebs-Ringer solution and the muscle is allowed to equilibrate at 37 degrees for a minimum of 30 minutes until stable twitch height is attained upon stimulation.

To attain adequate diagnostic criteria, a minimum of three muscle strips should be tested in each of the solutions. The solutions will include halothane and caffeine. The primary solution will again be carbogenated Krebs-Ringer with a pH of 7.4 and a temperature of 37 degrees centigrade. Halothane will be administered via a calibrated vaporizer to maintain

a concentration of 3% (19-24 mm Hg partial pressure). Caffeine will be used in increasing concentrations from 0.5 mM to 32 mM.

Positive results (the patient is susceptible to malignant hyperthermia) are considered with the following responses: contracture of muscle as  $\geq 0.5$  g as measured by the force transducer in the presence of 3% halothane by 10 minutes duration;  $\geq 0.3$ g increase in tension on exposure to 2 mM caffeine. The combined results of testing six strips gives statistical validation with the thresholds determined by the North American Malignant Hyperthermia consultants with a 98% sensitivity and 78% specificity of the test results. Each result is interpreted to review the characteristics of the testing, the validity of the testing in regards to the muscle specimen which was obtained and the suitability of the testing conditions. The technician obtains and records measurements for physician review.

The physician must remain on site throughout the procedure for consultation with the laboratory technician

Description of Post-Service Work: The physician reports all control measurements and all test results to the North American Malignant Hyperthermia Registry. The physician also prepares documentation regarding the indications for biopsy, prior history of adverse reaction to anesthesia, previous laboratory findings, and a detailed family tree with all adverse anesthetic reactions graphed to determine hereditary patterns as possible. The results of the caffeine halothane contracture testing and recommendations for both the patient and family members regarding further testing and the management of future anesthetics are included in the report. A face-to-face or telephone conversation occurs with the patient and family members. The physician discusses the testing results with the patient (or parents). Family members must be contacted via the patient who has been tested for their suitability for testing and also for the potential of considerations of MH susceptibility in their descendants as well as in previous generations within their ancestry who are still alive. The susceptibility to MH is transmitted in an autosomal dominant pattern, so once a family member is identified as MH susceptible, other family members may have a 50% risk of being susceptible.

## SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2005				
Presenter(s):		From ASA: James D. Grant, MD, Brenda S Lewis, DO From MHAUS: Henry Rosenberg, MD, Joseph Tobin, MD				
Specialty(s):		Anesthesiology				
CPT Code:		89049				
Sample Size:	27	Resp n:	19	Response: 70.37 %		
Sample Type:		Panel				
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:		2.40	2.57	3.30	4.48	7.28
Pre-Service Evaluation Time:				5.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		30.00	30.00	0.00	90.00	180.00
Post-Service		Total Min**	CPT code / # of visits			
Immed. Post-time:		<u>40.00</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>
99254	XXX	2.64

CPT Descriptor Initial inpatient consultation for new or established patient, which requires three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
93312	XXX	2.20

CPT Descriptor 1 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99291	XXX	3.99

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99255	XXX	3.64

CPT Descriptor Initial inpatient consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high 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: 11      % of respondents: 57.8 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u> 89049	<u>Key Reference CPT Code:</u> 99254
Median Pre-Service Time	5.00	10.00
Median Intra-Service Time	0.00	65.00
Median Immediate Post-service Time	40.00	9.00
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	84.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.82	3.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.36
Urgency of medical decision making	2.36	3.18

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.09	3.27
Physical effort required	1.82	2.09
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.09	3.55
Outcome depends on the skill and judgment of physician	4.36	3.82
Estimated risk of malpractice suit with poor outcome	3.18	3.27

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.91	3.00
Intra-Service intensity/complexity	4.27	3.91
Post-Service intensity/complexity	3.36	3.18

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An Expert Panel Methodology was used. The Panel included physicians from the ASA Committee on Economics and physicians affiliated with the Malignant Hyperthermia Association of the United States (MHAUS). We did not expect to get 30+ responses as the CHCT is performed in only six centers in the US. This number is down from 12 centers just a few years ago. Centers are closing because they cannot continue to provide the service without any reimbursement. The Panel met via conference call. The Code Change Proposal (CCP) was made available to the MHAUS participants because the work survey was closed. They did not see the CCP until after all survey responses were received by ASA.

The results of the survey were not made available to them in order to avoid any chance of the results influencing their input to the call. The MHAUS participants provided detailed accounts of the work and resources required to perform the CHCT. From that information, the group was able to identify all elements of the service, distinguish physician work from technician work and determine precise times required for each element of the procedure. The group reviewed the work descriptions and frequency information that was included on the code proposal and updated that information to reflect the opinions of the expert physicians from MHAUS.

The times determined by the Expert Panel differ from the survey results. The survey participants may have included technician time in their responses (60 minutes of pre-service time, 90 minutes intra-service time and 60 minutes post-service for a total of 210 minutes). The Panel thoroughly reviewed each and every element of the CHCT, not only to determine whether it is physician or technician work, but also to allocate accurate times. The Panel determined that the CHCT entails 90 minutes of physician work (50 pre-service, 0 intra-service, 40 post-service) Per Pre-Facilitation Committee recommendation, we removed most of the pre-service physician work because that should be part of a separately reportable E/M. The remaining 5 minutes of physician pre-service time (discussions with surgeon performing biopsy) is not part of that E/M. We recommend that the RUC use the physician time estimates as determined by the Expert Panel and refined by the Pre-facilitation Committee (5 pre-service, 0 intra-service, 40 post-service) rather than the survey responses.

We also note that the RUC database lists 84 minutes (Harvard) time for the reference code 99254. Sixty-five minutes are specified as intra-service time. There is no breakdown between pre- and post-service time for the remaining 19 minutes. We allocated 10 minutes for pre-service and 9 minutes for post-service as we felt that was a reasonable estimation.

The complete results of the Expert Panel's work and the Pre-facilitation committee's refinements can be found in Addendum A.

Seventy four percent of the survey respondents indicated that the typical patient described on the survey was representative of their practice. The respondents who indicated that their typical patient differed commented that the test was done when either the patient or an immediate member of the patient's family had had a previous adverse reaction to anesthesia.

We recommend a work RVU of 1.40. We used a building block methodology as follows

**Physician Work Physician Time**  
**Pre-Service**

The physician performing the CHCT discusses with the surgeon the indications for the biopsy, the preferred technique for obtaining the muscle (including the site and size of the muscle sample), the time of the procedure to ensure the laboratory is prepared, and the process of preserving and transporting the muscle sample

	..5 minutes
Total pre-service	5 minutes

**Intra-service**

No intra-service physician work

	.0 minutes
Total intra-service	..0 minutes

**Post service**

The physician reports all control measurements and all test results to the North American Malignant Hyperthermia Registry (see Addendum B) .20 minutes

The physician also prepares documentation regarding the indications for biopsy, prior history of adverse reaction to anesthesia, previous laboratory findings, and a detailed family tree with all adverse anesthetic reactions graphed to determine hereditary patterns as possible. The results of the halothane-caffeine contracture testing and recommendations for both the patient and family members regarding further testing and the management of future anesthetics are included in the report .10 minutes

A face-to-face or telephone conversation occurs with the patient and family members. Communicate directly with each patient the results of their testing. Family members must be contacted via the patient who has been tested for their suitability for testing and also for the potential of considerations of MH susceptibility in their descendants as well as in previous generations within their ancestry who are still alive. The susceptibility to MH is transmitted in an autosomal dominant pattern, so once a family member is identified as MH susceptible, other family members may have a 50% risk of being susceptible .10 minutes

Total post-service 40 minutes

**TOTAL PHYSICIAN TIME 45 minutes**

The Expert Panel determined that the physician work of the CHCT is comparable in intensity to that of

Code 80502 - Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records.  
Intensity = 1.33 RVUw /42 minutes = 0.0317

Code 99375 - Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more  
Intensity = 1.73 RVUw/57 minutes = 0.0304

Comparison codes suggested by the Pre-facilitation committee:

Code 93015 - Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report  
Intensity = .75 RVUw/21 (Harvard) minutes = 0.036

Code 88361 - Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual using computer assisted technology

Intensity = 1.18 RVUw/40 minutes = .0295 (RUC approved October 2004)

The building block is further validated by multiplying the physician time of the CHCT by the intensity associated with an E/M service: 45 minutes \*0.031 = 1.45

## 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 test requires freshly excised muscle. A physician other than the one performing the CHCT will excise the muscle. That work is not accounted for in the new code and was specifically excluded from the survey.

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 physician harvesting the muscle will typically report code 27324 - Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular). Global: 090 Work RVU: 4.89 Pre-service time:43 minutes (Harvard) Intra-service time: 41 minutes (Harvard) Post-service time: 62 minutes (Harvard) Total time 146 minutes (Harvard). Multiple procedure reductions are not relevant as there are no duplicative elements between the CHCT and the harvesting of the muscle.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Code 89240 - Unlisted miscellaneous pathology test or code 95999 - Unlisted neurological or neuromuscular diagnostic procedure. The RUC database does not include frequency data for code 89240. Per the RUC database, 2002 Medicare frequency for code 95999 was 895.



	A	B	C	D	E	F
1	C					
2				CPT Code 89049		
3	Meeting Date: Feb 2005 RUC Recommendation			Code Descriptor: Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report		
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	
5	GLOBAL PERIOD			XXX		
6	TOTAL CLINICAL LABOR TIME	L035A	Lab Tech/Histo - technologist	304.0	0.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L035A	Lab Tech/Histo - technologist	0.0	0.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L035A	Lab Tech/Histo - technologist	304.0	0.0	
9	TOTAL POST-SERV CLINICAL LABOR TIME	L035A	Lab Tech/Histo - technologist	0.0	0.0	
10						
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	Follow-up phone calls & prescriptions					
16	Other Clinical Activity (please specify)					
17	End: When patient enters office/facility for surgery/procedure					
18						
19	Start: When patient enters office/facility for surgery/procedure					
20	Pre-service services					
21	Review charts					
22	Greet patient and provide gowning					
23	Obtain vital signs					
24	Provide pre-service education/obtain consent					
25	Prepare room, equipment, supplies					
26	Setup scope (non facility setting only)					
27	Prepare and position patient/ monitor patient/ set up IV					
28	Sedate/apply anesthesia					
29	Intra-service					
30	Obtain permission to enter patient data/results into MH registry	L035A	Lab Tech/Histo - technologist	3		
31	Prepare fresh Krebs-Ringer solution and the apparatus required for test. Confirm quality control	L035A	Lab Tech/Histo - technologist	45		
32	Secure sample, place in Krebs-Ringer solution and maintain at room temperature	L035A	Lab Tech/Histo - technologist	15		
33	Transport sample from OR to anesthesia testing lab	L035A	Lab Tech/Histo - technologist	5		
34	Assist physician in performing procedure					
35	Inspect specimen to ensure it is not stretched, distorted or otherwise injured	L035A	Lab Tech/Histo - technologist	3		
36	Dissect sample to achieve required size	L035A	Lab Tech/Histo - technologist	30		
37	Mount muscle strips for two sequential test runs. Equilibrate and adjust as indicated.	L035A	Lab Tech/Histo - technologist	90		
38	Expose samples to halothane	L035A	Lab Tech/Histo - technologist	15		
39	Expose samples to increasing concentrations of caffeine	L035A	Lab Tech/Histo - technologist	28		
40	Obtain and record measurements for physician review	L035A	Lab Tech/Histo - technologist	10		
41	Post-Service					
42	Monitor pt. following service/check tubes, monitors, drains					
43	Clean room/equipment by physician staff					
44	Clean Scope					
45	Clean Surgical Instrument Package					
46	Complete diagnostic forms, lab & X-ray requisitions					
47	Review/read X-ray, lab, and pathology reports					
48	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
49	Discharge day management 99238 - 12 minutes					
50	Other Clinical Activity (please specify)					
51	Preservation of muscle and clean up activities (time includes terminal clean-up)	L035A	Lab Tech/Histo - technologist	30		
52	Prepare reports to North American Malignant Hyperthermia Registry for physician review and confirmation	L035A	Lab Tech/Histo - technologist	30		
53	End: Patient leaves office					
54	Start: Patient leaves office/facility					
55	Conduct phone calls/call in prescriptions					

	A	B	C	D	E	F
2	Meeting Date: Feb 2005 RUC Recommendation			CPT Code 89049		
3				Code Descriptor Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report		
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	
57	Office visits:					
58	List Number and Level of Office Visits					
59	99211 16 minutes		16			
60	99212 27 minutes		27			
61	99213 36 minutes		36			
62	99214 53 minutes		53			
63	99215 63 minutes		63			
64	Other					
65	Total Office Visit Time			0	0	
66	Other Activity (please specify)					
67	End: with last office visit before end of global period					
68						
69	Cap, surgical	SB001		1		
70	Gloves, latex	SB022		1		
71	Lab Coat	SB030		1		
72	Shoe covers	SB039		1		
73	4-0 suture	SF050		2		
74	2-0 suture	SF050		2		
75	thermo recording paper	SK060		30		
76	Pipet tips 5-ml and 1-ml	SL110		24		
77	PP test tubes	SL143		8		
78	Biohazard waste bags and waste disposal	SM004		1		
79	Disinfectant	SM013		8 oz		
80	Kimwipes	SM027		50		
81	Halothane			24.0 cc		
82	CHCT Solution - includes NaCl, NaHCO3, dextrose, KCl KH2PO4, MgSO4, CaCl2-2H2O			1 liter		
83	Caffeine			2.0 grams		
84	KOH			1.0 gram		
85	HCl			1.0 cc		
86	Standard buffer			2.0 cc		
87	Weighing boats			4		
88	Gas Cylinder G			.1 of a cylinder/test		
89	Gas Cylinder H			.1 of a cylinder/test		
90	Liner/absorbent paper lab bench			8 feet		
91	Detergent/Sparklean			30.0 grams		
92						
93						
94	Mettler Toledo Balance	EL004	15 min			
95	Hood, biohazard	EL016	300 minutes			
96	Microscope, binocular-dissecting	EL023	20 minutes			
97	Open water bath with isotemp circulation		270 minutes	\$ 1,600.00		
98	Orion pH meter		10 minutes	\$ 870.00		
99	Illuminator		15 minutes	\$ 562.00		
100	Grass stimulator		270 minutes	\$ 3,775.00		
101	Stimuli-splitter		270 minutes	\$ 2,680.00		
102	Stimuli-attenuator		270 minutes	\$ 610.00		
103	Regulators for gas cylinders (cylinders G and H)		300 minutes	\$ 500.00		
104	Halothane vaporizer		10 minutes	\$ 1,399.00		
105	FT-03 force transducers x3		130 minutes	\$ 522.00		
106	DigiData 1332A+ Axoscope fitting		270 minutes	\$ 4,000.00		
107	CyperAmp 380		270 minutes	\$ 7,000.00		
108	Grass recorder		270 minutes	\$ 6,995.00		
109	Computer		300 minutes	\$ 600.00		

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations  
October 2004

**Drug Administration Services**

The RUC reviewed work relative value recommendations and direct practice expense inputs presented by a coalition of six specialties: oncology, hematology, infectious disease, rheumatology, gastroenterology, and urology. The specialty societies informed the RUC that the survey results were only valid in reviewing the levels of intensity between services, as the respondents were not able to differentiate between the supervision of drug administration and evaluation and management services. The specialty societies developed their recommendations via a consensus panel approach, basing their recommendations on a comparison to 99211 *Level 1 office visits* (Work RVU = 0.17) and other services evaluated by the RUC.

The RUC reviewed all twenty new codes by first allocating them into three categories (hydration, TX/DX and chemotherapy). For each of these categories, anchors were developed in order to create relativity amongst the codes. The RUC first assessed the relationship between 90760 *Intravenous infusion, hydration; initial, up to one hour*, 90765 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour*, and 96413 *Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug*. The RUC agreed that 99211 serves as an appropriate anchor for CPT code 90760 *hydration*. The RUC reviewed existing code 93798 *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)* (Work RVU= 0.28) and determined that it was an appropriate reference code for 96413 *Chemotherapy* as the physician supervision requirements are equivalent and the patient acuity and risk of adverse outcomes are similar. The RUC then based all of the recommendations for these twenty codes within a range between 0.17 and 0.28, accounting for differences in time and intensity for each service.

The RUC considered only those codes that were approved by the CPT Editorial Panel and did not include other activities, such as physician time related to treatment management or clinical staff activities related to nutrition or psychological counseling in these specific drug administration services.

A number of supporting documents are attached to this recommendations including: 1) a summary of the RUC review of drug administration; 2) an overview of the CPT coding changes for *CPT 2006*; 3) an excel spreadsheet that summarizes the RUC recommendations; 4) an excel spreadsheet predicting the utilization of the new CPT codes; 5) excel spreadsheets with direct practice expense inputs; and 6) separate documents summarizing the specialties work recommendations for each of the 20 new codes.

***Hydration***

**90760 (H1)**

The RUC examined 90760 *Intravenous infusion, hydration; initial, up to one hour*. The RUC agreed that this service had similar complexity and intensity as a 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician* (work RVU = 0.17). In addition, the RUC agreed that the time associated with this code (7 minutes of total service time) was equal to the physician supervision time of the reference code (7 minutes of total service time). **The RUC recommends a work relative value of 0.17 for 90760.**

**90761 (H2)**

The RUC reviewed the recommendation for 90761 *Intravenous infusion, hydration; each additional hour, up to eight (8) hours*. Although this code is the second hour of hydration, the RUC agreed that there would be a need for some nurse/physician interaction. The RUC agreed that the work related to 90761 was about half of the work associated with 90760. The RUC recommends that the total physician time is 3 minutes. **The RUC recommends a work relative value of 0.09 for 90761**

***Therapeutic/Diagnostic Infusions and Injections***

**90765 (H3)**

The RUC assessed 90765 *Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); initial, up to one hour* and decided that in order to maintain relativity between the codes, the work RVUs for this code should be placed between the work RVUs for 90760 (recommended work RVU of 0.17) and 96413 (recommended work RVU of 0.28). After discussing the differences between all three codes, the RUC agreed that the service provided in 90765 was more closely related to 90760 than 96413 when considering the intensity and complexity of the patient, risk of complications, and likelihood that that the physician would be asked to intervene during the course of an infusion. The RUC recommends that the total physician time is 9 minutes. **The RUC recommends a work relative value of 0.21 for 90765.**

**90766 (H5)**

The RUC examined the recommendations for 90766 *Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)*. The RUC agreed that the agents being administered for this code would not only require additional hours of administration but also would be very different from the agents that would be administered when 90765 would be reported alone. Due to the higher levels of toxicity of these agents, there would be more nurse/physician interaction. The RUC recommends 3 minutes of total physician time. The RUC believes that the intensity of this increment of physician involvement is greater than the increment between the first and subsequent hours of hydration, and therefore, recommends only a .03 reduction in physician work between the first and second hour of infusions for therapeutic agents. **The RUC recommends a work RVU of 0.18 for 90766.**

**90767 (H4)**

The RUC reviewed the recommendations for 90767 *Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)*. After reviewing the service, the RUC agreed that when this service is reported the patient would be receiving a second hour of administration with a second drug. The RUC agreed that complications may occur with administering a second drug and there is a greater likelihood of additional nurse/physician interaction as compared to 90766 (recommended work RVUs of 0.18). The RUC recommends 6 minutes of total physician time. **The RUC recommends a work RVU of 0.19 for 90767.**

**90768 (H6)**

The RUC examined the recommendations for 90768 *Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration)*. After reviewing the service, the RUC agreed that when this service is reported the patient would be receiving two drugs at the same time, which would account for some nurse/physician interaction but less interaction than that of 90766 or 90767. Therefore the RUC agreed that the work and intensity associated with this service would be similar to 90760, the first hour of hydration, or 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician* (work RVU=0.17). The RUC recommends 4 minutes of total physician time. **The RUC recommends a work RVU of 0.17 for 90768.**

**90772 (H7)**

The RUC assessed the recommendations for 90772 *Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*. The RUC identified a reference code for this service, 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)* (Work RVU=0.00, RUC Recommended Work RVU= 0.17, 7 minutes total service time) which is similar in intensity, work and time. The RUC recommends 7 minutes of total physician time. **The RUC recommends a work RVU of 0.17 for 90772.**

**The RUC reaffirms its recommendations for vaccination codes (90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)*, 90472 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)*, 90473 *Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)* and 90474 *Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)* ) of 0.17, 0.15, 0.17 and 0.15; respectively. All of these codes are currently valued at 0.00 work RVUs. However, the RUC urges CMS to publish work values for these services as part of the drug administration review. The RUC also acknowledges that the direct practice expense inputs for immunization administration may need to be re-reviewed. The RUC recommendations for these services are attached.**

**90774 (H9)**

The RUC assessed the RUC recommendations for 90774 *Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug*. The RUC used magnitude estimation to determine the appropriate work RVU for this procedure. The RUC agreed that an appropriate reference code would be 90760 *Intravenous infusion, hydration; initial, up to one hour* (RUC Recommended Work RVU=0.17) The RUC deemed 90774 to be more intense and require additional time to perform (7 minutes total time for 90760 and 9 minutes of total time for 90774) as compared to 90760. **The RUC recommends a work RVU of 0.18 for 90774.**

**90775 (H10)**

The RUC examined the recommendations for 90775 *Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)*. The RUC identified a reference code for 90775 that was similar in work and intensity, 90761 *Intravenous infusion, hydration; each additional hour,*

*RUC Drug Administration Recommendations – Page Five*

*up to eight (8) hours* (RUC Recommended Work RVU=0.09). However, 90775 requires more time to perform (4 minutes total service time) than 90761 (3 minutes total service time). The RUC agreed that in order to maintain relativity, a 0.01 increment should be added to the work RVU of 90761. **The RUC recommends a work RVU of 0.10 for 90775.**

***Chemotherapy Infusions and Injections***

**96401 (H11)**

The RUC examined the recommendations for 96401 *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic*. The RUC agreed that the service identified with this CPT code is more complex, has higher risk and has higher probability of nurse/physician interaction than 90772 (RUC Recommended Work RVU of 0.17). In addition, the RUC observed that 96401 requires more time than 90772, 9 and 7 minutes respectively. In addition, the RUC agreed that the work described in 96401 is similar to 90765, initial therapeutic/diagnostic infusion, up to one hour. **The RUC recommends a work RVU of 0.21 for 96401.**

**96402 (H12)**

The RUC reviewed the RUC recommendations for 96402 *Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic*. Upon reviewing the recommendations for this code, the RUC identified a reference service code for this procedure, 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)* (Work RVU=0.00, RUC Recommended Work RVU= 0.17, 7 minutes total service time). The RUC recommends 9 minutes of physician time related to 96402. The RUC agreed that this code should be valued between 90772 *therapeutic injection* (RUC recommended Work RVU= 0.17) and 96401 *chemotherapy injection* (RUC Recommended Work RVU=0.21). **The RUC recommends a work RVU of 0.19 for 96402.**

**96409 (H13)**

The RUC examined the recommendations for 96409 *Chemotherapy administration, subcutaneous or intramuscular; intravenous push technique, single or initial substance/drug*. The RUC agreed that in order to maintain relativity between the chemotherapy administration codes, this procedure should be relatively placed between 96401 *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic* (RUC Recommended Work RVU=0.21) and 96413 *Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug* (RUC Recommended Work RVU=0.28). The RUC agreed that because 96409 had 2 minutes less intra service time than 96413 and 2 minutes more intra service time than 96401, the

work relative value recommendation should be placed directly between the work relative value recommendations for the other two codes, in order to maintain relativity. The total physician time for 96409 is 11 minutes. **The RUC recommends a work RVU of 0.24 for 96409.**

**96411(H14)**

The RUC examined the recommendations for 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)*. When examining the recommendation for 96411, the RUC agreed that the work associated with this code was twice the amount of work associated with 90775 due to differences in intensity, complexity and total service times (4 minutes total service time for 90775 and 7 minutes total service time for 96411). **The RUC recommends a work RVU of 0.20 for 96411.**

**96413 (H15)**

The RUC examined 96413 *Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug*. The RUC agreed that 93798 *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)* (Work RVU= 0.28) was an appropriate reference code for 96413. The RUC agreed that 93798 was a good reference code for 96413 because both services have similar intensity, complexity and involve similar physician direct supervision times (12 minutes total service time for 93798 and 13 minutes total service time for 96413). Both of these codes require supervision that may occur for more than one patient at a time. The RUC agreed that the patient acuity and risk adverse outcomes are similar for both services. **The RUC recommends a work relative value of 0.28 for 96413.**

**96415 (H16)**

The RUC examined the 96415 *Chemotherapy administration, intravenous infusion technique; each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)*. The RUC agreed that an increment of physician work (.01) above 90766 *therapeutic/diagnostic infusion, subsequent hour* would be appropriate. The RUC agreed that the work of 96415 is equivalent to 90767 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)* (RUC Recommended Work RVU=0.19). The RUC recommends five minutes of total physician time. **The RUC recommends a work RVU of 0.19 for 96415.**

**96416 (H17)**

The RUC reviewed 96416 *Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump* and agreed that an appropriate reference code would be 90765 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour* (RUC Recommended Work RVU= 0.21) because both codes have similar intensity, complexity and nurse/physician interaction. In addition, both codes have similar total service times, 9 minutes total service time for 90765 and 10 minutes total service time for 96416. **The RUC recommends a work RVU of 0.21 for 96416.**

**96417 (H18)**

The RUC reviewed the recommendations for 96417 *Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure)*. After reviewing the service, the RUC agreed that when this service was reported the patient would be receiving a second hour of administration with a second drug. The RUC agreed that because of the complications that may occur with administering a second drug, there would be additional nurse/physician interaction as compared to 96415 (recommended work RVU of 0.19). The RUC agreed that 96417 is equivalent to 90765 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour* (RUC Recommended Work RVU= 0.21). The RUC recommends a total of 8 minutes of physician time. **The RUC recommends a work RVU of 0.21 for 96417.**

**96521 (H24)**

The RUC reviewed 96521 *Refilling and maintenance of portable pump* and determined that this service has similar complexity, work and total service time as 96416 (Total service times for 96416, 96521 and 96522 are 10 minutes). **The RUC recommends a work RVU of 0.21 for 96521.**

**96522 (H26)**

The RUC reviewed CPT code 96522 *Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)* and determined that this service has similar complexity, work and total service times as 96416 (Total service times for 96416, 96521 and 96522 are 10 minutes). **The RUC recommends a work RVU of 0.21 for 96522.**

**96523 (H25)**

The RUC examined 96523 *Irrigation of implanted venous access device for drug delivery systems*. The RUC observed that this service had no intra-service or post service activities and only required 2 minutes on pre-service to perform. Therefore the RUC agreed comfortable using an IWPUT analysis to establish a work relative value recommendation for this code. By using IWPUT analysis, the RUC determined that 2 minutes of pre-service same day evaluation would equate to 0.04 work RVUs (2 minutes x 0.0224 = 0.04 RVUs). **The RUC recommends a work RVU of 0.04 for 96523.**

***Physician Time***

The RUC recommends that all times associated with these codes, when placed in the RUC database, include a notation to clarify that the physician times associated with these codes are direct supervision and interactions with clinical staff, rather than face-to-face with the patient.

***Practice Expense***

The RUC reviewed the practice expense inputs for the existing codes which were approved by the PEAC and subsequently by the RUC in 2002. The RUC observed that when these codes were first reviewed, a 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician* was billed with the majority of these codes over fifty percent of the time. However, because the current CMS rules and CCI edits do not allow a 99211 to be billed with this series of codes, the RUC noted that some of the activities that were eliminated in 2002 are not appropriate to add back to these codes. In addition, the RUC's recommendations incorporate the new coding structure and the ability to capture practice expense for subsequent drug infusions. The revised practice expense inputs are attached to this recommendation.

**Therapeutic or Diagnostic Infusions (Excludes Chemotherapy)**

These codes encompass prolonged intravenous infusions.

These codes require the presence of the physician during the infusion. These codes are not to be used for intradermal, subcutaneous, intramuscular or routine IV drug injections. For these services, see 90782-90788.

These codes may not be used in addition to prolonged services codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
90780		Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour	XXX	N/A
+90781		<p>each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)</p> <p><u>(Use 90781 in conjunction with code 90780)</u></p> <p><u>(Codes 90780 and 90781 have been deleted. To report, see 90760, 90761, 90765-90768)</u></p>	ZZZ	N/A

**Hydration, Injections, Therapeutic or Diagnostic Infusions (Excludes Chemotherapy)**

Physician work related to hydration, injection and infusion services predominantly involves treatment planning and *direct* supervision of staff.

If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported utilizing modifier 25 in addition to 90765-90799. For same day E/M service a different diagnosis is not required.

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

- a. Use of local anesthesia
- b. IV start
- c. Access to indwelling IV, subcutaneous catheter or port
- d. flush at conclusion of infusion
- e. standard tubing, syringes and supplies

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>(For declotting a catheter or port, see 36550)</p> <p><u>When multiple drugs are administered, report the service(s) and the specific materials or drugs for each.</u></p> <p><u>When administering multiple infusions, injections or combinations, only one "initial" service code should be reported, unless protocol requires that two separate IV sites must be utilized. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported (e.g. the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code).</u></p> <p><u>When reporting codes for which infusion time is a factor, use the actual time over which the infusion is administered.</u></p>				
<p><b><u>Hydration</u></b></p> <p><u>Codes 90760-90761 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-½ normal saline+30mEq KCl/liter), but are not used to report infusion of drugs or other substances. Hydration IV infusions typically require direct physician supervision for purposes of consent, safety oversight or intra-service supervision of staff. Typically such infusions require little special handling to prepare or dispose of, and staff which administer these don't typically require advanced practice training. After initial set-up, infusion typically entails little patient risk and thus little monitoring.</u></p>				
●90760	H1	Intravenous infusion, hydration; initial, up to one hour	XXX	0.17
●+90761	H2	<p>each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)</p> <p><u>(Use 90760 in conjunction with code 90761)</u></p> <p><u>(Report 90761 for hydration infusion intervals of greater than thirty minutes beyond one hour increments)</u></p> <p><u>(Report 90761 to identify hydration if provided as a secondary or subsequent service after a different initial service [90760, 90765, 90775, 96409, 96413] is provided)</u></p> <p><u>Do not report 90760 if performed as a concurrent infusion service</u></p>	ZZZ	0.09

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b><u>Therapeutic, Prophylactic and Diagnostic Injections and Infusions</u></b>				
<p><u>A therapeutic, prophylactic or diagnostic IV infusion or injection (90765-90799) (other than hydration) is for the administration of substances/drugs. The fluid used to administer the drug(s) is incidental hydration and is not separately reportable. These services typically require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically, such infusions require special consideration to prepare, dose or dispose of, require practice training and competency for staff who administer the infusions, and infusions require periodic patient assessment with vital sign monitoring during the infusion</u></p> <p><u>Intravenous or intra-arterial push is defined as a) an injection in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient or b) an infusion of 15 minutes or less.</u></p> <p><u>(Do not report 90760-90775 with codes (including 96401-96549) for which IV push or infusion is an inherent part of the procedure(e.g. administration of contrast material for a diagnostic imaging study))</u></p>				
•90765	H3	Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); initial, up to one hour	XXX	0.21
•+90766	H5	each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)	ZZZ	0.18
•+90767	H4	<p>additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)</p> <p><u>(Report 90766 in conjunction with 90765, 90767)</u></p> <p><u>(Report 90766 for additional hour(s) of sequential infusion)</u></p> <p><u>(Report 90766 for infusion intervals of greater than 30 minutes beyond one hour increments)</u></p> <p><u>(Report 90767 in conjunction with 90765, 90775 96409, 96413 if provided as a secondary or subsequent service after a different initial service. Report 90767 only once per sequential infusion of same infusate mix.)</u></p>	ZZZ	0.19

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•+90768	H6	<p>concurrent infusion (List separately in addition to code for primary procedure)</p> <p><u>(Report only once per encounter)</u></p> <p><u>(Report 90768 in conjunction with code 90765 or 96413)</u></p>	ZZZ	0.17
<p><u>Intravenous or intra-arterial push is defined as an injection/infusion of short duration (i.e. thirty minutes or less) in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient.</u></p>				
•90772	H7	<p>Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular</p> <p><u>(For administration of vaccines/toxoids, see 90465,90466, 90471-90472)</u></p> <p><u>(Report 90772 for non-antineoplastic hormonal therapy injections)</u></p> <p><u>(Report 96401 for anti-neoplastic hormonal injection therapy)</u></p> <p><u>(Do not report 90772 for injections given without direct physician supervision. To report, use 99211)</u></p>	XXX	0.17
90773	H8	<i>intra-arterial</i>	XXX	No RUC recommendation
•90774	H9	<p>intravenous push, single or initial substance/drug</p> <p><u>(90772-90774 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95115-95117)</u></p>	XXX	0.18
+•90775	H10	each additional sequential intravenous push (List separately in	ZZZ	0.10

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>addition to code for primary procedure)</p> <p><u>(Use 90775 in conjunction with 90765, 90774, 96409, 96413)</u></p> <p><u>(Report 90775 to identify intravenous push of a substance/drug if provided as a secondary or subsequent service after a different initial service is provided)</u></p>		
•90779		<p>Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial, injection or infusion</p> <p><u>(For allergy immunizations, see 95004 et seq)</u></p>	XXX	Carrier Priced
<b>Therapeutic, Prophylactic or Diagnostic Injections</b>				
90782		<p><del>Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular</del></p> <p><del>For administration of vaccines/toxoids, see 90471, 90472)</del></p> <p><del>(90782 has been deleted. To report, use 90772)</del></p>	XXX	N/A
90783		<p><del>intra-arterial</del></p> <p><del>(90783 has been deleted. To report, use 90773)</del></p>	XXX	N/A
90784		<p><del>intravenous</del></p> <p><del>(90782-90784 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95155-95117)</del></p> <p><del>(90784 has been deleted. To report, use 90774)</del></p>	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
90788		<p><del>Intramuscular injection of antibiotic (specify)</del></p> <p><del>(90788 has been deleted; to report, use 90772)</del></p> <p><del>(90790-90796 have been deleted. To report, see 95990, 96408, 96414, 96420, 96425, 96440, 96450, 96530, 96545, 96549)</del></p>	XXX	N/A
90799		<p><del>Unlisted therapeutic, prophylactic or diagnostic injections</del></p> <p><del>(For allergy immunizations, see 95004 et seq)</del></p> <p><del>(90799 has been deleted. To report, use 90779)</del></p>	XXX	N/A

### **Chemotherapy Administration**

Procedures 96400-96549 are independent of the patient's visit.

Chemotherapy administration codes 96400-96549 apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of non-cancer diagnoses (eg, cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents and other biologic response modifiers. These services can be provided by any physician. Chemotherapy services are typically highly complex and require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician about these issues.

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

- a. Use of local anesthesia
- b. IV start
- c. Access to indwelling IV, subcutaneous catheter or port
- d. flush at conclusion of infusion
- e. standard tubing, syringes and supplies
- f. Preparation of chemotherapy agent(s)

(For declotting a catheter or port, see 36550)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p><u>Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. Medications (eg, antibiotics, steroidal agents, antiemetics, narcotics, analgesics) administered independently or sequentially as supportive management of chemotherapy administration, should be separately reported using 90760, 90761, 90765, 90767, 90766, 90768, 90772, 90773, 90774, 90775, 90799 as appropriate.</u></p> <p><u>Report both the specific service as well as code(s) for the specific substance(s) or drug(s) provided. The fluid used to administer the drug(s) is considered incidental hydration and is not separately reportable.</u></p> <p><u>When administering multiple infusions, injections or combinations, only one "initial" service code should be reported, unless protocol requires that two separate IV sites must be utilized. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported (e.g. the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code).</u></p> <p><u>When reporting codes for which infusion time is a factor, use the actual time over which the infusion is administered.</u></p> <p><u>If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported utilizing modifier 25 in addition to 96401-96549. For same day E/M service, a different diagnosis is not required.</u></p> <p><u>Either may occur independently on any date of service, or they may occur sequentially on the same day.</u></p> <p><u>Preparation of chemotherapy agent(s) is included in the service for administration of the agent.</u></p> <p><i>Regional (isolation) chemotherapy perfusion should be reported using the codes for intra-arterial infusion (96420-96425). Placement of the intra-arterial catheter should be reported using the appropriate code from the Cardiovascular Surgery section. Placement of arterial and venous cannula(s) for extracorporeal circulation via a membrane oxygenator perfusion pump should be reported using code 36823. Code 36823 includes dose calculation and administration of the chemotherapy agent by injection into the perfusate. Do not report code(s) 96409-96425 in conjunction with code 36823.</i></p> <p><u>(For Home Infusion services, see 99601-99602)</u></p>				
<p><b><u>Injection and Intravenous Infusion Chemotherapy</u></b></p>				
<p><u>Intravenous or intra-arterial push is defined as a) an injection in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient, or b) an infusion of 15 minutes or less.</u></p>				
96400		Chemotherapy administration, subcutaneous or intramuscular with or without local anesthesia	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Code 96400 has been deleted. To report, see 96401, 96402)		
•96401	H11	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	XXX	0.21
•96402	H12	hormonal anti-neoplastic	XXX	0.19
▲96405		Chemotherapy administration; <del>intralesional;</del> <u>intralesional</u> , up to and including 7 lesions	000	0.52 (No Change)
▲96406		more than 7 lesions	000	0.80 (No Change)
96408		Chemotherapy administration, intravenous; push technique (96408 has been deleted. To report, use 96409)	XXX	N/A
▲96409	H13	intravenous; push technique, <u>single or initial substance/drug</u>	XXX	0.24
96410		<del>intravenous infusion technique; up to one hour</del> (96410 has been deleted. To report, use 96413)	XXX	N/A
+•96411	H14	intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)  (Use 96411 in conjunction with code 96409)	ZZZ	0.20

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<del>+96412</del>		<del>infusion techniques, one to 8 hours, each additional hour (List separately in addition to code for primary procedures)</del>  <del>(Use 96412 in conjunction with code 96410)</del>  <del>(96412 has been deleted. To report, use 96415)</del>	<del>ZZZ</del>	<del>N/A</del>
▲96413	H15	Chemotherapy administration, intravenous infusion technique; up to one hour, <u>single or initial substance/drug</u>	XXX	0.28
<del>96414</del>		<del>infusion techniques, initiation of prolonged infusion (more than 8 hours), requiring use of a portable or implantable pump</del>  <del>(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96520, 96530)</del>  <del>(96414 has been deleted. To report, use 96416)</del>	<del>XXX</del>	<del>N/A</del>
+▲96415	H16	<del>infusion technique, each additional hour, one to eight (8) hours, each additional hour (List separately in addition to code for primary procedure)</del>  <del>(Use 96415 in conjunction with 96413)</del>  <del>(Report 96415 for infusion intervals of greater than thirty minutes beyond one hour increments)</del>  <del>(Report 90761 to identify hydration, or 90766, 90767, 90775 to identify therapeutic, prophylactic, or diagnostic drug infusion or injection, if provided as a secondary or subsequent service in association with 96413)</del>	<del>ZZZ</del>	<del>0.19</del>

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲96416	H17	<p><del>infusion technique</del>; initiation of prolonged <u>chemotherapy</u> infusion (more than eight hours), requiring use of a portable or implantable pump</p> <p><u>(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96521-96523)</u></p>	XXX	0.21
+•96417	H18	<p>each additional <u>sequential</u> infusion (different substance/drug), up to one hour <u>(List separately in addition to code for primary procedure)</u></p> <p><u>(Use 96417 in conjunction with code 96413)</u></p> <p><u>(Report only once per sequential infusion; report 96415 for additional hour(s) of sequential infusion)</u></p>	ZZZ	0.21
<b><u>Intra-Arterial Chemotherapy</u></b>				
96420	H19	Chemotherapy administration, intra-arterial; push technique	XXX	No RUC recommendation
96422	H20	infusion technique, up to one hour	XXX	No RUC recommendation
▲+96423	H21	<p>infusion technique, <u>one to 8 hours, each additional hour up to 8 hours (List separately in addition to code for primary procedure)</u></p> <p><u>(Use 96423 in conjunction with 96422)</u></p> <p><u>(Report 96423 for infusion intervals of greater than thirty minutes beyond</u></p>	ZZZ	No RUC recommendation

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>one hour increments)</u>  (For regional chemotherapy perfusion via membrane oxygenator perfusion pump to an extremity, use 36823)		
96425	H22	infusion technique, initiation of prolonged infusion (more than eight hours), requiring the use of a portable or implantable pump  (For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96521, 96523 or 96522)	XXX	No RUC recommendation
<b><u>Other Chemotherapy</u></b>				
<u>Code 96523 does not require direct physician supervision. Codes 96521-96523 may be reported when these devices are used for therapeutic drugs other than chemotherapy.</u>				
<u>(For collection of blood specimen from a completely implantable venous access device, use 36540)</u>				
96440		<i>Chemotherapy administration into pleural cavity, requiring and including thoracentesis</i>	000	2.37 (No Change)
96445		<i>Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis</i>	000	2.20 (No Change)
96450	H23	<i>Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture</i>  (For intravesical (bladder) chemotherapy administration, see 51720)  (For insertion of subarachnoid catheter and reservoir for infusion of drug, see 62350, 62351, 62360, 62361, 62362; for insertion of intraventricular catheter and reservoir, see 61210, 61215)	000	1.53 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
96520		Refilling and maintenance of portable pump  (96520 has been deleted. To report, use 96521)	XXX	N/A
•96521	H24	Refilling and maintenance of portable pump	XXX	0.21
•96522	H26	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)  (For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)	XXX	0.21
•96523	H25	Irrigation of implanted venous access device for drug delivery systems  (Do not report 96523 if an injection or infusion is provided on the same day)	XXX	0.04
<del>96530</del>		<del>Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)</del>  <del>(For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)</del>  <del>(For collection of blood specimen form a completely implantable venous access device, use 36540)</del>  (96530 has been deleted. To report, use 96522)	XXX	N/A
96542	H27	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	XXX	0.75  (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
96545		<del>Provision of chemotherapy agent</del> <u>(96545 has been deleted.)</u>  <i>(For radioactive isotope therapy, use 79005)</i>		Carrier Priced
96549		<i>Unlisted chemotherapy procedure</i>	XXX	Carrier Priced

**AMA/Specialty Society RVS Update Committee**  
**Drug Administration Services**  
**October 4, 2004**

The American Medical Association/Specialty Society RVS Update Committee (RUC) met on September 30-October 2, 2004 and recommended relative values for a number of new and revised procedure codes to describe drug administration. The recommendations now will be sent to the Centers for Medicare and Medicaid Services (CMS) which has the final responsibility for assigning values for the new codes.

These coding revisions grew out of a provision in the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) which called for a review of the current drug administration codes. Based on that directive, the CPT Editorial Panel, which maintains and updates the coding system most Medicare codes are based on, conducted an extensive review and made substantial modifications in the drug administration codes at the panel's August 2004 meeting. The RUC, which provides advice to CMS on relative values for new and revised codes, expedited its normal process in order to permit completion of the process in time for adoption of the new codes and values next year.

In making its recommendations, the RUC considered proposed work values and practice expense inputs submitted by a coalition of specialties, including: oncology, hematology, infectious disease, gastroenterology, urology and rheumatology. These proposals were developed by consensus panels and based on previous RUC recommendations for drug administration and other services that could serve as a reference point in discussing the work and practice expense associated with the new codes for drug administration.

Although their recommendations varied by service, the specialties' proposal called for an overall increase in work relative values for drug administration services above the level one new patient office visit required in the MMA. Practice expense direct inputs (clinical staff, medical supplies and equipment) also were revised to incorporate the coding revisions and as part of these revisions, the groups proposed to add certain elements of clinical staff time that are part of a standard package utilized across other services.

The RUC, and a facilitation committee of RUC participants, spent more than 15 hours over a three day period reviewing and discussing the specialties' proposed values. In general, the RUC agreed that physician supervision and interactions with nursing staff did warrant physician work relative values for these services, and that for many of the specific codes, this work is more intense than the physician work assigned to a level one office visit. Practice expense inputs suggested by the affected specialties and accepted by the RUC generally were based on a 2002 review of these expenses by the RUC and its Practice Expense Advisory Committee (PEAC). However, the RUC will recommend several modifications to incorporate the new coding structure. For example, the clinical staff time required for mixing additional chemotherapy drugs was included in the recommendations.

Although the RUC's recommendations, if adopted by CMS, are expected to have a positive impact on drug administration payments, the degree to which these changes will offset other revenue losses associated with the MMA is not yet known. Practice expense values are the primary factor in determining payment for these services and the direct inputs suggested by the RUC are only one piece in CMS's complex formula for determining practice expense values.

The RUC's recommendations will be finalized and submitted to CMS on Friday, October 8. It is anticipated that CMS will announce its decisions regarding the RUC recommendations in the November 1, 2004 *Final Rule* for the 2005 Physician Payment Schedule.

## Medicine

### **Therapeutic or Diagnostic Infusions (Excludes Chemotherapy)**

These codes encompass prolonged intravenous infusions.

These codes require the presence of the physician during the infusion. These codes are not to be used for intradermal, subcutaneous, intramuscular or routine IV drug injections. For these services, see 90782-90788.

These codes may not be used in addition to prolonged services codes.

90780 Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour

+90781 each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)

(Use 90781 in conjunction with code 90780)

(Codes 90780 and 90781 have been deleted. To report, see 90760, 90761)

### **Hydration, Injections, Therapeutic or Diagnostic Infusions (Excludes Chemotherapy)**

Physician work related to hydration, injection and infusion services predominantly involves treatment planning and direct supervision of staff.

If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported utilizing modifier 25 in addition to 90765-90779. For same day E/M service a different diagnosis is not required.

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

a. Use of local anesthesia

b. IV start

c. Access to indwelling IV, subcutaneous catheter or port

d. flush at conclusion of infusion

e. standard tubing, syringes and supplies

(For clotting a catheter or port, see 36550)

When multiple drugs are administered, report the service(s) and the specific materials or drugs for each.

When administering multiple infusions, injections or combinations, only one "initial" service code should be reported, unless protocol requires that two separate IV sites must be utilized. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported (e.g. the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code).

## **Hydration**

Codes 90760-90761 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-½ normal saline+30mEq KCl/liter), but are not used to report infusion of drugs or other substances. Hydration IV infusions typically require direct physician supervision for purposes of consent, safety oversight or intra-service supervision of staff. Typically such infusions require little special handling to prepare or dispose of, and staff which administer these don't typically require advanced practice training. After initial set-up, infusion typically entails little patient risk and thus little monitoring.

- 90760 (H1) Intravenous infusion, hydration; initial, up to one hour
- +90761 (H2) each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)

(Use 90760 in conjunction with code 90761)

(Report 90761 for hydration infusion intervals of greater than thirty minutes beyond one hour increments, or hydration greater than thirty minutes provided as a secondary or sequential service after a different initial infusion or chemotherapy service is provided)

Do not report 90760 if performed as a concurrent infusion service.

## **Therapeutic and Diagnostic Injections**

A therapeutic or diagnostic IV infusion (90765-90768) (other than hydration) is for the administration of substances/drugs. The fluid used to administer the drug(s) is incidental hydration and is not separately reportable. These services typically require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically, such infusions require special consideration to prepare, dose or dispose of, require practice training and competency for staff who administer the infusions, and infusions require periodic patient assessment with vital sign monitoring during the infusion

(Do not report 90765-90775 with codes (including 96401-96549) for which IV push or infusion is an inherent part of the procedure (e.g. administration of contrast material for a diagnostic imaging study))

- 90765 (H3) Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour
- +90766 (H5) each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)
- +90767 (H4) additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)

(Report 90766, 90767 in conjunction with code 90765)

(Report 90767 for additional hour(s) of sequential infusion)

(Report 90766 for infusion intervals of greater than thirty minutes beyond one hour increments)

(Report 90766 or 90767 to identify additional hour(s) of substance/drug infusion, or 90761 for hydration infusion, if provided as a secondary or subsequent service after a different initial service is provided)

- +90768 (H6) concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration)

(Report 90768 in conjunction with code 90765 or 96413)

Intravenous or intra-arterial push is defined as an injection/infusion of short duration (i.e. thirty minutes or less) in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient.

- 90772 (H7) Therapeutic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

(For administration of vaccines/toxoids, see 90471-90472)

(Report 90772 for non-antineoplastic hormonal therapy injections)

(Report 96401 for anti-neoplastic hormonal injection therapy)

- 90773 (H8) intra-arterial

- 90774 (H9) intravenous push, single or initial substance/drug

(90772-90774 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95115-95117)

- +●90775 (H10) each additional sequential intravenous push (List separately in addition to code for primary procedure)

(Use 90775 in conjunction with code 90774)

(Use 90775 to report an intravenous push subsequent or concurrent to a hydration or therapeutic/diagnostic infusion)

- 90779 Unlisted therapeutic, prophylactic or diagnostic injection, or intravenous or intra-arterial, injection or infusion

(For allergy immunizations, see 95004 et seq)

### **~~Therapeutic, Prophylactic or Diagnostic Injections~~**

- ~~90782 Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular~~

~~(For administration of vaccines/toxoids, see 90471-90472)~~

~~(90782 has been deleted. To report, use 90772)~~

- ~~90783 intra-arterial~~

(90783 has been deleted. To report, use 90773)

~~90784~~ ~~intravenous~~

~~(90782-90784 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95115-95117)~~

(90784 has been deleted. To report, use 90774)

~~90788~~ ~~Intramuscular injection of antibiotic (specify)~~

(90788 has been deleted; to report, use 90772)

~~(90790-90796 have been deleted. To report, see 95990, 96408-96414, 96420-96425, 96440, 96450, 96530, 96545, 96549)~~

~~90799~~ ~~Unlisted therapeutic, prophylactic or diagnostic injection~~

~~(For allergy immunizations, see 95004 et seq)~~

(90799 has been deleted. To report, use 90779)

## Medicine

### Chemotherapy Administration

~~Procedures 96400-96549 are independent of the patient's visit.~~

Chemotherapy administration codes 96401-96549 apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of non-cancer diagnoses (eg, cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents and other biologic response modifiers. These services can be provided by any physician. Chemotherapy services are typically highly complex and require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician about these issues.

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

a. Use of local anesthesia

b. IV start

c. Access to indwelling IV, subcutaneous catheter or port

d. flush at conclusion of infusion

e. standard tubing, syringes and supplies

f. preparation of chemotherapy agent(s)

(For declotting a catheter or port, see 36550)

Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. Medications (eg, antibiotics, steroidal agents, antiemetics, narcotics, analgesics) administered independently or sequentially as supportive management of chemotherapy administration, should be separately reported using 90760, 90761, 90765, 90766, 90767, 90768, 90772, 90773, 90774, 90775, 90779 as appropriate.

Report both the specific service as well as code(s) for the specific substance(s) or drug(s) provided.

When administering multiple infusions, injections or combinations, only one "initial" service code should be reported, unless protocol requires that two separate IV sites must be utilized. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported (e.g. the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code).

If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported utilizing modifier 25 in addition to 96400-96401-96549. For same day E/M service, a different diagnosis is not required.

Either may occur independently on any date of service, or they may occur sequentially on the same day.

Preparation of chemotherapy agent(s) is included in the service for administration of the agent.

*Regional (isolation) chemotherapy perfusion should be reported using the codes for intra-arterial infusion (96420-96425). Placement of the intra-arterial catheter should be reported using the appropriate code from the Cardiovascular Surgery section.*

*Placement of arterial and venous cannula(s) for extracorporeal circulation via a membrane oxygenator perfusion pump should be reported using code 36823. Code 36823 includes dose calculation and administration of the chemotherapy agent by injection into the perfusate. Do not report code(s) 96408-96409-96425 in conjunction with code 36823.*

~~Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. Medications (eg, antibiotics, steroidal agents, antiemetics, narcotics, analgesics, biological agents) administered independently or sequentially as supportive management of chemotherapy administration, should be separately reported using 90780-90788, as appropriate.~~

(For Home Infusion services, see 99601-99602)

## Injection and Intravenous Infusion Chemotherapy

- 96400      ~~Chemotherapy administration, subcutaneous or intramuscular with or without local anesthesia~~  
(Code 96400 has been deleted. To report, see 96401, 96402)
- 96401 (H11) Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
- 96402 (H12)      hormonal anti-neoplastic
- ▲96405      Chemotherapy administration; intralesional, up to and including 7 lesions
- ▲96406      intralesional, more than 7 lesions
- ~~96408~~      ~~Chemotherapy administration, intravenous; push technique~~  
(96408 has been deleted. To report, use 96409)
- 96409 (H13)      intravenous, push technique, single or initial substance/drug
- ~~96410~~      ~~intravenous infusion technique; up to one hour~~  
(96410 has been deleted. To report, use 96413)
- †●96411 (H14)      intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)  
(Use 96411 in conjunction with code 96409)
- †~~96412~~      ~~infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)~~  
(Use 96412 in conjunction with code 96410)  
(96412 has been deleted. To report, use 96415)
- ~~96414~~      ~~infusion technique, initiation of prolonged infusion (more than 8 hours), requiring use of a portable or implantable pump~~  
(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96520, 96530)  
(96414 has been deleted. To report, use 96416)

●96413 (H15) Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug

+●96415 (H16) each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)

(Use 96415 in conjunction with 96413)

(Report 96415 for infusion intervals of greater than thirty minutes beyond one hour increments)

(Report 90761 to identify hydration, or 90767 to identify nonchemotherapy drug infusion, if provided as a secondary or subsequent service in association with 96413)

●96416 (H17) initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump

(For insertion of pump, use 36563)

(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96521, 96522, 96523)

+●96417 (H18) each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure)

(Use 96417 in conjunction with code 96413; report only once per sequential infusion; report 96415 for additional hour(s) of sequential infusion)

### **Intra-Arterial Chemotherapy**

96420 (H19) *Chemotherapy administration, intra-arterial; push technique*

96422 (H20) *infusion technique, up to one hour*

▲ +96423 (H21) *infusion technique, each additional hour, one to eight hours, each ~~additional hour~~ (List separately in addition to code for primary procedure)*

*(Use 96423 in conjunction with 96422)*

(Report 96423 for infusion intervals of greater than thirty minutes beyond one hour increments)

*(For regional chemotherapy perfusion via membrane oxygenator perfusion pump to an extremity, use 36823)*

96425 (H22) *infusion technique, initiation of prolonged infusion (more than eight hours), requiring the use of a portable or implantable pump*

(For insertion of pump, use 36260)

*(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96520, 96521, 96522, 96523 96530)*

### **Other Chemotherapy**

(See 36555-36597 for related intravascular access services)

96440 *Chemotherapy administration into pleural cavity, requiring and including thoracentesis*

96445 *Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis*

96450 (H23) *Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture*

*(For intravesical (bladder) chemotherapy administration, see 51720)*

*(For insertion of subarachnoid catheter and reservoir for infusion of drug, see 62350, 62351, 62360, 62361, 62362; for insertion of intraventricular catheter and reservoir, see 61210, 61215)*

~~96520~~ — ~~Refilling and maintenance of portable pump~~  
~~(96520 has been deleted. To report, use 96521)~~

●96521 (H24) Refilling and maintenance of portable pump

●96522 (H26) Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)

(For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)

(For collection of blood specimen from a completely implantable venous access device, use 36540)

●96523 (H25) Irrigation of implanted venous access device for drug delivery systems

(Do not report 96523 if an injection or infusion is provided on the same day)

~~96530~~ — ~~Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)~~

~~(For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)~~

~~(For collection of blood specimen from a completely implantable venous access device, use 36540)~~

(96530 has been deleted. To report, use 96522)

96542 (H27) *Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents*

96545 *Provision of chemotherapy agent*

(96545 has been deleted)

96549 *Unlisted chemotherapy procedure*

## FINAL RUC WORK RECOMMENDATIONS FOR DRUG ADMINISTRATION CODES

	Hydration				Therapeutic/Diagnostic				Chemotherapy			
	CPT	ID	RVU	Time*	CPT	ID	RVU	Time*	CPT	ID	RVU	Time*
Initial infusion, up to 1 hr	90760	H1	0.17	2/3/2	90765	H3	0.21	2/5/2	96413	H15	0.28	4/7/2
each add'l hr	90761	H2	0.09	0/3/0	90766	H5	0.18	0/3/0	96415	H16	0.19	0/5/0
additional sequential infusion, up to 1 hr					90767	H4	0.19	1/5/0	96417	H18	0.21	2/6/0
concurrent infusion					90768	H6	0.17	1/3/0				
Injection, single/initial					90772	H7	0.17	2/3/2	96401	H11	0.21	4/3/2
									96402	H12	0.19	4/3/2
IV push					90774	H9	0.18	2/5/2	96409	H13	0.24	4/5/2
each add'l push					90775	H10	0.10	1/3/0	96411	H14	0.20	3/4/0
<i>Other chemo:</i>												
Initiation of prolonged chemo									96416	H17	0.21	4/4/2
Portable pump refill/maintenance									96521	H24	0.21	4/4/2
Irrigation implanted venous access device									96523	H25	0.04	2/0/0
Implantable pump/reservoir refill/maint									96522	H26	0.21	4/4/2

\* Times: pre/intra/post

\*\* Physician time for these codes reflect the direct supervision and interactions with clinical staff, rather than face-to-face with the patient.

**Projected Utilization for Drug Administration Services October 2004**

Surveyed CPT Code	How was service previously reported	Specialty Breakdown	For previously reported code, %age performed by each specialty in 2002 (from Medicare claims)	# Times Performed in 2002 (from Medicare claims)	How often do physicians in your specialty perform this service?	Projected number of times code will be reported
<b>90760</b>	<b>90780</b>	ACR <sub>h</sub>	5.49%	128,569	Sometimes	1,000
<b>H1</b>		AGA	0.28%	6,557	Sometimes	984
		ASCO/ASH*	65.45%	1,532,757	Commonly	306,551
		IDSA	5.53%	129,506	Sometimes	6,475
		All other specialties	23.25%	544,486	Varies	108,897
		<b>TOTAL</b>	<b>100.00%</b>	<b>2,341,876</b>	<b>N/A</b>	<b>423,907</b>
<b>90761</b>	<b>90781</b>	ACR <sub>h</sub>	14.49%	195,356	Sometimes	1,000
<b>H2</b>		AGA	0.61%	8,224	Sometimes	1,234
		ASCO/ASH*	46.99%	633,524	Commonly	306,551
		IDSA	4.35%	58,647	Sometimes	8,797
		All other specialties	33.56%	452,459	Varies	90,492
		<b>TOTAL</b>	<b>100.00%</b>	<b>1,348,210</b>	<b>N/A</b>	<b>408,074</b>
<b>90765</b>	<b>90780</b>	ACR <sub>h</sub>	5.49%	128,569	Rarely	0
<b>H3</b>		AGA	0.28%	6,557	Rarely	328
		ASCO/ASH*	65.45%	1,532,757	Commonly	1,226,206
		IDSA	5.53%	129,506	Sometimes	116,555
		All other specialties	23.25%	544,486	Varies	530,295
		<b>TOTAL</b>	<b>100.00%</b>	<b>2,341,876</b>	<b>N/A</b>	<b>1,873,384</b>
<b>90767</b>	<b>N/A</b>	ASCO/ASH* (90781)	N/A	N/A	Sometimes	122,620
<b>H4</b>		IDSA (90781)	N/A	N/A	Sometimes	38,121
		All other specialties	N/A	N/A	Varies	29,273
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>190,014</b>
<b>90766</b>	<b>90781</b>	ACR <sub>h</sub>	14.49%	195,356	Rarely	0
<b>H5</b>		AGA	0.61%	8,224	Rarely	411
		ASCO/ASH*	46.99%	633,524	Commonly	506,819
		IDSA	4.35%	58,647	Sometimes	11,729
		All other specialties	33.56%	452,459	Varies	534,049
		<b>TOTAL</b>	<b>100.00%</b>	<b>1,348,210</b>	<b>N/A</b>	<b>1,052,597</b>
<b>90768</b>	<b>N/A</b>	ASCO/ASH*	N/A	N/A	Sometimes	2,000
<b>H6</b>		IDSA (90780)	N/A	N/A	Sometimes	6,475
		All other specialties	N/A	N/A	Varies	2,000
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>10,475</b>

\*For the purposes of projecting utilization, Medicare frequency data for medical oncology, hematology, and hematology/oncology were combined.

Projected Utilization for Drug Administration Services October 2004						
Surveyed CPT Code	How was service previously reported	Specialty Breakdown	For previously reported code, %age performed by each specialty in 2002 (from Medicare claims)	# Times Performed in 2002 (from Medicare claims)	How often do physicians in your specialty perform this service?	Projected number of times code will be reported
90772	90782	ACRrh	2.46%	63,738	Sometimes	63,738
H7		ASCO/ASH*	31.23%	809,165	Commonly	809,165
		All other specialties	66.31%	1,718,084	Varies	1,718,084
		<b>TOTAL</b>	<b>100.00%</b>	<b>2,590,988</b>	<b>N/A</b>	<b>2,590,987</b>
90774	90784	ACRrh	1.32%	829	Sometimes	829
H9		ASCO/ASH*	52.35%	32,884	Sometimes	32,884
		All other specialties	46.33%	29,102	Varies	29,102
		<b>TOTAL</b>	<b>100.00%</b>	<b>62,815</b>	<b>N/A</b>	<b>62,815</b>
90775	N/A	ASCO/ASH*	N/A	N/A	Sometimes	49,326
H10		All other specialties	N/A	N/A	Varies	43,653
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>92,979</b>
96401	96400	ASCO/ASH*	17.35%	134,309	Sometimes	75,213
H11		All other specialties	82.65%	639,805	Varies	2,411
		<b>TOTAL</b>	<b>100.00%</b>	<b>774,114</b>	<b>N/A</b>	<b>77,624</b>
96402	96400	ASCO/ASH*	17.35%	134,309	Sometimes	59,096
H12		AUA	76.62%	593,126	Commonly	540,000
		All other specialties	6.03%	46,679	Varies	96,703
		<b>TOTAL</b>	<b>100.00%</b>	<b>774,114</b>	<b>N/A</b>	<b>695,799</b>
96409	96408	ASCO/ASH*	86.77%	550,288	Commonly	550,288
H13		All other specialties	13.23%	83,904	Varies	83,904
		<b>TOTAL</b>	<b>100.00%</b>	<b>634,192</b>	<b>N/A</b>	<b>634,192</b>
96411	N/A	ASCO/ASH*	N/A	N/A	Commonly	220,115
H14		All other specialties	N/A	N/A	Varies	33,562
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>253,677</b>

\*For the purposes of projecting utilization, Medicare frequency data for medical oncology, hematology, and hematology/oncology were combined.

**Projected Utilization for Drug Administration Services October 2004**

Surveyed CPT Code	How was service previously reported	Specialty Breakdown	For previously reported code, %age performed by each specialty in 2002 (from Medicare claims)	# Times Performed in 2002 (from Medicare claims)	How often do physicians in your specialty perform this service?	Projected number of times code will be reported
<b>96413</b>	<b>90780</b>	ACR <sub>h</sub>	5.49%	128,569	Sometimes	127,569
<b>H15</b>		AGA	0.28%	6,557	Sometimes	5,246
		ASCO/ASH*	65.45%	1,532,757	N/A	see below
		All other specialties	28.78%	673,992	Varies	17,654
		<b>(Sub)Total minus ASCO/ASH</b>	<b>34.55%</b>	<b>809,118</b>	<b>N/A</b>	<b>150,469</b>
	<b>96410</b>	ASCO/ASH*	85.81%	1,515,887	Commonly	1,515,887
		ACR <sub>h</sub>	0.01%	177	N/A	see above
		AGA	0.02%	353	N/A	see above
		All other specialties minus ACR <sub>h</sub> and AGA	14.16%	250,262	Varies	250,262
		<b>(Sub)Total minus ACR<sub>h</sub> and AGA</b>	<b>99.97%</b>	<b>1,766,856</b>	<b>N/A</b>	<b>1,766,856</b>
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>1,917,325</b>
<b>96415</b>	<b>90781</b>	ACR <sub>h</sub>	14.49%	195,356	Sometimes	194,356
<b>H16</b>		AGA	0.61%	8,224	Sometimes	6,579
		ASCO/ASH*	46.99%	633,524	N/A	see below
		All other specialties	37.91%	511,106	Varies	13,289
		<b>(Sub)Total minus ASCO/ASH</b>	<b>53.01%</b>	<b>714,686</b>	<b>N/A</b>	<b>214,224</b>
	<b>96412</b>	ASCO/ASH*	84.95%	1,325,833	Commonly	662,917
		ACR <sub>h</sub>	0.01%	156	N/A	see above
		AGA	0.04%	624	N/A	see above
		All other specialties	15.00%	234,117	Varies	117,059
		<b>(Sub)Total minus ACR<sub>h</sub> and AGA</b>	<b>99.95%</b>	<b>1,559,999</b>	<b>N/A</b>	<b>779,976</b>
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>994,200</b>
<b>96416</b>	<b>96414</b>	ASCO/ASH*	86.17%	23,074	Sometimes	23,074
<b>H17</b>		All other specialties	13.83%	3,703	Varies	3,703
		<b>TOTAL</b>	<b>100.00%</b>	<b>26,777</b>	<b>N/A</b>	<b>26,777</b>
<b>96417</b>	<b>964X2</b>	ASCO/ASH*	N/A	N/A	Commonly	1,061,121
<b>H18</b>		All other specialties	N/A	N/A	Varies	125,396
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>1,186,517</b>
<b>96521</b>	<b>96520</b>	ASCO/ASH*	71.99%	24,123	Sometimes	24,123
<b>H24</b>		All other specialties	28.01%	9,386	Varies	9,386
		<b>TOTAL</b>	<b>100.00%</b>	<b>33,509</b>	<b>N/A</b>	<b>33,509</b>
<b>96523</b>	<b>96530</b>	ASCO/ASH*	44.12%	80,546	Sometimes	64,437
<b>H25</b>		All other specialties	55.88%	102,016	Varies	81,613
		<b>TOTAL</b>	<b>100.00%</b>	<b>182,562</b>	<b>N/A</b>	<b>146,050</b>

\*For the purposes of projecting utilization, Medicare frequency data for medical oncology, hematology, and hematology/oncology were combined.

<b>Projected Utilization for Drug Administration Services October 2004</b>						
<b>Surveyed CPT Code</b>	<b>How was service previously reported</b>	<b>Specialty Breakdown</b>	<b>For previously reported code, %age performed by each specialty in 2002 (from Medicare claims)</b>	<b># Times Performed in 2002 (from Medicare claims)</b>	<b>How often do physicians in your specialty perform this service?</b>	<b>Projected number of times code will be reported</b>
<b>96522</b>	<b>96530</b>	<b>ASCO/ASH*</b>	<b>44.12%</b>	<b>80,546</b>	<b>Sometimes</b>	<b>16,109</b>
<b>H26</b>		<b>All other specialties</b>	<b>55.88%</b>	<b>102,016</b>	<b>Varies</b>	<b>20,403</b>
		<b>TOTAL</b>	<b>100.00%</b>	<b>182,562</b>	<b>N/A</b>	<b>36,512</b>

\*For the purposes of projecting utilization, Medicare frequency data for medical oncology, hematology, and hematology/oncology were combined.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

**CPT Family:** Hydration and Therapeutic and Diagnostic Infusions of Non-chemotherapy per attached spreadsheet (90760-90775)

Sample Size: N/A Response Rate: (%): N/A Global Period: xxx

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**ASCO, ASH, ACRh, AGA, IDSA, and AUA convened to review practice expense inputs for the 90760-90775 family of codes. The groups used as a basis for discussion the March 2002 PEAC approved inputs for this family. The group considered input from two oncology certified nurses and considered recommendations outlined by the Community Oncology Alliance task force.**

**(Background on the March 2002 PEAC recommendations: ASCO and ASH first convened a panel of nurses, who perform these procedures on a daily basis, to determine the inputs for clinical staff time and procedure-specific medical supplies and equipment. The data were then carefully scrutinized by a consensus panel of experts who approved the inputs. Both of these panels included a combination of rural, suburban, and urban practices; solo, single and multi-specialty groups, as well as medical school faculty were represented. The AUA and the Endocrine Society reviewed and accepted the inputs that were recommended in 2002.)**

Please describe the clinical activities of your staff:

**Pre-Service Clinical Labor Activities: The RN/OCN escorts patient to chemo chair and completes a pre-chemotherapy check to insure that patient is able to receive treatment. The nurse prepares the drug(s) and educates patient on adverse effects.**

**Intra-Service Clinical Labor Activities: The nurse administers drug to the patient and monitors response to treatment throughout. Nurse consults with supervising physician during course of treatment.**

**Post-Service Clinical Labor Activities: The nurse continues to monitor the patient after treatment is completed. S/he documents the treatment in the medical record and reviews instructions with patient. The nurse makes follow up phone calls to the patient and others with whom care is being coordinated.**

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

**CPT Family:** Therapeutic and Diagnostic Infusions and Injections of Chemotherapy per attached spreadsheet (96401 – 96522)

Sample Size: N/A Response Rate: (%): N/A Global Period: xxx

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**ASCO, ASH, ACRh, AGA, IDSA, and AUA convened to review practice expense inputs for the 96401-96522 family of codes. The groups used as a basis for discussion the March 2002 PEAC approved inputs for this family. The group considered input from two oncology certified nurses and considered recommendations outlined by the Community Oncology Alliance task force.**

**(Background on the March 2002 PEAC recommendations: ASCO and ASH first convened a panel of nurses, who perform these procedures on a daily basis, to determine the inputs for clinical staff time and procedure-specific medical supplies and equipment. The data were then carefully scrutinized by a consensus panel of experts who approved the inputs. Both of these panels included a combination of rural, suburban, and urban practices; solo, single and multi-specialty groups, as well as medical school faculty were represented. The AUA and the Endocrine Society reviewed and accepted the inputs that were recommended in 2002.)**

Please describe the clinical activities of your staff:

**Pre-Service Clinical Labor Activities: The RN/OCN escorts patient to chemo chair and completes pre-chemotherapy check to insure that patient is able to receive treatment. The nurse prepares the drug(s) and educates patient on adverse effects.**

**Intra-Service Clinical Labor Activities: The nurse administers drug to the patient and monitors for toxicity throughout. Nurse consults with supervising physician during course of treatment.**

**Post-Service Clinical Labor Activities: The nurse continues to monitor the patient after treatment is completed. S/he documents the treatment in the medical record and reviews instructions with patient. The nurse makes follow up phone calls to the patient and others with whom care is being coordinated.**

	A	B	C	D	E	F	I	J	M	N
1			2004 Recommendation H11		2004 Recommendation H12		2004 Recommendation H13		2004 Recommendation H14	
2		Tracking #								
3		CPT code	96401		96402		96409		96411	
4		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic		Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic		Chemotherapy administration; intravenous, push technique, single or initial substance/drug		Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure) (Use 964X1 in conjunction with code 96408)	
5	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
6	GLOBAL PERIOD		XXX	XXX	XXX	XXX	XXX	XXX	ZZZ	ZZZ
7	TOTAL CLINICAL LABOR TIME		59	45	45	45	85	46	46	46
8	STAFF TYPE L051A=RN, L056A=RN/OCN		L056A	L051A	L051A	L056A	L056A	L056A	L056A	L056A
9	Total Pre-time		6	6	6	6	6	0	0	0
10	Total Intra-time		50	36	36	73	46	46	46	46
11	Total Post-time		3	3	3	6	0	0	0	0
12	<b>PRE-SERVICE PERIOD</b>									
13	Start: Following visit when decision for surgery or procedure made									
14	Complete pre-service diagnostic & referral forms		3	3	3	3	3	0	0	0
15	Coordinate pre-surgery services		3	3	3	3	3	0	0	0
16	Office visit before surgery/procedure: Review test and exam results		0	0	0	0	0	0	0	0
17	Provide pre-service education/obtain consent		0	0	0	0	0	0	0	0
18	Follow-up phone calls & prescriptions		0	0	0	0	0	0	0	0
19	Other Clinical Activity (please specify)		0	0	0	0	0	0	0	0
20	End: When patient enters office for surgery/procedure		0	0	0	0	0	0	0	0
21	<b>SERVICE PERIOD</b>									
22	Start: When patient enters office for surgery/procedure	RN/OCN								
23	Pre-service services									
24	treatment & obtain chemotherapy-related medical hx	L056A	4	2	2	4	0	0	0	0
25	Greet patient and provide gowning		2	2	2	2	0	0	0	0
26	Obtain vital signs		3	3	3	3	3	0	0	0
27	education of 1 hr amortized over average of 6 cycles)		5	5	5	8	2	2	2	2
28	Prepare room, equipment, supplies		2	2	2	2	0	0	0	0
29	Prepare and position patient and mix chemotherapy		2	2	2	2	2	0	0	0
30	te/apply anesthesia		13	8	8	19	19	19	19	19
31	-service		0	0	0	0	0	0	0	0
32	perform procedure or Assist physician in performing procedure		1	1	1	15	15	15	15	15
33	Post-Service									
34	Monitor pt. following service/check tubes, monitors, drains		5	0	0	5	5	5	5	5
35	Clean room/equipment by physician staff		3	3	3	3	0	0	0	0
36	Complete medical record documentation, diagnostic forms, lab & X-ray requisitions		5	3	3	5	2	2	2	2
37	Review/read X-ray, lab, and pathology reports		0	0	0	0	0	0	0	0
38	Post procedure education /conditions for which patient should call office (side effects, complications) home care instructions /coordinate office visits /prescriptions		5	5	5	5	0	0	0	0
39	End: Patient leaves office									
40	<b>POST-SERVICE PERIOD</b>									
41	Start: Patient leaves office									
42	Conduct phone calls/call in prescriptions		3	3	3	6				
43	Office visits Greet patient, escort to room; provide gowning; interval history & vital signs and chart, assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care									
44	List Number and Level of Office Visits									
45	99211 16 minutes									
46	99212 27 minutes									
47	99213 36 minutes									
48	99214 53 minutes									
49	99215 63 minutes									
50	Other									
51	Total Office Visit Time									
52	Conduct phone calls between office visits									
53	Other Activity (please specify)									
54	End: with last office visit before end of global period									
55	<b>LOCAL SUPPLIES</b>									
56	gown, non-sterile, sheet 40in x 60in	SB005					0			
57	gown, patient	SB026								
58	paper, exam table	SB036	7	7	7					
59	gloves, non-sterile	SB022		1	1	1	1	1	1	1
60	gloves, sterile	SB024								
61	gloves, non-sterile, nitrile	SB023	1			0	0	0	0	0
62	gown, staff, impervious	SB027	1			1	1	1	1	1
63	cover, thermometer probe	SB004	1	1	1					
64	swab-pad, alcohol	SJ053	1	1	1	2	2	2	2	2
65	povidone swabsticks (3 pack uou)	SJ043								

A	B	C		D		E		F		I		J		M	N
	Tracking #	2004 Recommendation H11		2004 Recommendation H12		2004 Recommendation H13		2004 Recommendation H14							
	CPT code	96401		96402		96409		96411							
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic		Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic		Chemotherapy administration; intravenous, push technique, single or initial substance/drug		Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure) (Use 964X1 in conjunction with code 96408)							
	LOCATION	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office		
1	bandage, strp 0.75in x 3in	SG021	1		1			1							
1	needle, 19-25g, butterfly	SC030						1				1			
1	infusion pump cassette-reservoir	SC013													
1	iv infusion set	SC018						1				1			
1	synnqe w-needle, OSHA compliant (SafetyGlide)	SC058	1					3				1			
0	synnqe 10-12ml	SC051	1					1				1			
1	synnqe 1ml	SC052	1					1				1			
2	synnqe 20ml	SC053						1							
3	synnqe 50-60ml	SC056						1							
4	water, sterile inj	SH075	1					2				1			
5	angiocatheter 14g-24g	SC001													
8	sodium chlonde 0.9% inj bactenostatic (30ml uou)	SH068													
7	gauze, non-sterile 2in x 2in	SG050	2		2										
8	dressing, 4in x 4.75in (Tegaderm)	SG037													
9	sten-stmp (6 strip uou)	SG074													
0	iv tubing (extension)	SC019													
1	battery, 9 volt	SK010													
2	synnqe 3ml	SC055													
3	albumin saline	SH004													
4	stop cock, 3-way	SC041													
5	synnqe 30 ml	SC054													
6	blood collection bag	SC004													
7	eye shield, non-fox	SG049						0							
8	sodium chlonde, 99.0% min.	SL126													
9	bandage, elastic, self-adherent wrap 1in (Coban)	SG014													
0	pack, minimum multi-specialty visit	SA048						0							
1	needle, Huber point	SC039													
2	Synnqe with needle, OSHA compliant	SC058			0										
3	tray, lumbar puncture	SA065													
4	graham crackers, 1 packet	SK040													
5	juice, apple, 1 oz	SK042													
6	cup, drnking	SK018													
7	hepann 1,000 units-ml inj	SH039						1				1			
8	Equipment														
9	biohazard hood (\$7,612.00)		15					15				15			
0	chemo couch	E91004						71				1			
1	infusion pump	E91001													
2	exam table	E1001	46		1										

	A	B	O	P	S	T	W	X	AA	AB
1			2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation	
2		Tracking #	H15		H16		H17		H18	
3		CPT code	96413		96415		96416		96417	
4		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug		Chemotherapy administration, intravenous infusion technique; each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)(Use 96412 in conjunction with 96410)		Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump		Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure)	
5	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
6	GLOBAL PERIOD		XXX		ZZZ		XXX		ZZZ	
7	TOTAL CLINICAL LABOR TIME		98		20		108		49	
8	STAFF TYPE L051A=RN, L056A=RN/OCN		L056A		L056A		L056A		L056A	
9	Total Pre-time		6		0		6		0	
10	Total Intra-time		86		20		96		49	
11	Total Post-time		6		0		6		0	
12	PRE-SERVICE									
13	Start: Following visit when decision for surgery or procedure made									
14	Complete pre-service diagnostic & referral forms		3		0		3		0	
15	Coordinate pre-surgery services		3		0		3		0	
16	Office visit before surgery/procedure. Review test and exam results		0		0		0		0	
17	Provide pre-service education/obtain consent		0		0		0		0	
18	Follow-up phone calls & prescriptions		0		0		0		0	
19	Other Clinical Activity (please specify)		0		0		0		0	
20	End:When patient enters office for surgery/procedure		0		0		0		0	
21	SERVICE PERIOD									
22	Start: When patient enters office for surgery/procedure	RN/OCN								
23	Pre-service services									
24	treatment & obtain chemotherapy-related medical hx	L056A	4		0		4		0	
25	Greet patient and provide gowning		2		0		2		0	
26	Obtain vital signs		3		3		3		3	
27	education of 1 hr amortized over average of 6 cycles)		8		0		8		0	
28	Prepare room, equipment, supplies		2		0		2		0	
29	Prepare and position patient and max chemotherapy		2		0		2		0	
	ate/apply anesthesia		20		0		28		18	
	a-service		0		0		0		0	
49	perform procedure or Assist physician in performing procedure		27		17		19		23	
62	Post-Service									
63	Monitor pt. following service/check tubes, monitors, drains		5		0		5		5	
64	Clean room/equipment by physician staff		3		0		3		0	
65	Complete medical record documentation, diagnostic forms, lab & X-ray requisitions		5		0		5		0	
66	Review/read X-ray, lab, and pathology reports		0		0		0		0	
67	Post procedure education /conditions for which patient should call office (side effects, complications) home care instructions /coordinate office visits /prescriptions		5		0		15		0	
68	End: Patient leaves office									
69	POST-SERVICE PERIOD									
70	Start: Patient leaves office									
71	Conduct phone calls/call in prescriptions		6				6			
72	Office visits: Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam, assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care									
73	List Number and Level of Office Visits									
74	99211 16 minutes									
75	99212 27 minutes									
76	99213 36 minutes									
77	99214 53 minutes									
78	99215 63 minutes									
79	Other									
80	Total Office Visit Time									
81	Conduct phone calls between office visits									
82	Other Activity (please specify)									
	End: with last office visit before end of global period									
	MEDICAL SUPPLIES									
	ape, non-sterile, sheet 40in x 60in	SB006	0				1			
	gown, patient	SB026								
87	paper, exam table	SB036								
88	gloves, non-sterile	SB022	1						1	
89	gloves, sterile	SB024					1		0	
90	gloves, non-sterile, nitrile	SB023	0				0		0	
91	gown, staff, impervious	SB027	1				1		0	
92	cover, thermometer probe	SB004	1		1				1	
93	swab-pad, alcohol	SJ053	2				3		3	
94	powdnone swabsticks (3 pack uou)	SJ043					1		1	

A	B	O	P	S	T	W	X	AA	AB
	Tracking #	2004 Recommendation H15		2004 Recommendation H16		2004 Recommendation H17		2004 Recommendation H18	
	CPT code	96413		96415		96416		96417	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug		Chemotherapy administration, intravenous infusion technique; each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)(Use 96412 in conjunction with 96410)		Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump		Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure)	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
bandage, strp 0.75in x 3in	SG021	1							
needle, 19-25g, butterfly	SC030	1							
infusion pump cassette-reservoir	SC013	1				1			
iv infusion set	SC018	1						1	
1 syringe w-needle, OSHA compliant (SafetyGlide)	SC058	3				3		2	
0 syringe 10-12ml	SC051	1				2		2	
1 syringe 1ml	SC052	1							
2 syringe 20ml	SC053	1				2		2	
3 syringe 50-60ml	SC056	1							
4 water, sterile inj	SH075	2							
5 angiocatheter 14g-24g	SC001								
6 sodium chloride 0.9% inj bactenostatic (30ml uou)	SH068					1		1	
7 gauze, non-sterile 2in x 2in	SG050					2		2	
8 dressing, 4in x 4.75in (Tegaderm)	SG037					1		0	
9 sten-strip (6 strip uou)	SG074					1		1	
0 iv tubing (extension)	SC019	1							
1 battery, 9 volt	SK010					2			
2 syringe 3ml	SC055								
3 albumin saline	SH004								
4 stop cock, 3-way	SC041								
5 syringe 30 ml	SC054								
6 blood collection bag	SC004								
7 eye shield, non-fax	SG049	0				0		0	
8 sodium chloride, 99.0% min.	SL126	1				1		1	
9 bandage, elastic, self-adherent wrap 1in (Coban)	SG014								
0 pack, minimum multi-specialty visit	SA048	0				0		0	
1 needle, Huber point	SC039			0				0	
2 Syringe with needle, OSHA compliant	SC058								
3 tray, lumbar puncture	SA065								
4 graham crackers, 1 packet	SK040	1		1					
5 juice, apple, 1 oz	SK042	6		6					
6 cup, drinking	SK018	1		1					
7 hepann 1,000 units-ml inj	SH039	1		1		1		1	
8 equipment									
9 biohazard hood (\$7,612.00)		22				31		22	
10 chemo couch	E91004	83				100		60	
11 infusion pump	E91001	83						60	
12 exam table	E1001								

A	B	AC	AD	AG	AH	AI	AJ
1		2004 Recommendation		2004 Recommendation		2004 Recommendation	
2	Tracking #	H24		H25		H26	
3	CPT code	96521		96523		96522	
4	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Refilling and maintenance of portable pump		Irrigation of implanted venous access device for drug delivery systems (Do not report 9652X if an injection or infusion is provided on the same day)		Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	
5	LOCATION	In Office	Out Office	In Office	Out Office	In Office	Out Office
6	GLOBAL PERIOD	XXX		XXX		XXX	
7	TOTAL CLINICAL LABOR TIME	82		16		85	
8	STAFF TYPE L051A=RN, L056A=RN/OCN	L056A		L056A			
9	Total Pre-time	6		0		6	
10	Total Intra-time	70		16		73	
11	Total Post-time	6		0		6	
12	<b>PRE-SERVICE</b>						
13	Start: Following visit when decision for surgery or procedure made						
14	Complete pre-service diagnostic & referral forms	3		0		3	
15	Coordinate pre-surgery services	3		0		3	
16	Office visit before surgery/procedure: Review test and exam results	0		0		0	
17	Provide pre-service education/obtain consent	0		0		0	
18	Follow-up phone calls & prescriptions	0		0		0	
19	Other Clinical Activity (please specify)	0		0		0	
20	End: When patient enters office for surgery/procedure	0		0		0	
21	<b>SERVICE PERIOD</b>						
22	Start: When patient enters office for surgery/procedure	RN/OCN					
23	Pre-service services						
24	treatment & obtain chemotherapy-related medical hx	L056A	4	2		5	
25	Greet patient and provide gowning		2	2		2	
26	Obtain vital signs		3	3		3	
27	education of 1 hr amortized over average of 6 cycles)		3	0		4	
28	Prepare room, equipment, supplies		2	2		2	
29	Prepare and position patient and mix chemotherapy		2	2		2	
30	mix chemotherapy		28	0		17	
31	date/apply anesthesia		0	0		0	
32	Pre-service						
33	Perform procedure or Assist physician in performing procedure		8	5		20	
34	<b>Post-Service</b>						
35	Monitor pt. following service/check tubes, monitors, drains		5	0		5	
36	Clean room/equipment by physician staff		3	0		3	
37	Complete medical record documentation, diagnostic forms, lab & X-ray requisitions		5	0		5	
38	Review/read X-ray, lab, and pathology reports		0	0		0	
39	Post procedure education /conditions for which patient should call office (side effects, complications) home care instructions /coordinate office visits /prescriptions		5	0		5	
40	End: Patient leaves office						
41	<b>POST-SERVICE PERIOD</b>						
42	Start: Patient leaves office						
43	Conduct phone calls/call in prescribers		6			6	
44	Office visits. Greet patient, escort to room, provide gowning; interval history & vital signs and chart, assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care						
45	<b>List Number and Level of Office Visits</b>						
46	99211 16 minutes						
47	99212 27 minutes						
48	99213 36 minutes						
49	99214 53 minutes						
50	99215 63 minutes						
51	Other						
52	<b>Total Office Visit Time</b>						
53	Conduct phone calls between office visits						
54	Other Activity (please specify)						
55	End: with last office visit before end of global period						
56	<b>DRUG SUPPLIES</b>						
57	gown, non-sterile, sheet 40in x 60in	SB006	1	1		1	
58	gown, patient	SB026					
59	paper, exam table	SB036		7			
60	gloves, non-sterile	SB022	1	1		1	
61	gloves, sterile	SB024	1	1		1	
62	gloves, non-sterile, nitrile	SB023	0	0		0	
63	gown, staff, impervious	SB027	1	0		1	
64	cover, thermometer probe	SB004					
65	swab-pad, alcohol	SJ053					
66	povidone swabsticks (3 pack uou)	SJ043					

A	B	AC	AD	AG	AH	AI	AJ
	Tracking #	2004 Recommendation H24		2004 Recommendation H25		2004 Recommendation H26	
	CPT code	96521		96523		96522	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Refilling and maintenance of portable pump		Irrigation of implanted venous access device for drug delivery systems (Do not report 9652X if an injection or infusion is provided on the same day)		Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office
5 bandage, stnp 0.75in x 3in	SG021			1		1	
6 needle, 19-25g, butterfly	SC030						
7 infusion pump cassette-reservoir	SC013	1					
8 iv infusion set	SC018						
9 syringe w-needle, OSHA compliant (SafetyGlide)	SC058	2		2		3	
10 syringe 10-12ml	SC051	2		2		2	
11 syringe 1ml	SC052						
12 syringe 20ml	SC053	2					
13 syringe 50-60ml	SC056						
14 water, sterile inj	SH075						
15 angiocatheter 14g-24g	SC001						
16 sodium chloride 0.9% inj bectenostatic (30ml uou)	SH068	1		1		1	
17 gauze, non-sterile 2in x 2in	SG050			1		1	
18 dressing, 4in x 4.75in (Tegaderm)	SG037			1			
19 sten-stnp (6 stnp uou)	SG074						
20 iv tubing (extension)	SC019					1	
1 battery, 9 volt	SK010	2					
2 syringe 3ml	SC055						
3 albumin saline	SH004						
4 stop cock, 3-way	SC041					1	
5 syringe 30 ml	SC054					1	
6 blood collection bag	SC004						
7 eye shield, non-fox	SG049	0		0		0	
8 sodium chloride, 99 0% min.	SL126						
9 bandage, elastic, self-adherent wrap 1in (Coban)	SG014						
10 pack, minimum multi-specialty visit	SA048	0		0		0	
11 needle, Huber point	SC039	0					
12 Syringe with needle, OSHA compliant	SC058						
13 tray, lumbar puncture	SA065						
14 graham crackers, 1 packet	SK040						
15 juice, apple, 1 oz	SK042						
16 cup, drinking	SK018						
17 heparin 1,000 units-ml inj	SH039			1			
18 Equipment							
19 biohazard hood (\$7,612.00)		31				22	
20 chemo couch	E91004	73				79	
21 infusion pump	E91001						
22 exam table	E1001			20			

A	B	C		D		E		F		G		H		K	L
1		2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation			
2	Tracking #	H1		H2		H3		H4							
3	CPT code	90760		90761		90765		90767							
4	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Intravenous infusion, hydration; initial, up to one hour		Intravenous infusion, hydration; each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure) (Use 90780X2 in conjunction with code 90780X1)		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)							
5	LOCATION	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office		
6	GLOBAL PERIOD	xxx		zzz		XXX		ZZZ							
7	TOTAL CLINICAL LABOR TIME	40		10		50		22							
8	Staff Type L056A=RN/OCN	L056A		L056A		L056A		L056A							
9	Total Pre-time	3		0		6		0							
10	Total Intra-time	34		10		41		22							
11	Total Post-time	3		0		3		0							
12	<b>PRE-SERVICE</b>														
13	Start: Following visit when decision for surgery or procedure made														
14	Complete pre-service diagnostic & referral forms	0		0		3		0							
15	Coordinate pre-surgery services	3		0		3		0							
16	Office visit before surgery/procedure: Review test and exam results	0		0		0		0							
17	Provide pre-service education/obtain consent	0		0		0		0							
18	Follow-up phone calls & prescriptions	0		0		0		0							
19	Other Clinical Activity (please specify)	0		0		0		0							
20	End:When patient enters office for surgery/procedure														
21	<b>SERVICE PERIOD</b>														
22	Start: When patient enters office for surgery/procedure														
23	Pre-service services														
24	Review charts - obtain medical history	2		0		2		0							
25	Greet patient and provide gowning	2		0		2		0							
26	Obtain vital signs	3		3		3		3							
27	Provide pre-service education/obtain consent	3		0		3		0							
28	Prepare room, equipment, supplies	2		0		2		0							
29	Prepare and position patient and mix drug	2		0		2		0							
30	Administer drug	0		0		7		7							
31	Induce/apply anesthesia	0		0		0		0							
32	Perform procedure	10		7		12		9							
33	<b>Post-Service</b>														
34	Monitor pt. following service/check tubes, monitors, drains	2		0		0		0							
35	Clean room/equipment by physician staff	3		0		3		0							
36	Complete medical record documentation	2		0		2		3							
37	Review/read X-ray, lab, and pathology reports	0		0		0		0							
38	Post procedure education / Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	3		0		3		0							
39	End: Patient leaves office														
40	<b>POST-SERVICE PERIOD</b>														
41	Start: Patient leaves office														
42	Conduct phone calls/call in prescriptions	3		0		3		0							
43	Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results; assist physician during exam. assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care														
44	List Number and Level of Office Visits														
45	99211 16 minutes														
46	99212 27 minutes														
47	99213 36 minutes														
48	99214 53 minutes														
49	99215 63 minutes														
50	Other														
51	Total Office Visit Time														
52	Conduct phone calls between office visits														
53	Other Activity (please specify)														
54	End: with last office visit before end of global period														

A	B	C	D	E	F	G	H	K	L
	CPT code	90760		90761		90765		90767	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Intravenous infusion, hydration; initial, up to one hour		Intravenous infusion, hydration; each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure) (Use 90780X2 in conjunction with code 90780X1)		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
<b>MEDICAL SUPPLIES</b>									
1	drape, non-sterile, sheet 40in x 60in	SB006							
1	gown, patient	SB026							
1	paper, exam table	SB036	7			7			
1	gloves, non-sterile	SB022	2			2		1	
1	gloves, sterile	SB024				0		0	
1	gloves, non-sterile, nitrile	SB023							
1	gown, staff, impervious	SB027							
1	cover, thermometer probe	SB004	1			1			
1	swab-pad, alcohol	SJ053	2			2			
1	povidone swabsticks (3 pack uou)	SJ043							
1	bandage, stmp 0.75in x 3in	SG021	1			1			
1	needle, 19-25g, butterfly	SC030							
1	infusion pump cassette-reservoir	SC013							
1	iv infusion set	SC018	1			1			
1	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	1			1			
1	syringe 10-12ml	SC051	1			1			
1	syringe 1ml	SC052							
1	syringe 20ml	SC053							
1	syringe 50-60ml	SC056							
1	water, sterile inj	SH075	0			0			
1	angiocatheter 14g-24g	SC001	1			1			
1	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068							
1	gauze, non-sterile 2in x 2in	SG050	2			2			
1	dressing, 4in x 4.75in (Tegaderm)	SG037							
1	steri-strip (6 stmp uou)	SG074							
1	iv tubing (extension)	SC019							
1	battery, 9 volt	SK010							
1	syringe 3ml	SC055							
1	albumin saline	SH004							
1	stop cock, 3-way	SC041							
1	syringe 30 ml	SC054							
1	blood collection bag	SC004							
1	eye shield, non-fox	SG049	0			0			
1	sodium chloride, 99.0% mn.	SL126							
1	bandage, elastic, self-adherent wrap 1in (Coban)	SG014	1			1			
<b>Equipment</b>									
1	biohazard hood (\$7612.00)					0		0	
1	chemo couch	E91004							
1	infusion pump	E91001	1			1		1	
1	exam table	E11001	1			1		1	

A	B	O	P	Q	R
1		2004 Recommendation		2004 Recommendation	
2	Tracking #	H5		H6	
3	CPT code	90766		90768	
4	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Intravenous infusion, for therapy/diagnosis, (specify substance or drug); each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration)	
5	LOCATION	In Office	Out Office	In Office	Out Office
6	GLOBAL PERIOD	ZZZ		ZZZ	
7	TOTAL CLINICAL LABOR TIME	12		11	
8	Staff Type L056A=RN/OCN	L056A		L056A	
9	Total Pre-time	0		0	
10	Total Intra-time	12		11	
11	Total Post-time	0		0	
12	<b>PRE-SERVICE</b>				
13	Start: Following visit when decision for surgery or procedure made				
14	Complete pre-service diagnostic & referral forms	0		0	
15	Coordinate pre-surgery services	0		0	
16	Office visit before surgery/procedure: Review test and exam results	0		0	
17	Provide pre-service education/obtain consent	0		0	
18	Follow-up phone calls & prescriptions	0		0	
19	Other Clinical Activity (please specify)	0		0	
20	End: When patient enters office for surgery/procedure				
21	<b>SERVICE PERIOD</b>				
22	Start: When patient enters office for surgery/procedure				
23	Pre-service services				
24	Review charts - obtain medical history	0		0	
25	Greet patient and provide gowning	0		0	
26	Obtain vital signs	3		0	
27	Provide pre-service education/obtain consent	0		0	
28	Prepare room, equipment, supplies	0		0	
29	Prepare and position patient and mix drug	0		0	
30	Inject drug	0		6	
31	Induce/apply anesthesia	0		0	
32	Perform procedure	9		3	
33	Post-Service				
34	Monitor pt. following service/check tubes, monitors, drains	0		2	
35	Clean room/equipment by physician staff	0		0	
36	Complete medical record documentation	0		0	
37	Review/read X-ray, lab, and pathology reports	0		0	
38	Post procedure education / Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	0		0	
39	End: Patient leaves office				
40	<b>POST-SERVICE PERIOD</b>				
41	Start: Patient leaves office				
42	Conduct phone calls/call in prescriptions	0		0	
43	Office visits: Greet patient, escort to room; provide gowning, interval history & vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care				
44	List Number and Level of Office Visits				
45	99211 16 minutes				
46	99212 27 minutes				
47	99213 36 minutes				
48	99214 53 minutes				
49	99215 63 minutes				
50	Other				
51	Total Office Visit Time				
52	Conduct phone calls between office visits				
53	Other Activity (please specify)				
54	End: with last office visit before end of global period				

A	B	O	P	Q	R
	CPT code	90766		90768	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Intravenous infusion, for therapy/diagnosis, (specify substance or drug); each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration)	
LOCATION		In Office	Out Office	In Office	Out Office
<b>MEDICAL SUPPLIES</b>					
4	drape, non-sterile, sheet 40in x 60in	SB006			
5	gown, patient	SB026			
7	paper, exam table	SB036			
9	gloves, non-sterile	SB022	1		
9	gloves, sterile	SB024			
0	gloves, non-sterile, nitrile	SB023			
1	gown, staff, impervious	SB027			
2	cover, thermometer probe	SB004			
3	swab-pad, alcohol	SJ053			
4	povidone swabsticks (3 pack uou)	SJ043			
5	bandage, strip 0.75in x 3in	SG021			
6	needle, 19-25g, butterfly	SC030			
7	infusion pump cassette-reservoir	SC013			
8	iv infusion set	SC018			
9	syringe w-needle, OSHA compliant (SafetyGlide)	SC058			
0	syringe 10-12ml	SC051			
1	syringe 1ml	SC052			
2	syringe 20ml	SC053			
3	syringe 50-60ml	SC056			
4	water, sterile inj	SH075			
5	angiocatheter 14g-24g	SC001			
6	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068			
7	gauze, non-sterile 2in x 2in	SG050			
8	dressing, 4in x 4.75in (Tegaderm)	SG037			
9	steri-strip (6 strip uou)	SG074			
0	iv tubing (extension)	SC019			
1	battery, 9 volt	SK010			
2	syringe 3ml	SC055			
3	albumin saline	SH004			
4	stop cock, 3-way	SC041			
5	syringe 30 ml	SC054			
6	blood collection bag	SC004			
7	eye shield, non-fox	SG049			
8	sodium chloride, 99.0% min.	SL126			
9	bandage, elastic, self-adherent wrap 1in (Coban)	SG014			
0	<b>Equipment</b>				
1	biohazard hood (\$7612.00)			0	
2	chemo couch	E91004			
3	infusion pump	E91001	1		
4	exam table	E11001	1		

A	B	S	T	W	X	AA	AB
1		2004 Recommendation		2004 Recommendation		2004 Recommendation	
2	Tracking #	H7		H9		H10	
3	CPT code	90772		90774		90775	
4	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Therapeutic, or diagnostic injection (specify material injected substance or drug); subcutaneous or intramuscular		Therapeutic, or diagnostic injection (specify material injected substance or drug); intravenous push, single or initial substance/drug		Therapeutic, or diagnostic injection (specify material injected substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)	
5	LOCATION	In Office	Out Office	In Office		In Office	Out Office
6	GLOBAL PERIOD	XXX		XXX		ZZZ	
7	TOTAL CLINICAL LABOR TIME	32		41		16	
8	Staff Type L056A=RN/OCN	L056A		L056A		L056A	
9	Total Pre-time	3		6		0	
10	Total Intra-time	26		32		16	
11	Total Post-time	3		3		0	
12	<b>PRESERVICE</b>						
13	Start: Following visit when decision for surgery or procedure made						
14	Complete pre-service diagnostic & referral forms	3		3		0	
15	Coordinate pre-surgery services	0		3		0	
16	Office visit before surgery/procedure: Review test and exam results	0		0		0	
17	Provide pre-service education/obtain consent	0		0		0	
18	Follow-up phone calls & prescriptions	0		0		0	
19	Other Clinical Activity (please specify)	0		0		0	
20	End: When patient enters office for surgery/procedure						
21	<b>SERVICE PERIOD</b>						
22	Start: When patient enters office for surgery/procedure						
23	Pre-service services						
24	Review charts - obtain medical history	2		2		0	
25	Greet patient and provide gowning	2		2		0	
26	Obtain vital signs	0		3		3	
27	Provide pre-service education/obtain consent	3		3		0	
28	Prepare room, equipment, supplies	2		2		0	
29	Prepare and position patient and mix drug	2		2		0	
30	Inject drug	6		5		5	
31	Induce/apply anesthesia	0		0		0	
32	Intra-service						
33	Perform procedure	1		8		6	
34	Post-Service						
35	Monitor pt. following service/check tubes, monitors, drains	0		3		2	
36	Clean room/equipment by physician staff	3		0		0	
37	Complete medical record documentation	2		2		0	
38	Review/read X-ray, lab, and pathology reports	0		0		0	
39	Post procedure education / Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	3		0		0	
40	End: Patient leaves office						
41	<b>POST-SERVICE PERIOD</b>						
42	Start: Patient leaves office						
43	Conduct phone calls/call in prescriptions	3		3		0	
44	Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care						
45	List Number and Level of Office Visits						
46	99211 16 minutes						
47	99212 27 minutes						
48	99213 36 minutes						
49	99214 53 minutes						
50	99215 63 minutes						
51	Other						
52	Total Office Visit Time					0	
53	Conduct phone calls between office visits						
54	Other Activity (please specify)						
55	End: with last office visit before end of global period						

A	B	S	T	W	X	AA	AB
	CPT code	90772		90774		90775	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Therapeutic, or diagnostic injection (specify material injected substance or drug); subcutaneous or intramuscular		Therapeutic, or diagnostic injection (specify material injected substance or drug); intravenous push, single or initial substance/drug		Therapeutic, or diagnostic injection (specify material injected substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)	
LOCATION		In Office	Out Office	In Office		In Office	Out Office
<b>MEDICAL SUPPLIES</b>							
1	drape, non-sterile, sheet 40in x 60in	SB006					
	gown, patient	SB026					
	paper, exam table	SB036					
1	gloves, non-sterile	SB022	1		1	1	
	gloves, sterile	SB024					
	gloves, non-sterile, nitrile	SB023					
	gown, staff, impervious	SB027					
	cover, thermometer probe	SB004	1		1		
	swab-pad, alcohol	SJ053	1		1	2	
	povidone swabsticks (3 pack uou)	SJ043					
	bandage, strip 0.75in x 3in	SG021	1		1		
	needle, 19-25g, butterfly	SC030					
	infusion pump cassette-reservoir	SC013					
	iv infusion set	SC018					
	synnqe w-needle, OSHA compliant (SafetyGlide)	SC058	1		1	1	
	syringe 10-12ml	SC051			1	1	
	synnqe 1ml	SC052					
	synnqe 20ml	SC053					
	syringe 50-60ml	SC056					
	water, sterile inj	SH075					
	angiocatheter 14g-24g	SC001			1		
	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068					
	gauze, non-sterile 2in x 2in	SG050			2		
	dressing, 4in x 4.75in (Tegaderm)	SG037					
	steri-strip (6 strip uou)	SG074					
	iv tubing (extension)	SC019					
1	battery, 9 volt	SK010					
2	synnqe 3ml	SC055	1		1	1	
3	albumin saline	SH004					
4	stop cock, 3-way	SC041					
5	synnqe 30 ml	SC054					
6	blood collection bag	SC004					
7	eye shield, non-fox	SG049	0		0		
8	sodium chloride, 99.0% min.	SL126					
9	bandage, elastic, self-adherent wrap 1in (Coban)	SG014			1		
<b>Equipment</b>							
1	biohazard hood (\$7612.00)		0				
2	chemo couch	E91004					
3	infusion pump	E91001					
4	exam table	E11001	13		1		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:90760 Tracking Number: H1 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .17

RUC RVU: 0.17

CPT Descriptor: Intravenous infusion, hydration; initial, up to one hour

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 49 year old female has a diagnosis of viral gastroenteritis. Intravenous hydration is prescribed. A peripheral IV line needs to be established.

Percentage of Survey Respondents who found Vignette to be Typical: 43%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 36%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

**Description of Post-Service Work:**

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD AGA – Joel Brill, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD IDSA - Lawrence Martinelli, MD
<b>Specialty(s):</b>	American College of Rheumatology (ACRh) American Gastroenterological Association (AGA) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) Infectious Diseases Society of America (IDSA)

<b>CPT Code:</b> 90760					
<b>Sample Size:</b> 377	<b>Resp n:</b> 111		<b>Response:</b> %		
<b>Sample Type:</b> Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.10	0.45	1.00	1.50	15.00
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	1.00	5.00	10.00	15.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>5.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99214	XXX	1.10

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	..45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23      % of respondents: 20.7 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 90760	Key Reference CPT Code: 99214
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	10.00	25.00
Median Immediate Post-service Time	5.00	13.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	25.00	38.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.11	2.96
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.99	2.88
Urgency of medical decision making	3.24	2.71

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.54	2.46
Physical effort required	2.36	2.28

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.94	2.56
Outcome depends on the skill and judgment of physician	2.96	2.86
Estimated risk of malpractice suit with poor outcome	2.87	2.66

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.81	2.57
Intra-Service intensity/complexity	2.79	2.73
Post-Service intensity/complexity	2.66	2.49

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

**CONSENSUS PANEL RECOMMENDATIONS**

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

**Consensus Panel Time Recommendation**

Pre: 2 minutes

Intra: 5 minutes RUC modified to 3 minutes

Post: 2 minutes

Total Time: 9 minutes The RUC modified to 7 minutes

Consensus Panel Work Recommendation: .17 RVU

**CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION**

The Consensus Panel compared CPT code 90760 to other RUC-surveyed codes.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed codes that provided additional support for the reasonableness of the recommendation.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

The Consensus Panel also discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel composed of physicians from multiple specialties concluded that they had made a reasonable argument for a value of .17 RVU for CPT code 90760. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. BASE CODE: 90760; ADD-ON CODE: +90761

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) SEE ATTACHMENT SUBMITTED SEPARATELY

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

- Specialty                      How often?
- Specialty                      How often?
- Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

- Specialty                      Frequency 0                      Percentage 0.00 %
- Specialty                      Frequency 0                      Percentage 0.00 %
- Specialty                      Frequency 0                      Percentage %

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? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90780.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +90761 Tracking Number: H2 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .13

RUC RVU: 0.09

CPT Descriptor: Intravenous infusion, hydration; each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure) (Use +90761 in conjunction with code 90760)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 49 year old female with a diagnosis of viral gastroenteritis has two liters of IV hydration prescribed. At the end of the first hour another 1500cc remain to be infused and the infusion is continued. (This is an add-on code: the 90780X1 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 64%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- No physician pre-service work

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

**Description of Post-Service Work:**

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD AGA – Joel Brill, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD IDSA - Lawrence Martinelli, MD
<b>Specialty(s):</b>	American College of Rheumatology (ACR <sup>h</sup> ) American Gastroenterological Association (AGA) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) Infectious Diseases Society of America (IDSA)
<b>CPT Code:</b>	+90761

<b>Sample Size:</b> 377	<b>Resp n:</b> 74	<b>Response:</b> 19.62 %			
<b>Sample Type:</b> Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.10	0.17	0.44	1.06	3.28
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	1.00	3.00	5.00	10.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>5.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

**CPT Descriptor** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

**CPT Descriptor 1** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

**CPT Descriptor 2** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23      % of respondents: 31.0 %

**TIME ESTIMATES (Median)**

<b>TIME ESTIMATES (Median)</b>	<b>New/Revised CPT Code: +90761</b>	<b>Key Reference CPT Code: 99211</b>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	7.00

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.54	2.40
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.35	2.27
--	------	------

Urgency of medical decision making	2.61	2.38
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.25	2.13
--------------------------	------	------

Physical effort required	2.04	2.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.63	2.19
---	------	------

Outcome depends on the skill and judgment of physician	2.62	2.38
--	------	------

Estimated risk of malpractice suit with poor outcome	2.53	2.35
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.45	2.27
----------------------------------	------	------

Intra-Service intensity/complexity	2.39	2.25
------------------------------------	------	------

Post-Service intensity/complexity	2.53	2.14
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA), conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA), and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 0 minutes

Intra: 5 minutes RUC modified to 3 minutes

Post: 0 minutes

Total Time: 5 minutes RUC modified to 3 minutes

Consensus Panel Work Recommendation: .13 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Consensus Panel compared CPT code 90760 to other RUC-surveyed codes.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90760.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (+90761 - .13RVU)

By extension, +90780X2, which is an add-on code to 90760, was felt to deserve a lower RVU and this is reflected in the RVU value chosen. Since +90761 is billed in conjunction with 90760, there is no pre- or post-service time with this code. The Consensus Panel also discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel composed of physicians from multiple specialties concluded that they had made a reasonable argument for a value of .13 RVU for CPT code +90761. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are 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. ASE CODE: 90780X1; ADD-ON CODE: +90761

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) ATTACHMENT SUBMITTED SEPARATELY

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty                                      How often?

Specialty                                      How often?

Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period?  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90781.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:90765 Tracking Number: H3 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: .24  
RUC RVU: 0.21

CPT Descriptor: Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); initial, up to one hour

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 69 year old male presents with a history of a left olecranon bursitis due to oxacillin-resistant Staphylococcus aureus. He is receiving daily infusions on an outpatient basis and has been clinically improving. A PICC line has been previously established (placement of the PICC line is reported separately).

Percentage of Survey Respondents who found Vignette to be Typical: 57%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

**Description of Post-Service Work:**

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
	ASH - Samuel H. Silver, MD, PhD				
	IDSA - Lawrence Martinelli, MD				
<b>Specialty(s):</b>	American Society of Hematology (ASH)				
	American Society of Clinical Oncology (ASCO)				
	Infectious Diseases Society of America (IDSA)				
<b>CPT Code:</b>	90765				
<b>Sample Size:</b>	174	<b>Resp n:</b>	46	<b>Response:</b> 26.43 %	
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>

<b>Survey RVW:</b>	0.11	0.49	<b>0.90</b>	1.49	3.00
<b>Pre-Service Evaluation Time:</b>			<b>10.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.0</b>		
<b>Intra-Service Time:</b>	2.00	5.00	<b>10.00</b>	15.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>6.00</b>				
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b>0.0</b>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b>0.0</b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10      % of respondents: 21.7 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 90765</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	10.00	5.00
Median Immediate Post-service Time	6.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	26.00	7.00

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.23	2.80
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	2.78
--	------	------

Urgency of medical decision making	3.07	2.60
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.61	2.28
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Physical effort required	2.24	2.02
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.72	2.69
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Outcome depends on the skill and judgment of physician	3.54	2.89
--	------	------

Estimated risk of malpractice suit with poor outcome	3.54	2.76
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.33	2.64
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Intra-Service intensity/complexity	3.04	2.78
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Post-Service intensity/complexity	2.91	2.51
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 2 minutes

Intra: 5 minutes

Post: 2 minutes

Total Time: 9 minutes

Consensus Panel Work Recommendation: .24 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (90765 - .24RVU)

This code represents up to one hour of infusion of a drug under the physician's supervision. The Intensity/Complexity Measures in the survey data reflect this increased level of service. The Consensus Panel further felt that the provision of a drug with the infusion justifies the increased RVU which was assigned to this code. There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .24 RVU for CPT code 90765. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. BASE CODE: 90765; ADD ON CODES USED WITH BASE CODE: +90767, +90766, +90768

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) ATTACHMENT TO BE SUBMITTED SEPARATELY

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty                                      How often?

Specialty                                      How often?

Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period?  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty                      Frequency                                      Percentage                      %

Specialty                      Frequency                                      Percentage                      %

Specialty                      Frequency                                      Percentage                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty                      Frequency                                      Percentage                      %

Specialty                      Frequency                                      Percentage                      %

Specialty                      Frequency                                      Percentage                      %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90780.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +90767 Tracking Number: H4 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .21

RUC RVU: 0.19

CPT Descriptor: Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70 year old female status post a ruptured colonic diverticula presents for infusion of two drugs. She has a single lumen PICC line in place. (This is an add-on code: the 9078X1 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 64%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician confirms orders

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
	ASH - Samuel H. Silver, MD, PhD				
	IDSA - Lawrence Martinelli, MD				
<b>Specialty(s):</b>	American Society of Hematology (ASH)				
	American Society of Clinical Oncology (ASCO)				
	Infectious Diseases Society of America (IDSA)				
<b>CPT Code:</b>	+90767				
<b>Sample Size:</b>	174	<b>Resp n:</b>	42	<b>Response:</b>	24.13 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.10	0.22	1.00	1.40	3.00
<b>Pre-Service Evaluation Time:</b>			6.0		
<b>Pre-Service Positioning Time:</b>			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		1.00	3.75	<b>5.50</b>	13.50	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>5.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13      % of respondents: 30.9 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: +90767</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	6.00	0.00
Median Intra-Service Time	5.50	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	16.50	7.00

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.15	2.88
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.15	2.90
--	------	------

Urgency of medical decision making	3.12	2.63
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.61	2.32
--------------------------	------	------

Physical effort required	2.17	2.02
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.39	2.60
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Outcome depends on the skill and judgment of physician	3.24	2.78
--	------	------

Estimated risk of malpractice suit with poor outcome	3.32	2.56
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	2.68
----------------------------------	------	------

Intra-Service intensity/complexity	2.95	2.75
------------------------------------	------	------

Post-Service intensity/complexity	2.92	2.63
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA), conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 1 minute

Intra: 5 minutes

Post: 0 minutes

Total Time: 6 minutes

Consensus Panel Work Recommendation: .21 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (+90767 - .21RVU)

This code describes the sequential infusion of a drug after the initial 90765 service. The physician work for this infusion parallels that of 90765, however the pre-service work is less, and the post-service work is accounted for in the base code, 90765. There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .21 RVU for CPT code +90767. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. BASE CODE: 90765; ADD-ON CODES: +90767, +90766, +90768

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) **TO BE SUBMITTED IN A SEPARATE ATTACHMENT**

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

- Specialty                      How often?
- Specialty                      How often?
- Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period?  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

- Specialty                      Frequency                      Percentage                      %
- Specialty                      Frequency                      Percentage                      %
- Specialty                      Frequency                      Percentage                      %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

- Specialty                      Frequency                      Percentage                      %
- Specialty                      Frequency                      Percentage                      %
- Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90781.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +90766 Tracking Number: H5 Global Period: ZZZ  
**Recommended Work Relative Value**  
 Specialty Society RVU: .21  
 RUC RVU: 0.18

CPT Descriptor: Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)  
 (Report +90767, 90766 in conjunction with code 90765)  
 (Report +90766 for additional hour(s) of sequential infusion)  
 (Report +90766 for infusion intervals of greater than thirty minutes beyond one hour increments)  
 (Report +90767 or +90766 to identify additional hour(s) of substance/drug infusion, or +90761 for hydration infusion, if provided as a secondary or subsequent service after a different initial service is provided)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 32 year old male insulin-dependent diabetic, who is status post renal transplantation, is receiving liposomal Amphotericin B infusion for Cryptococcus meningitis through an established PICC line. He is now to receive another hour of infusion. (This is an add-on code: the 9078X1 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- No physician pre-service work

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

**Description of Post-Service Work:**

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2005	
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD IDSA - Lawrence Martinelli, MD	
<b>Specialty(s):</b>	American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) Infectious Diseases Society of America (IDSA)	
<b>CPT Code:</b>	+90766	
<b>Sample Size:</b>	174	<b>Resp n:</b> 41 <b>Response:</b> 23.56 %
<b>Sample Type:</b>	Convenience	

	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.15	0.20	0.63	1.46	3.20
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	3.00	5.00	10.00	150.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>5.00</b>				
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b>0.0</b>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b>0.0</b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14      % of respondents: 34.1 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: +90766</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>15.00</b>	<b>7.00</b>

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.95	2.71
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.76	2.71
--	------	------

Urgency of medical decision making	2.98	2.40
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.54	2.29
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Physical effort required	2.12	1.98
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.28	2.56
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Outcome depends on the skill and judgment of physician	3.15	2.71
--	------	------

Estimated risk of malpractice suit with poor outcome	3.29	2.66
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.93	2.50
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Intra-Service intensity/complexity	3.00	2.58
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Post-Service intensity/complexity	2.75	2.40
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA), conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 0 minute

Intra: 5 minutes RUC modified to 3 minutes

Post: 0 minutes

Total Time: 5 minutes RUC modified to 3 minutes

Consensus Panel Work Recommendation: .21 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (+90766 - .21RVU)

This code describes the continuation of the infusion of a drug beyond the first hour. It is an add-on code to 90765, and thus the pre and post work is captured in the base code. There is a risk of adverse reaction for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .21 RVU for CPT code +90766. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. BASE CODE: 90765; +90767, +90766, +90768

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) **TO BE SUBMITTED IN A SEPARATE ATTACHMENT**

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

- Specialty                      How often?
- Specialty                      How often?
- Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

- Specialty                      Frequency 0                      Percentage                      %
- 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? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90781.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +90768 Tracking Number: H6 Global Period: ZZZ

**Recommended Work Relative Value**  
Specialty Society RVU: .17  
RUC RVU: **0.17**

CPT Descriptor: Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration).

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 73 year old patient with a diabetic ulcer and osteomyelitis presents for infusion. His wound culture was positive for several bacteria, including oxacillin-resistant Staphylococcus aureus. He is to receive an infusion of two antibiotics simultaneously through his previously established two lumen central catheter. (This is an add-on code: the 9078X1 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 66%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No.

**Description of Pre-Service Work:**

- Physician provides and confirms orders

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

**Description of Post-Service Work:**

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
	ASH - Samuel H. Silver, MD, PhD				
	IDSA - Lawrence Martinelli, MD				
<b>Specialty(s):</b>	American Society of Hematology (ASH)				
	American Society of Clinical Oncology (ASCO)				
	Infectious Diseases Society of America (IDSA)				
<b>CPT Code:</b>	+90768				
<b>Sample Size:</b>	174	<b>Resp n:</b>	35	<b>Response:</b> 20.11 %	
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.15	0.24	1.00	1.50	3.40
<b>Pre-Service Evaluation Time:</b>			9.0		

<b>Pre-Service Positioning Time:</b>				<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		1.00	3.00	<b>7.00</b>	14.25	100.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>5.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23      % of respondents: 66.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: +90768</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	9.00	0.00
Median Intra-Service Time	7.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>21.00</b>	<b>7.00</b>

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.43	2.94
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.00
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Urgency of medical decision making	3.34	2.80
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.94	2.57
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Physical effort required	2.34	2.17
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.77	2.77
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Outcome depends on the skill and judgment of physician	3.54	2.91
--	------	------

Estimated risk of malpractice suit with poor outcome	3.49	2.69
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.37	2.60
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Intra-Service intensity/complexity	3.09	2.63
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Post-Service intensity/complexity	3.11	2.49
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA), conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA), and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 1 minute

Intra: 3 minutes

Post: 0 minutes

Total Time: 4 minutes

Consensus Panel Work Recommendation: .22 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (+90768 - .22RVU)

This code describes the concurrent administration of more than one drug to a patient. Since it is to be used in conjunction with 90765, the pre-service work is thus partly accounted for by 90765, and there is no post-service work involved with this code. The Consensus Panel felt that the intensity of service due to the potential additive and/or toxicities, drug interactions and adverse effects of simultaneous drug administration justifies a higher RVU than for continuing or sequential drug administration. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .22 RVU for CPT code +90768. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)



**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90781.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:90772 Tracking Number: H7 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: .17  
RUC RVU: 0.17

CPT Descriptor: Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

(For administration of vaccines/toxoids, see 90471-90472)

(Report 90772 for non-antineoplastic hormonal therapy injections)

(Report 96401 for anti-neoplastic hormonal injection therapy)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 19 year old male presents with severe dysuria. A urethral swab is performed and found to be consistent with gonorrhea

Percentage of Survey Respondents who found Vignette to be Typical: 17%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

**Description of Post-Service Work:**

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD
<b>Specialty(s):</b>	American College of Rheumatology (ACRH) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)
<b>CPT Code:</b>	90772

<b>Sample Size:</b> 263	<b>Resp n:</b> 58	<b>Response:</b> 22.05 %			
<b>Sample Type:</b> Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.10	0.17	0.63	1.20	2.20
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	2.00	5.00	15.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>5.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 22      % of respondents: 38.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 90772</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	7.00

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.91	2.49
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.77	2.51
--	------	------

Urgency of medical decision making	2.77	2.37
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.33	2.25
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Physical effort required	2.12	2.09
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.89	2.40
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Outcome depends on the skill and judgment of physician	2.78	2.49
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Estimated risk of malpractice suit with poor outcome	2.86	2.42
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.61	2.25
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Intra-Service intensity/complexity	2.39	2.34
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Post-Service intensity/complexity	2.48	2.27
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 2 minute

Intra: 3 minutes

Post: 2 minutes

Total Time: 7 minutes

Consensus Panel Work Recommendation: .17 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (90772 - .17RVU)

The Consensus Panel agreed that a straightforward crosswalk to CPT code 99211 correctly reflected the level of physician work for this procedure and resulted in a reasonable value of .17 RVU. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .17 RVU for CPT code 90772. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty                      How often?  
 Specialty                      How often?  
 Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency	Percentage %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90782

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:90774 Tracking Number: H9 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: .20  
RUC RVU: 0.18

CPT Descriptor: Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug. (90772-90774 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95115-95117)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58 year old woman with no major underlying health problems presents for evaluation of nausea and vomiting, She is diagnosed with Gastroenteritis with mild dehydration. An intravenous anti-emetic is prescribed, along with one liter of IV hydration. (Liter of hydration is separately reported.)

Percentage of Survey Respondents who found Vignette to be Typical: 28%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American College of Rheumatology (ACRH) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	90774				
<b>Sample Size:</b>	263	<b>Resp n:</b>	64	<b>Response:</b>	24.33 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>

<b>Survey RVW:</b>	0.15	0.25	<b>0.72</b>	1.48	3.00
<b>Pre-Service Evaluation Time:</b>			<b>6.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.0</b>		
<b>Intra-Service Time:</b>	0.00	4.50	<b>6.50</b>	15.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b><u>5.00</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15      % of respondents: 23.0 %

**TIME ESTIMATES (Median)**

<b>TIME ESTIMATES (Median)</b>	<b>New/Revised CPT Code: 90774</b>	<b>Key Reference CPT Code: 99211</b>
Median Pre-Service Time	6.00	0.00
Median Intra-Service Time	6.50	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	17.50	7.00

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.44	2.73
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.09	2.70
--	------	------

Urgency of medical decision making	3.39	2.61
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.79	2.62
--------------------------	------	------

Physical effort required	2.46	2.34
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.47	2.69
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Outcome depends on the skill and judgment of physician	3.31	2.82
--	------	------

Estimated risk of malpractice suit with poor outcome	3.25	2.67
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.13	2.56
----------------------------------	------	------

Intra-Service intensity/complexity	3.05	2.67
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Post-Service intensity/complexity	2.80	2.41
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American College of Rheumatology (ACR<sup>h</sup>), American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA), and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 2 minute

Intra: 5 minutes

Post: 2 minutes

Total Time: 9 minutes

Consensus Panel Work Recommendation: .20 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (90774 - .20RVU)

This code describes the intravenous push of a drug. The Consensus Panel felt that the intensity of service for this code exceeds that of a saline hydration, but is not quite equivalent to that of the other infusion codes that include drug administration. The physician work includes pre-, intra- and post service physician time. There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .20 RVU for CPT code 90774. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.



**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90784.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +90775 Tracking Number: H10 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .16

RUC RVU: 0.10

CPT Descriptor: Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure). (Use +90775 in conjunction with code 90774)

(Report +90775 to report an intravenous push subsequent or concurrent to a hydration or therapeutic/diagnostic infusion)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58 year old woman with no major underlying health problems presents for evaluation of nausea and vomiting, diagnosed as having gastroenteritis with mild dehydration. An intravenous anti-emetic is prescribed, along with one liter of IV hydration. The nausea persists and the physician prescribes a benzodiazepine by IV push. (The physician evaluations are reported separately. Hydration is reported separately.) (This is an add-on code: the 90784 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 54%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician provides and confirms orders

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

**Description of Post-Service Work:**

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American College of Rheumatology (ACR <sup>h</sup> ) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	+90775				
<b>Sample Size:</b>	263	<b>Resp n:</b>	54	<b>Response:</b>	20.53 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>

<b>Survey RVW:</b>	0.15	0.25	<b>0.60</b>	1.48	5.00
<b>Pre-Service Evaluation Time:</b>			<b>5.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.0</b>		
<b>Intra-Service Time:</b>	0.00	3.00	<b>6.00</b>	15.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b><u>5.00</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12      % of respondents: 22.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: +90775</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	6.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	16.00	7.00

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.24	2.78
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.02	2.80
--	------	------

Urgency of medical decision making	3.42	2.69
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.89	2.68
--------------------------	------	------

Physical effort required	2.56	2.44
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.45	2.72
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Outcome depends on the skill and judgment of physician	3.37	2.83
--	------	------

Estimated risk of malpractice suit with poor outcome	3.37	2.65
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.02	2.48
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Intra-Service intensity/complexity	3.06	2.79
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Post-Service intensity/complexity	3.00	2.50
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American College of Rheumatology (ACR), American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 1 minute

Intra: 5 minutes RUC modified to 3 minutes

Post: 0 minutes

Total Time: 6 minutes RUC modified to 4 minutes

Consensus Panel Work Recommendation: .16 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M – Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (+90775 - .16 RVU)

This code describes the additional intravenous push of a drug after an initial intravenous push administration. The code is to be used in conjunction with 90774. The physician work for this infusion parallels that of 90774, however the pre-service work is less, and the post-service work is accounted for in the 90774, the base code. There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .16 RVU for CPT code +90775. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. BASE CODE: 90774; ADD-ON CODE: +90775

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) **TO BE SUBMITTED IN A SEPARATE ATTACHMENT**

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty                      How often?  
Specialty                      How often?  
Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty                      Frequency 0                      Percentage 0.00 %  
Specialty                      Frequency 0                      Percentage 0.00 %  
Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty                      Frequency 0                      Percentage 0.00 %  
Specialty                      Frequency 0                      Percentage 0.00 %  
Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90781.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96401 Tracking Number: H11 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .21

RUC RVU: 0.21

CPT Descriptor: Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 34-year old patient with testicular cancer who has the appropriate indications for chemotherapy.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? Yes

**Description of Pre-Service Work:**

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews lab results as necessary

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

**Description of Post-Service Work:**

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2005				
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
	ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American Society of Hematology (ASH)				
	American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	96401				
<b>Sample Size:</b>	145	<b>Resp n:</b>	40	<b>Response:</b>	27.58 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.17	0.41	0.95	1.50	2.58
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	1.00	5.00	5.00	10.00	40.00

<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>
<b>Immed. Post-time:</b>	<b>5.00</b>	
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0 99292x 0.0
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0 99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<b>0.0</b>	99238x 0.00 99239x 0.00
<b>Office time/visit(s):</b>	<b>0.0</b>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9      % of respondents: 22.5 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96401	Key Reference CPT Code: 99211
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	7.00

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.55	3.08
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.48	2.97
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Urgency of medical decision making	3.13	2.73
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.75	2.65
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Physical effort required	2.15	2.15
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.78	2.68
---	------	------

Outcome depends on the skill and judgment of physician	3.70	3.13
--	------	------

Estimated risk of malpractice suit with poor outcome	3.55	2.98
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.34	2.73
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Intra-Service intensity/complexity	2.98	2.90
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Post-Service intensity/complexity	2.95	2.60
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 4 minutes

Intra: 3 minutes

Post: 2 minutes

Total Time: 9 minutes

Consensus Panel Work Recommendation: .21RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 RVU for CPT code 96401.

Once the Workgroup agreed to the value of .21 RVU for 96401, the remaining codes in the family were discussed relative to this value.

There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .21 RVU for CPT code 96401. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

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) TOBE SUBMITTED IN A SEPARATE ATTACHMENT

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

- Specialty                                      How often?
- Specialty                                      How often?
- Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period?  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

- Specialty                      Frequency                      Percentage                      %
- Specialty                      Frequency                      Percentage                      %
- Specialty                      Frequency                      Percentage                      %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

- Specialty                      Frequency                      Percentage                      %
- Specialty                      Frequency                      Percentage                      %
- Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96408

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 96402 Tracking Number: H12 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .19

RUC RVU: 0.19

CPT Descriptor: Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72-year-old man with prostate cancer who has the appropriate indications for LHRH agonist therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 3%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

**Description of Post-Service Work:**

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ASH - Samuel H. Silver, MD, PhD AUA - Dr. Cooper and Dr. Regan				
<b>Specialty(s):</b>	American Society of Hematology (ASH) American Urological Association (AUA)				
<b>CPT Code:</b>	96402				
<b>Sample Size:</b>	729	<b>Resp n:</b>	62	<b>Response:</b>	8.50 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.17	0.45	0.60	1.10	3.80
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	5.00	5.00	10.00	30.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			

<b>Immed. Post-time:</b>	<u><b>5.00</b></u>	
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0 99292x 0.0
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0 99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00 99239x 0.00
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	0.45

**CPT Descriptor** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

**CPT Descriptor 1** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

**CPT Descriptor 2** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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**CPT Descriptor****RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21      % of respondents: 33.8 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96402	Key Reference CPT Code: 99212
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	10.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	15.00	15.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.93	3.32
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.95	2.76
Urgency of medical decision making	2.61	2.69

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.56	2.52
Physical effort required	2.44	3.08

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.61	3.08
Outcome depends on the skill and judgment of physician	2.82	3.18
Estimated risk of malpractice suit with poor outcome	2.66	2.72

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.79	2.63
Intra-Service intensity/complexity	2.82	2.66
Post-Service intensity/complexity	2.81	2.60

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Urological Association (AUA) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA), and the American Urological Association (AUA).

**CONSENSUS PANEL RECOMMENDATIONS**

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

**Consensus Panel Time Recommendation**

Pre: 4 minutes

Intra: 3 minutes

Post: 2 minutes

Total Time: 9 minutes

Consensus Panel Work Recommendation: .19RVU

**CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION**

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre=10/Intra=15/Post=5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 9640X1.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

**EVIDENCE FOR THIS RECOMMENDATION**

CPT code 96402 represents an intramuscular or subcutaneous injection of a hormonal chemotherapeutic agent. The work is identical to that described in 96401, as is the post-service work. Since the adverse effects of a hormonal agent are less than that of a chemotherapeutic agent and the surveyed mental effort and judgment and psychological stress reflect this as well, this code was valued less than 96401.

There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .19 RVU for CPT code 96402. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) **FREQUENCY DATA TO BE SUBMITTED AS SEPARATE ATTACHMENT**

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

- Specialty                                      How often?
- Specialty                                      How often?
- Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period?  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96408.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96409 Tracking Number: H13 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .27

RUC RVU: **0.24**

CPT Descriptor: Chemotherapy administration, subcutaneous or intramuscular; intravenous, push technique, single or initial substance/drug

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 67 year old male with bladder cancer presents for an IV push The patient does not have a venous access device and requires an IV initiation.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews any appropriate lab results as necessary
- Physician calculates dose

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

**Description of Post-Service Work:**

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	96409				
<b>Sample Size:</b>	145	<b>Resp n:</b>	41	<b>Response:</b>	28.27 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.17	0.50	0.90	1.33	3.75
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		2.00	5.00	<b>10.00</b>	15.00	55.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>7.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	0.45

**CPT Descriptor** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

**CPT Descriptor 1** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

**CPT Descriptor 2** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13      % of respondents: 31.7 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96409	Key Reference CPT Code: 99212
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	10.00	10.00
Median Immediate Post-service Time	7.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	27.00	15.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.00
Urgency of medical decision making	3.46	2.83

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.58	2.90
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Physical effort required	2.73	2.35
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.20	2.93
Outcome depends on the skill and judgment of physician	4.08	3.10
Estimated risk of malpractice suit with poor outcome	3.78	2.90

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.75	2.75
Intra-Service intensity/complexity	3.35	2.93
Post-Service intensity/complexity	3.50	2.68

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

**CONSENSUS PANEL RECOMMENDATIONS**

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

**Consensus Panel Time Recommendation**

Pre: 4 minutes

Intra: 5 minutes

Post: 2 minutes

Total Time: 11 minutes

Consensus Panel Work Recommendation: .27RVU

**CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION**

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

**EVIDENCE FOR THIS RECOMMENDATION**

CPT code 96408 is meant to reflect the work involved in providing chemotherapy administration via an intravenous push. The provision of this service involved more time than 90774, because chemotherapy administration requires reviews of laboratory studies and review of the calculation of the dose to be administered, work that is not required in 90774. Furthermore this service involves a higher intensity of service and greater potential for adverse reactions and liability than the administration of drugs delivered in 90774. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.



Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to existing code 96408.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +96411 Tracking Number: H14 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .23

RUC RVU: 0.20

CPT Descriptor: Chemotherapy administration, subcutaneous or intramuscular; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)  
(Use +964X1 in conjunction with code 96408)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 67 year old male with bladder cancer is to receive the 2nd drug for that day's treatment. The patient has just finished receiving an IV push of a first drug (reported separately under 96408) as part of the chemotherapy course. (This is an add-on code: the 96408 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 3%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician calculates dose

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

## Description of Post-Service Work:

- No post -service physician work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
	ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American Society of Hematology (ASH)				
	American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	+96411				
<b>Sample Size:</b>	145	<b>Resp n:</b>	35	<b>Response:</b> 24.13 %	
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.15	0.25	0.50	1.28	3.00
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		

<b>Intra-Service Time:</b>		2.00	2.00	<b>5.00</b>	10.00	25.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b>5.00</b>					
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b>0.0</b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b>0.0</b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10      % of respondents: 28.5 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: +96411</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	7.00

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.67	2.60
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.59	2.50
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Urgency of medical decision making	3.31	2.45
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.43	2.63
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Physical effort required	1.83	2.10
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.03	2.73
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Outcome depends on the skill and judgment of physician	3.99	2.93
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Estimated risk of malpractice suit with poor outcome	3.77	2.65
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.43	2.40
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Intra-Service intensity/complexity	3.76	2.58
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Post-Service intensity/complexity	2.99	2.24
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

#### Consensus Panel Time Recommendation

Pre: 3 minutes

Intra: 5 minutes RUC modified to 4 minutes

Post: 0 minutes

Total Time: 8 minutes RUC modified to 7 minutes

Consensus Panel Work Recommendation: .23RVU

### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre=10/Intra=15/Post=5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

### EVIDENCE FOR THIS RECOMMENDATION

CPT code +96411 is an add-on code to 96408. It was felt to deserve a lower RVU and this is reflected in the RVU value chosen. Since +96411 is billed in conjunction with 96409, there is no post-service time with this code. However, there is still some (but less) pre-service time, since dose calculations are required for the additional chemotherapeutic agent.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .23 RVU for CPT code +96411. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. BASE CODE: 96409; ADD-ON CODE: +96411

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) TO BE SUBMITTED IN A SEPARATE ATTACHMENT

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

- Specialty                      How often?
- Specialty                      How often?
- Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period?  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96408.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96413 Tracking Number: H15 Global Period: XXX

Recommended Work Relative Value

Specialty Society RVU: .31

RUC RVU: 0.28

CPT Descriptor: Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: This procedure is initiated for a 64 year old woman with ovarian cancer or rheumatoid arthritis. The patient has a venous access device in place.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 13%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews any appropriate lab results as necessary
- Physician calculates dose

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

**Description of Post-Service Work:**

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD AGA – Joel Brill, MD
<b>Specialty(s):</b>	American College of Rheumatology (ACR <sub>h</sub> ) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) American Gastroenterological Association (AGA)
<b>CPT Code:</b>	96413

<b>Sample Size:</b> 344	<b>Resp n:</b> 98	<b>Response:</b> 28.48 %			
<b>Sample Type:</b> Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.20	1.05	1.70	2.58	6.50
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	2.00	5.00	10.00	20.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>10.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99214	XXX	1.10

**CPT Descriptor** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

**CPT Descriptor 1** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

**CPT Descriptor 2** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25      % of respondents: 25.5 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96413	Key Reference CPT Code: 99214
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	10.00	25.00
Median Immediate Post-service Time	10.00	13.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	30.00	38.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.21	3.81
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.15	3.77
Urgency of medical decision making	4.10	3.54

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.71	3.45
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Physical effort required	3.17	3.02
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.67	3.67
Outcome depends on the skill and judgment of physician	4.48	3.82
Estimated risk of malpractice suit with poor outcome	4.45	3.63

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.15	3.40
Intra-Service intensity/complexity	3.96	3.61
Post-Service intensity/complexity	3.73	3.30

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA), and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 4 minutes

Intra: 7 minutes

Post: 2 minutes

Total Time: 13 minutes

Consensus Panel Work Recommendation: .31RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE FOR THIS RECOMMENDATION

This code represents up to one hour of infusion of a chemotherapeutic agent under the physician's supervision. The Intensity/Complexity Measures in the survey data reflect this increased level of service. It was felt by the Consensus Panel that the amount of physician time, work, responsibility, judgment and medical decision making exceeded that of a chest x-ray, and approached that of the intra-catheterization injection of contrast. Furthermore, there is increased interaction between the infusion nursing personnel and the physician during this service compared to 96409. The Consensus Panel further felt that the provision of a drug with the infusion justifies the increased RVU which was assigned to this code. There is an increased risk of adverse reactions for this procedure compared to 96409. The



Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96410.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +96415 Tracking Number: H16 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .22

RUC RVU: 0.19

CPT Descriptor: Chemotherapy administration, intravenous infusion technique; each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)

(Use +96415 in conjunction with 96413)

(Report +96415 for infusion intervals of greater than thirty minutes beyond one hour increments)

(Report +90760 to identify hydration, or +90766 to identify nonchemotherapy drug infusion, if provided as a secondary or subsequent service in association with 96413)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A previously started infusion is continued for a 64 year old woman with ovarian cancer or rheumatoid arthritis. The patient has a venous access device in place. (This is an add-on code: the 96410 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 5%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- No physician pre-service work

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

**Description of Post-Service Work:**

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD AGA – Joel Brill, MD
<b>Specialty(s):</b>	American College of Rheumatology (ACRrh) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) American Gastroenterological Association (AGA)
<b>CPT Code:</b>	+96415

<b>Sample Size:</b> 344	<b>Resp n:</b> 93	<b>Response:</b> 27.03 %			
<b>Sample Type:</b> Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.15	0.45	1.00	2.00	5.00
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	4.00	10.00	20.00	250.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>5.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	0.45

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18      % of respondents: 19.3 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: +96415	Key Reference CPT Code: <u>99212</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	10.00	10.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	20.00	15.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.51	3.25
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.39	3.20
--	------	------

Urgency of medical decision making	3.47	3.09
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.28	2.98
--------------------------	------	------

Physical effort required	2.90	2.63
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.32	3.28
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Outcome depends on the skill and judgment of physician	4.06	3.47
--	------	------

Estimated risk of malpractice suit with poor outcome	4.20	3.32
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.43	3.03
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Intra-Service intensity/complexity	3.52	3.14
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Post-Service intensity/complexity	3.41	2.99
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

**CONSENSUS PANEL RECOMMENDATIONS**

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

**Consensus Panel Time Recommendation**

Pre: 0 minutes

Intra: 6 minutes RUC modified to 5 minutes

Post: 0 minutes

Total Time: 6 minutes RUC modified to 5 minutes

Consensus Panel Work Recommendation: .22 RVU

**CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION**

The Consensus Panel first determined a value for the base code in the family, CPT code 96411.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

**EVIDENCE FOR THIS RECOMMENDATION**

This code describes the continuation of the infusion of a chemotherapy drug beyond the first hour. CPT code +96415 is designated as an add-on code to 96413, and thus the pre- and post-service work is captured in the initial code. There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.



Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96412.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96416 Tracking Number: H17 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .24

RUC RVU: 0.21

CPT Descriptor: Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump

(For insertion of pump, use 36563)

(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96521, 96523, 96522)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58 year old female having periodic prolonged infusions of fluorouracil presents for her therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews any appropriate lab results as necessary
- Physician calculates dose

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

**Description of Post-Service Work:**

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004		
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD		
	ASH - Samuel H. Silver, MD, PhD		
<b>Specialty(s):</b>	American Society of Hematology (ASH)		
	American Society of Clinical Oncology (ASCO)		
<b>CPT Code:</b>	96416		
<b>Sample Size:</b>	145	<b>Resp n:</b>	33
		<b>Response:</b>	%

Sample Type: Convenience					
	Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Survey RVW:	0.17	0.33	0.70	1.25	7.00
Pre-Service Evaluation Time:			10.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	2.00	5.00	10.00	20.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	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>
99212	XXX	0.45

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6      % of respondents: 18.1 %

TIME ESTIMATES (Median)

	New/Revised CPT Code: 96416	Key Reference CPT Code: 99212
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	10.00	10.00
Median Immediate Post-service Time	10.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	30.00	15.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.06	3.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	3.19
Urgency of medical decision making	3.73	2.94

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.79	2.88
Physical effort required	2.76	2.39

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.48	3.13
Outcome depends on the skill and judgment of physician	4.36	3.30
Estimated risk of malpractice suit with poor outcome	4.03	2.97

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.12	2.94
Intra-Service intensity/complexity	3.69	3.00
Post-Service intensity/complexity	3.79	2.79

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 4 minutes

Intra: 4 minutes

Post: 2 minutes

Total Time: 10 minutes

Consensus Panel Work Recommendation: .24 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination. (Pre = 10/Intra = 15/Post = 5)		.23
76076	Dual energy x-ray absorptiometry (DEXA) (Pre = 5/Intra = 5/Post = 10)		.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE FOR THIS RECOMMENDATION

This code describes initiation of prolonged chemotherapy infusion, requiring use of a portable pump. The interactions with nursing personnel are decreased as compared to 96413, and the surveyed mental effort and judgment was not as intense as 96413. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.



Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96414.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +96417 Tracking Number: H18 Global Period: ZZZ

**Recommended Work Relative Value**Specialty Society RVU: **.24**RUC RVU: **0.21**

CPT Descriptor: Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure)  
(Use +96417 in conjunction with code 96413; report only once per sequential infusion; report +96415 for additional hour(s) of sequential infusion)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 64 year old female with ovarian cancer presents for infusion. She has completed infusion of one chemotherapy drug and is now infused with a second drug through her implanted venous access device. (This is an add-on code: the 96413 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 6%

Is conscious sedation inherent in your reference code? Yes

## Description of Pre-Service Work:

- Physician confirms orders
- Physician conducts reassessment of patient status prior to commencing new drug infusion
- Physician calculates dose

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	+96417				
<b>Sample Size:</b>	145	<b>Resp n:</b>	32	<b>Response:</b>	22.06 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.13	0.40	0.90	1.14	6.50
<b>Pre-Service Evaluation Time:</b>			6.0		
<b>Pre-Service Positioning Time:</b>			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		1.00	3.00	<b>5.00</b>	12.75	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b>5.00</b>					
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b>0.0</b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b>0.0</b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	0.45

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8      % of respondents: 25.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: +96417	Key Reference CPT Code: <b>99211</b>
Median Pre-Service Time	6.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	16.00	7.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.72	2.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	2.84
Urgency of medical decision making	3.62	2.66

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.45	2.71
Physical effort required	2.58	2.29

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.13	2.52
Outcome depends on the skill and judgment of physician	3.94	2.81
Estimated risk of malpractice suit with poor outcome	3.81	2.59

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.66	2.66
Intra-Service intensity/complexity	3.50	2.81
Post-Service intensity/complexity	3.44	2.44

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

**CONSENSUS PANEL RECOMMENDATIONS**

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

**Consensus Panel Time Recommendation**

Pre: 2 minutes

Intra: 7 minutes RUC modified to 6 minutes

Post: 0 minutes

Total Time: 9 minutes RUC modified to 8 minutes

Consensus Panel Work Recommendation: .24 WRVU

**CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION**

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90780X1, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

**EVIDENCE FOR THIS RECOMMENDATION**

This code describes the sequential infusion of a drug after the initial 96413 service. The physician work for this infusion parallels that of 96413, however the pre-service work is less (but chemotherapy dosing still requires recalculation), and the post-service work is accounted for in the 96413 code which this code is an add on to. There is a risk of adverse reactions for this procedure.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a reasonable argument for a value of .24 RVU for CPT code +96417. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. BASE CODE: 96413; ADD-ON CODES: +96415, +96417

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) TO BE SUBMITTED IN A SEPARATE ATTACHMENT

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty                                      How often?

Specialty                                      How often?

Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period?  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty                                      Frequency                                      Percentage                                      %

Specialty                                      Frequency                                      Percentage                                      %

Specialty                                      Frequency                                      Percentage                                      %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96412.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96521 Tracking Number: H24 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: .24  
RUC RVU: 0.21

CPT Descriptor: Refilling and maintenance of portable pump

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58 year old female having a prolonged infusions of fluorouracil presents to have her portable infusion pump refilled.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews any lab results as necessary
- Physician calculates dose

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

## Description of Post-Service Work:

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
<b>Specialty(s):</b>	American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	96521				
<b>Sample Size:</b>	86	<b>Resp n:</b>	21	<b>Response:</b> 24.41 %	
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.15	0.31	1.00	1.10	4.50
<b>Pre-Service Evaluation Time:</b>			7.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	5.00	5.00	12.00	40.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			

<b>Immed. Post-time:</b>	<b><u>5.00</u></b>	
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0 99292x 0.0
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0 99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00 99239x 0.00
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	0.45

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6      % of respondents: 28.5 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96521	Key Reference CPT Code: 99212
Median Pre-Service Time	7.00	0.00
Median Intra-Service Time	5.00	10.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	17.00	15.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.43	2.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	2.62
Urgency of medical decision making	3.43	2.57

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.38	2.33
Physical effort required	2.67	1.86

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.14	2.52
Outcome depends on the skill and judgment of physician	3.76	2.67
Estimated risk of malpractice suit with poor outcome	3.86	2.76

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.48	2.33
Intra-Service intensity/complexity	3.14	2.67
Post-Service intensity/complexity	3.48	2.43

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) conducted an on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 4 minutes

Intra: 4 minutes

Post: 2 minutes

Total Time: 10 minutes

Consensus Panel Work Recommendation: .24 WRVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE FOR THIS RECOMMENDATION

This code describes refilling and maintenance of portable pump for chemotherapy infusion. The work, mental effort, and risk of this code are identical to 96416. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a reasonable argument for a value of .24 RVU for CPT code 96521. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.



Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96520.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:96523 Tracking Number: H25 Global Period: XXX Specialty Society RVU: **0.04** RUC RVU: **.04**

CPT Descriptor: Irrigation of implanted venous access device for drug delivery systems  
(Do not report 96523 if an injection or infusion is provided on the same day

)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72 year old male with lung carcinoma has an implanted venous access device for drug delivery and returns to the clinic for flushing and maintenance of the device on a day when chemotherapy or other treatments are not planned.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Physician provides orders

Description of Intra-Service Work:

- No physician intra-service work

Description of Post-Service Work:

- No Physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
<b>Specialty(s):</b>	American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	96523				
<b>Sample Size:</b>	86	<b>Resp n:</b>	23	<b>Response:</b>	26.74 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.00	0.16	0.25	0.43	2.50
<b>Pre-Service Evaluation Time:</b>			2.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	1.50	3.00	5.00	15.00

<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>
<b>Immed. Post-time:</b>	<b><u>1.00</u></b>	
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0 99292x 0.0
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0 99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00 99239x 0.00
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11      % of respondents: 47.8 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96523	Key Reference CPT Code: 99211
Median Pre-Service Time	2.00	0.00
Median Intra-Service Time	3.00	5.00
Median Immediate Post-service Time	1.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	6.00	7.00

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	1.73	1.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.70	1.74
Urgency of medical decision making	1.70	1.74

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.62	1.82
Physical effort required	1.71	1.50

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.57	1.91
Outcome depends on the skill and judgment of physician	2.04	2.04
Estimated risk of malpractice suit with poor outcome	2.35	2.00

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.78	1.78
Intra-Service intensity/complexity	2.04	1.91
Post-Service intensity/complexity	1.65	1.73

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) conducted an on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

**CONSENSUS PANEL RECOMMENDATIONS**

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

**Consensus Panel Time Recommendation**

Pre: 2 minutes

Intra: 0 minutes

Post: 0 minutes

Total Time: 2 minutes

Consensus Panel Work Recommendation: .04 WRVU

**CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION**

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE FOR THIS RECOMMENDATION

This code describes irrigation of an implanted venous access device for chemotherapy drug delivery systems. There is only 2 minutes of pre-service time.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a reasonable argument for a value of .04 RVU for CPT code 96523. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) **TO BE SUBMITTED IN A SEPARATE ATTACHMENT**

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty                      How often?

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96520.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:96522 Tracking Number: H26 Global Period: XXX Specialty Society RVU: .24 RUC RVU: 0.21

CPT Descriptor: Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)

(For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)

(For collection of blood specimen from a completely implantable venous access device, use 36540)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: The procedure is initiated for a 66 year old male patient with metastatic colorectal carcinoma with disease limited to the liver. A hepatic artery catheter has previously been placed by a surgeon, with an attached implanted pump (e.g. Infusaid pump). The pump is refilled.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews lab results as necessary

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician calculates and recalculates dosage and infusion rate

**Description of Post-Service Work:**

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	96522				
<b>Sample Size:</b>	145	<b>Resp n:</b>	17	<b>Response:</b>	11.72 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.30	0.71	1.08	1.49	6.00

<b>Pre-Service Evaluation Time:</b>				<b>10.0</b>		
<b>Pre-Service Positioning Time:</b>				<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		4.00	5.00	<b>12.00</b>	20.00	45.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>5.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99231	XXX	0.64

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4      % of respondents: 23.5 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96522	Key Reference CPT Code: 99231
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	12.00	15.00
Median Immediate Post-service Time	5.00	4.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	27.00	19.00

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.71	2.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	3.18
Urgency of medical decision making	3.53	2.94

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	3.00
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Physical effort required	3.24	2.65
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.35	3.18
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Outcome depends on the skill and judgment of physician	3.94	3.35
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Estimated risk of malpractice suit with poor outcome	3.71	2.94
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.06	2.94
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Intra-Service intensity/complexity	3.59	3.06
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Post-Service intensity/complexity	3.41	2.76
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

**CONSENSUS PANEL RECOMMENDATIONS**

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

**Consensus Panel Time Recommendation**

Pre: 4 minutes

Intra: 4 minutes

Post: 2 minutes

Total Time: 10 minutes

Consensus Panel Work Recommendation: .24 WRVU

### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96400 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

### EVIDENCE FOR THIS RECOMMENDATION

This code describes refilling and maintenance of implantable pump or reservoir for chemotherapy drug delivery. The work, mental effort, and risk of this code are identical to 96416. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a reasonable argument for a value of .24 RVU for CPT code 96522. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)



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	Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day  <u>(Do not report 90465 in conjunction with 90467)</u>	XXX	0.17
+●90466	N6	each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)  <u>(Use 90466 in conjunction with 90465 or 90467)</u>	ZZZ	0.15

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●90467	N7	Immunization administration under age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day  (Do not report 90467 in conjunction with 90465)	XXX	0.17
+●90468	N8	each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)  (Use 90468 in conjunction with 90465 or 90467)	ZZZ	0.15
▲90471	N1	Immunization administration (includes percutaneous, intradermal, subcutaneous, and intramuscular <del>and jet injections</del> ); one vaccine (single or combination vaccine/toxoid)  (Do not report 90471 in conjunction with 90473)	XXX	0.17  (Previous RUC Recommendation)
▲+90472	N2	each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)  (Use 90472 in conjunction with 90471 or 90473)(For administration of immune globulins, use 90780-90784, and see 90281-90399)  (For intravesical administration of BCG vaccine, use 51720, and see 90586)	ZZZ	0.15  (Previous RUC Recommendation)
90473	N3	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)  (Do not report 90473 in conjunction with 90471)	XXX	0.17  (Previous RUC Recommendation)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+90474	N4	<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 90471 or 90473)</p>	ZZZ	<p>0.15</p> <p>(Previous RUC Recommendation)</p>

## 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.

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	
		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	
HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE									
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
<b>PRE-SERVICE PERIOD</b>									
Start: Following visit when decision for surgery or procedure made									
Complete pre-service diagnostic & referral forms									
Coordinate pre-surgery services									
Office visit before surgery/procedure. Review test and exam results									
Provide pre-service education/obtain consent									
Follow-up phone calls & prescriptions									
Other Clinical Activity (please specify)									
End: When patient enters office for surgery/procedure									
<b>SERVICE PERIOD</b>									
Start: When patient enters office for surgery/procedure									
Pre-service services									
Review charts	L042A	1	0	0	0	1	0	0	0
Greet patient and provide gowning									
Obtain vital signs									
Provide pre-service education/obtain consent									
Prepare room, equipment, supplies									
Prepare and position patient/ monitor patient/ set up IV									
Sedate/apply anesthesia									
F/u on physician's discussion w/patient/parent & obtain actual consent signature	L042A	3	0	3	0	3	0	3	0
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									
<b>POST-SERVICE PERIOD</b>									
Start: Patient leaves office									
Conduct phone calls/call in prescriptions									
Follow-up to ensure that patient's medical record reflects immunizations given, thereby ensuring continuity of care in the medical home	L042A	0	3	0	0	0	3	0	0
Total Office Visit Time									
		#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									

DIRECT PE INPUTS AS APPROVED BY THE PEAC (MARCH 2002) AND THE RUC (FEBRUARY 2001) FOR CODES 90471-90474		90465		90466		90467		90468	
HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		Immunization administration (percutaneous, intradermal, subcutaneous, intramuscular) under age 8 years when physician counsels the patient/family; first injection		each additional injection		Immunization administration (oral/intranasal) under age 8 years when physician counsels the patient/family; first administration		each additional administration	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
<b>MEDICAL SUPPLIES</b>									
CDC information sheet	SK012	1	N/A	1	N/A	1	N/A	1	N/A
exam table paper, one foot	SB036	7	N/A	N/A	N/A	7	N/A	N/A	N/A
gloves, non-sterile	SB022	1	N/A	N/A	N/A	1	N/A	N/A	N/A
swab, alcohol	SJ053	2	N/A	2	N/A	N/A	N/A	N/A	N/A
band-aid, 0.75 in x 3 in	SG021	1	N/A	1	N/A	N/A	N/A	N/A	N/A
Syringe w-needle, OSHA compliant (SafetyGlide)	SC058	1	N/A	1	N/A	N/A	N/A	N/A	N/A
<b>EQUIPMENT</b>									
Exam table	E11001	X	N/A	X	N/A	X	N/A	X	N/A

## RUC Comment Letters – Excerpts on Immunization Administration

### ***Comment on the 2003 MFS Final Rule:***

The RUC joins many others who will comment that CMS should be applauded for addressing the overall payment for immunization administration via a significant increase to the practice expense relative values. We are pleased that the CMS has accepted the RUC's recommendations for the direct practice expense inputs for these codes.

The RUC has commented on the issue of assigning physician work relative values for immunization administration repeatedly over the past few years. The RUC firmly believes that although the nurse may administer the vaccine and often addresses questions posed by the patient/parent, this is in follow-up to the physician's discussion with the patient/parent.

As the RUC has indicated in the past, the physician does discuss with the patient/parent the benefits and risks related to the vaccine(s). These interactions are similar to other services where CMS has acknowledged, through acceptance of RUC recommendations, that a nurse may follow-up or repeat earlier discussions that the patient has had with the physician. The RUC concluded that the physician work involved in immunization administration was comparable to the work involved in 99211 (*see Evaluation & Management, established Patient*) which has a work RVU of 0.17. **We continue to strongly urge you to publish work relative values of 0.17 and 0.15 for CPT codes 90471 and 90472, respectively. The RUC also offers to collect additional data regarding the physician involvement in these services, if CMS indicates that this data may be useful in reconsidering this issue.**

The RUC also urges CMS to eliminate the G codes that are duplicative of the CPT codes that may be used for the administration of Medicare covered vaccines.

### ***Comment on the 2003 MFS Proposed Rule:***

We are pleased that you have proposed to accept our direct practice expense input recommendations for CPT codes 90471 and 90472 *Immunization Administration*. The PEAC and RUC carefully reviewed these codes again this spring and agreed that these inputs represent fairly the nursing time and supply expense required to perform these important services. The NPRM was not specific regarding the updated data submitted to CMS in May 2002. We have, therefore, re-submitted the RUC's recommendations for these codes as an attachment to this letter.

The RUC urges you to reconsider your decision to not publish physician work relative values for these services. In the NPRM, you state that "We have not assigned immunization administration physician work RVUs because this service does not typically involve a physician. The nurse that administers the vaccine typically provides the necessary counseling to the patient and this time is accounted for in the practice expense RVU." In our practice expense recommendations, the RUC indicates that the

nurse does discuss the vaccines with the patient and obtains the actual consent signature. However, we specifically noted that this is in follow-up to the physician's discussion with the patient/parent. As the RUC has indicated in the past, the physician does discuss with the patient/parent the benefits and risks related to the vaccine(s). These interactions are similar to other services where CMS has acknowledged, through acceptance of RUC recommendations, that a nurse may follow-up or repeat earlier discussions that the patient has had with the physician. The RUC concluded that the physician work involved in immunization administration was comparable to the work involved in 99211 (*see Evaluation & Management, established Patient*) which has a work RVU of 0.17. **We strongly urge you to publish work relative values of 0.17 and 0.15 for CPT codes 90471 and 90472, respectively.**

***Comment on the 2001 MFS Final Rule:***

On several occasions, the RUC has recommended to CMS that CPT codes 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)* and 90472 *each additional vaccine* require physician involvement and should have assigned work relative value units of 0.17 and 0.15, respectively. In February 2001, the RUC again submitted recommendations for 90471 and 90472, along with work relative values of 0.17 and 0.15 for the new immunization administration by intranasal or oral route codes (90473 and 90474) that mirror the injection codes.

CMS continues to argue that these services are performed by a nurse and require no physician work. Ironically, on the same page (55308) of the November 1, 2001 *Federal Register* where this argument is presented, CMS announces that it will ignore a RUC recommendation that CPT code 93701 *Bioimpedance, 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 <del>and/or intranasal or oral administration</del> ); one vaccine (single or combination vaccine/toxoid)	XXX	.17  (previously accepted by RUC)
σ:90472	B2	each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)  (Use 90472 in conjunction with code 90471)	ZZZ	.15  (previously accepted by RUC)
●90473	B3	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)	XXX	.17
:●90474	B4	each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)  (Use 90474 in conjunction with code 90473)	ZZZ	.15

## **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.

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE**  
**SUMMARY OF RECOMMENDATIONS**  
**May 1999**

**IMMUNIZATION ADMINISTRATION**

***Work Relative Value Recommendations***

Code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)*, and code 90472 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); each additional vaccine (single or combination vaccine/toxoid)* were both editorially revised to more accurately reflect the work associated with administering vaccines. These changes were made so that the resources and work required to administer multiple vaccines would be more accurately identified and also to more accurately track the costs of administering immunizations.

While the specialty presented its median survey RVW as the recommended RVW, the RUC reviewed this recommendation and concluded that the RVW was too high since immunization administration is typically performed in conjunction with a evaluation and management code. The RUC concluded that the work involved in immunization administration was comparable to the work involved in 99211 (*see Evaluation & Management, established Patient*) which has a work RVU of 0.17. To maintain the originally proposed relativity between the administration of the first vaccine and each additional vaccine (which was .02 RVW's lower), the RUC recommended reducing 90472 by .02 RVUs, for a final recommended RVU of .15. The RUC therefore recommends a work RVU recommendation of .17 for code 90471 and an RVU of .15 for code 90472.

***Practice Expense Recommendations***

*CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.*

The RUC examined the direct inputs associated with immunization administration and added “ Xerox copy” as an additional supply item to both 90471 and 90472 to reflect the cost of documenting the immunization for public health purposes. The RUC discussed the marginal costs involved in code 90472 and agreed to reduce the clinical staff time to two minutes. The RUC decided that the time to provide an additional immunization was only two minutes, substantially lower than the time required to provide the first immunization.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲90471	CC1	Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); <u>one vaccine</u> (single or combination vaccine/toxoid)	XXX	.17
σ90472	CC2	<del>two or more</del> <u>each additional vaccine</u> (single or combination vaccine/toxoid)  (List 90472 in conjunction with 90471)	ZZZ	.15

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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
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Survey Total Time	Low: 2	25th%: 5	Med: 7	75th%: 10	High: 25
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**KEY REFERENCE SERVICE(S):**

<u>1999 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
0.17	XXX	94010	Spirometry, including graphic record, total and times vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
0.45	XXX	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patients and/or family needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

	<i>Mean</i>		
	Intensity/Complexity Measures		
<b>Time Estimates (Median)</b>	90471	94010	99212
PRE-service time	n/a	n/a	n/a
INTRA-service time (TOTAL time for XXX global)	7	7	10
POST-service time	n/a	n/a	n/a
<b>Mental Effort and Judgment</b>			
The number of possible diagnosis and/or the number of management options that must be considered	2.34	2.29	2.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained reviewed and analyzed	2.63	2.43	2.80
Urgency of medical decision making	2.17	2.00	2.90
<b>Technical Skill/physical Effort</b>			
Technical skill required	2.29	1.86	3.10
Physical effort required	2.11	1.57	2.60
<b>Psychological Stress</b>			
The risk of significant complications, morbidity and/or mortality	3.06	1.57	2.90
Outcome depends on skill and judgment of physician	2.43	2.07	3.20
Estimated risk of malpractice suit with poor outcome	3.69	1.85	3.40
<b>Time Segments</b>			
PRE-service intensity/complexity	n/a	n/a	2.43
INTRA-service intensity complexity	2.12	2.08	2.50
POST-service intensity complexity	n/a	n/a	2.43

**ADDITIONAL RATIONALE:**

The time and complexity/intensity data presented above indicate that 90471 (CC1) is more work than 94010 and less work than 99212, the reference procedures. Although the survey respondents reported 10 minutes total time for 99212, HCFA "total" time estimates for this code are 14-15 minutes. Taking into account this difference in total time and the difference in intensity/complexity averages for the survey code and the reference procedures, the survey median RVW of 0.20 is recommended for 90471.

**FREQUENCY INFORMATION****How was this service previously reported?**

90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); single or combination vaccine/toxoid

**How often do physicians in your specialty perform this service? (✓ one)**

✓Commonly      Sometimes      Rarely

**Estimate the number of times this service might be provided nationally in a one-year period?**

This is difficult to estimate because of the wide variety of application (eg, well-child immunizations, travelers to foreign countries, health care workers, annual flu vaccine, etc.)

**Is this service performed by many physicians across the United States? (✓ one)**

✓Yes      No

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION**

**Direct Practice Expense Inputs**

(April 1999)

**CPT Code:** 90471 (CC1)

**Global Period:** XXX

**CPT Descriptor:** Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)

**Reference Code 1:** 90782

**Reference Code 2:** 90788

**Specialty(s):** American Academy of Pediatrics

**CLINICAL LABOR (IN MINUTES)**

Clinical Staff	Staff Code	Pre-IN Office	TOTAL IN Office	Post-IN Office	Pre OUT Office	Intra OUT Office	Post OUT Office
RN/LPN/MA	10130	-	12	-	n/a	n/a	n/a

**MEDICAL SUPPLIES**

HCFA Supply Code	Supply Description	Unit	Quantity used IN-OFFICE for procedure AND pre- & post-op visits	QUANTITY used OUT-OF-OFFICE for pre- & post-op visits ONLY
NEW	APAP elixr 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):**

	Mean Intensity/Complexity Measures		
	90472	94010	N/A*
<b>Time Estimates (Median)</b>			
PRE-service time	n/a	n/a	--
INTRA-service time (TOTAL time for XXX global)	7	6	--
POST-service time	n/a	n/a	--
<b>Mental Effort and Judgment</b>			
The number of possible diagnosis and/or the number of management options that must be considered	2.35	2.33	--
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained reviewed and analyzed	2.68	2.58	--
Urgency of medical decision making	2.1	2.00	--
<b>Technical Skill/physical Effort</b>			
Technical skill required	2.23	1.83	--
Physical effort required	2.13	1.50	--
<b>Psychological Stress</b>			
The risk of significant complications, morbidity and/or mortality	2.97	1.50	--
Outcome depends on skill and judgment of physician	2.42	1.92	--
Estimated risk of malpractice suit with poor outcome	3.65	2.27	--
<b>Time Segments</b>			
PRE-service intensity/complexity	2.68	1.73	--
INTRA-service intensity complexity	2.28	2.08	--
POST-service intensity complexity	2.25	2.09	--

\*No other code was reported with a high enough frequency to report a meaningful mean measure of intensity/complexity.

**ADDITIONAL RATIONALE:**

Although it is an add-on code, new code 90472 (CC2) is only minimally less work than 90471 (CC1). With the provision of each additional vaccine come increased time requirements on the part of the physician for the legally required counseling of parents/guardians regarding the relative risks and benefits of vaccines and assessing the medical history to determine the safety of administering vaccines. Additionally, it should be noted that multiple vaccines at one visit may be administered by various means (eg, oral, intranasal, and/or injection). The median RVW of 0.18 for 90472 is recommended and reflects this work.

**FREQUENCY INFORMATION**

**How was this service previously reported?**

90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); two or more single or combination vaccine/toxoids

**How often do physicians in your specialty perform this service? (✓ one)**

✓Commonly      Sometimes      Rarely

**Estimate the number of times this service might be provided nationally in a one-year period?**

This is difficult to estimate because of the wide variety of application (eg, well-child immunizations, travelers to foreign countries, health care workers, annual flu vaccine, etc.)

**Is this service performed by many physicians across the United States? (✓ one)**

✓Yes      No

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION**  
**Direct Practice Expense Inputs** (April 1999)

**CPT Code:** 90472 (CC2) **Global Period:** XXX

**CPT Descriptor:** Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); each additional vaccine (single or combination vaccines/toxoids)

**Reference Code 1:** 90782

**Reference Code 2:** 90788

**Specialty(s):** American Academy of Pediatrics

**CLINICAL LABOR (IN MINUTES)**

Clinical Staff	Staff Code	Pre-IN Office	TOTAL IN Office	Post-IN Office	Pre OUT Office	Intra OUT Office	Post OUT Office
RN/LPN/MA	10130	-	9	-	n/a	n/a	n/a

**MEDICAL SUPPLIES**

HCFA Supply Code	Supply Description	Unit	Quantity used IN-OFFICE for procedure AND pre- & post-op visits	QUANTITY used OUT-OF-OFFICE for pre- & post-op visits ONLY
NEW	APAP elixir 160mg/5ml (50% of the time)	ml	5	n/a
31502	band aid, 3/4' x 3"	item	1	n/a
11115	patient education sheet	item	1	n/a
31101	swab, alcohol	item	2	n/a
91408	syringe, 1ml	item	1	n/a
NEW	record sheet (AFP)	item	1	n/a
NEW	school record form	item	1	n/a

**PROCEDURE SPECIFIC MEDICAL EQUIPMENT**

HCFA Equip Code	Procedure-specific Description	Quantity used IN-OFFICE for procedure AND pre- & post-op visits	QUANTITY used OUT-OF-OFFICE for pre- & post-op visits ONLY
E13605	refrigerator	1	n/a

**OVERHEAD MEDICAL EQUIPMENT:**

HCFA Equip Code	Overhead Equipment Description	Office Quantity
E91002	crash cart, no defibrillator	1
E11001	exam table	2

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Duodenal Manometry**

The CPT Editorial Panel created a new code 91022 *Duodenal motility (manometric) study* to assess small intestinal motility. It was believed that neither esophageal nor gastric motility studies provide information about duodenal and jejunal motility, and the new code allows for the reporting of this specific procedure.

The RUC discussed the work relative values in relation with the specialty selected key reference services: 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study*; (000 global, Work RVU=1.25) and 91020 *Gastric motility study* (000 global, Work RVU=1.44).

The RUC agreed that this new code fits into the same family as its key reference services and believed that code 91020 was very similar in physician work, time, and effort. **The RUC recommends a relative value of 1.44 Work RVUs new code 91022.**

The RUC reviewed the physician time components from the specialty survey and discussed them in relation to recently RUC reviewed codes: (91034 *Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation* (Work RVU=0.97) 91035 *Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation* (Work RVU= 1.59), and 91037 *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation*; (Work RVU=0.97), and believed this new code should have similar time components as the rest of its' family. The codes intra-service work per unit of time was agreed to be approximately equivalent to .025. With this knowledge, **the RUC recommends the following physician time components for code 91022:**

- **Pre-Service Evaluation time = 15 minutes**
- **Intra-Service Time = 30 minutes**
- **Immediate post operative time = 16 minutes**

**Practice Expense**

The RUC made some modifications to the clinical labor time to reflect changes in physician time, and reallocated existing time to appropriate clinical activity components. In addition, the specialty believed that the disposable catheter in line 73 of the medical supplies should be deleted as it would not typically be used. **The modified practice expense inputs are attached to this report and recommended by the RUC.**

**Physician Liability Crosswalk**

The facilitation committee believed that an appropriate crosswalk code for the physician liability is its reference code 91020 , and recommends this crosswalk to the RUC.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 91022	I1	Duodenal motility (manometric) study <u>(If gastrointestinal endoscopy is performed, use 43235)</u> <u>(If fluoroscopy is performed, use 76000)</u> <u>(If gastric motility study is performed, use 91020)</u>	000	1.44

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:91022 Tracking Number: O1 Global Period: 000

**Recommended Work Relative Value**  
Specialty Society RVU: 1.50  
RUC RVU: 1.44

CPT Descriptor: Duodenal motility (manometric) study

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 53-year old man presents for evaluation of persistent nausea, intermittent vomiting, abdominal pain, irregular bowel habits and weight loss. He had an extensive work-up including endoscopic studies, small bowel biopsy, and radiologic studies. The studies are negative for mucosal disease or mechanical obstruction. Duodenal manometry is requested to assess for duodenal dysmotility.

Percentage of Survey Respondents who found Vignette to be Typical: 65%

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 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: The test is performed after an overnight fast. After informed consent is obtained, and following nasal spray administration of 2% xylocaine, a thin motility probe, incorporating pressure transducers, is introduced through one nostril, down the back of the throat, and positioned into the duodenum as the patient swallows. The tip of the catheter contains a sensor that is positioned in the duodenum so that it is distal to the ligament of treitz. The catheter protruding from the nose is connected to a recorder that registers motility pressure. At the conclusion of the procedure, the catheter is withdrawn and the patient discharged to home.

**Description of Post-Service Work:**

The computer tracings are analyzed by the physician for the presence of normal and abnormal patterns of motility.

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**

<b>RUC Meeting Date (mm/yyyy)</b>	02/2005		
<b>Presenter(s):</b>	Joel Brill, MD (AGA) and Michael Levy, MD (ASGE)		
<b>Specialty(s):</b>	Gastroenterology and Gastrointestinal Endoscopy		
<b>CPT Code:</b>	91022		
<b>Sample Size:</b>	70	<b>Resp n:</b>	29
		<b>Response:</b>	41.42 %
<b>Sample Type:</b>	Random		

		CPT Code:				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		1.40	2.50	2.80	4.00	6.50
<b>Pre-Service Evaluation Time:</b>				15.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		15.00	30.00	30.00	60.00	68.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>16.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
91020	000	1.44

CPT Descriptor Gastric motility study**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
91020	000	1.44

CPT Descriptor 2 Gastric motility study --- NOT ON MPC LIST

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
91010	000	1.24

CPT Descriptor Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6      % of respondents: 20.6 %

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 91022</b>	<b>Key Reference CPT Code: 91020</b>
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	30.00	48.00
Median Immediate Post-service Time	16.00	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	61.00	48.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.60
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	3.50
--	------	------

Urgency of medical decision making	4.30	3.75
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	3.60
--------------------------	------	------

Physical effort required	3.40	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.10	2.95
---	------	------

Outcome depends on the skill and judgment of physician	3.80	3.70
--	------	------

Estimated risk of malpractice suit with poor outcome	3.70	3.35
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.23	2.95
----------------------------------	------	------

Intra-Service intensity/complexity	3.61	3.40
------------------------------------	------	------

Post-Service intensity/complexity	3.23	3.10
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**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.*

Describe the process by which your specialty society reached your final recommendation.

Duodenal manometry is a diagnostic procedure involving the placement of an indwelling probe into the duodenum, to determine the cause of dysmotility. In current practice duodenal manometry typically occurs over a period of less than 24 hours.

CPT Code:

The reference code responses were evenly split between codes 91010 esophageal motility study and 91020 gastric motility study. In January 2004, the RUC approved new codes 91035 esophagus, gastroesophageal reflux test, with mucosal attached telemetry pH electrode, recording, analysis and interpretation and 91037 esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s), recording, analysis and interpretation. Since these codes are new for 2005 they were not included on the reference list.

A consensus panel of the specialty, with representatives from pediatric and adult gastroenterology, finds that 910XX is somewhat more intense than 91020 with regards to the proper positioning of the motility catheter in the duodenum, and more closely related to 91035 in terms of physician work with an RVW of 1.59. The consensus panel finds that the work associated with 910XX falls between the work involved with codes 91020 and 91035. A consensus panel reviewed the survey results and concluded that the median time for performing the procedure of 50 minutes seemed high. The panel concluded that the 25th percentile of intra time or 30 minutes is much more realistic. We considered basing our work value recommendation on the RVW level for the 25th percentile of the survey results or 2.5. However, we concluded that this would be out of line with the work values, time and intensity of the reference codes and the work value assigned to Code 91035. We determined that an RVW of 1.5 would be much more appropriate for this procedure involving an agreed-upon intra time of 30 minutes. In our judgment, an RVW of 1.5 results in an appropriate rank order placement of this procedure with the values assigned to the reference codes and other related services. Moreover, the consensus panel felt that the physician work was similar to the following 000 day global procedures that have been reviewed by the RUC: 45335, Sigmoidoscopy, RVW 1.46, times 7/23/10; 49423 Exchange of previously placed cyst drainage catheter under radiologic guidance, RVW 1.46, time 15/30/15; 51725 Simple cystometrogram, RVW 1.51, time 20/25/15; 51784 Electromyography studies of anus or urethral sphincter other than needle, RVW 1.53, times 10/20/10; 99385 Initial comprehensive preventive medicine E/M, RVW 1.53, times 5/30/10 and we are recommending an RVW of 1.50.

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### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

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### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 42499, 91020, 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? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1500  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

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 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. 91020

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

	A	B	C	D	E
1		staff, supply, equip		91022	
2	Meeting Date: February 2005 RUC Recommendation	CODE	DESC	Duodenal motility (manometric) study	
3	LOCATION			Non Fac	Facility
4	GLOBAL PERIOD			000	000
5	TOTAL TIME	L037D	RN/LPN/MTA	82	22
6	PRE-service time	L037D	RN/LPN/MTA	9	19
7	SERVICE time	L037D	RN/LPN/MTA	60	0
8	POST-service time	L037D	RN/LPN/MTA	13	3
9	<b>PRE-SERVICE - BEFORE ADMISSION</b>				
10	<b>Start: Following decision for surgery visit</b>				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3
17	<b>End: When pt enters site for service</b>				
18	<b>SERVICE PERIOD - ADMISSION TO DISCHARGE</b>				
19	<b>Start: When pt enters site for procedure</b>				
20	<b>Pre-service services</b>				
21	Review charts	L037D	RN/LPN/MTA	2	
22	Greet patient and provide gowning	L037D	RN/LPN/MTA	3	
23	Obtain vital signs	L037D	RN/LPN/MTA	3	
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5	
25	Prepare room, calibrate equipment, prepare supplies	L037D	RN/LPN/MTA	12	
26	Setup scope (non facility setting only)	L037D	RN/LPN/MTA		
27	Prepare and position pt/ monitor pt/ set up IV	L037D	RN/LPN/MTA	2	
28	sedate, apply anesthesia	L051A	RN	0	
29	<b>Intra-service</b>				
30	Assist physician in performing procedure	L037D	RN/LPN/MTA	20	
31	<b>Post-Service</b>				
32	Monitor pt. - check tubes, monitors, drains	L037D	RN/LPN/MTA	5	
33	Clean room, clean all equipment	L037D	RN/LPN/MTA	5	
34	Clean Scope	L037D	RN/LPN/MTA		
35	Clean Surgical Instrument Package	L037D	RN/LPN/MTA		
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	
39	Dischg day mgmt outpt=6" 99238=12	L037D	RN/LPN/MTA		
40	Other Clinical Activity:	L037D	RN/LPN/MTA		
41	<b>End: Patient leaves office/facility</b>				
42	<b>POST-SERVICE Period - AFTER DISCHARGE</b>				
43	<b>Start: Patient leaves office/facility</b>				
44	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3

	A	B	C	D	E
1		staff, supply, equip		91022	
2	Meeting Date: February 2005 RUC Recommendation	CODE	DESC	Duodenal motility (manometric) study	
3	LOCATION			Non Fac	Facility
53	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	L037D	RN/LPN/MTA		
54	List Number and Level of Office Visits				
55	99211 16 minutes		16		
56	99212 27 minutes		27		
57	99213 36 minutes		36		
58	99214 53 minutes		53		
59	99215 63 minutes		63		
60	Other:				
61	Total office visit time:	L037D	RN/LPN/MTA		
62	Other Activity: Download data from recorder to workstation, print report, and prepare file for physician review	L037D	RN/LPN/MTA	10	
63	End: last office visit - end of global period				

	A	B	C	D	E
1		staff, supply, equip		91022	
2	Meeting Date: February 2005 RUC Recommendation	CODE	DESC	Duodenal motility (manometric) study	
3	LOCATION			Non Fac	Facility
64	<b>MEDICAL SUPPLIES</b>				
65	pack, minimum multi-specialty visit	SA048	pack	1	
66	cap, surgical	SB001	item	2	
67	drape, non-sterile, sheet 40in x 60in	SB006	item	2	
68	gown, staff, impervious	SB027	item	2	
69	mask, surgical, with face shield	SB034	item	2	
70	needle, 19-25g, butterfly	SC030	item		
71	syringe, 50-60ml	SC056	item	1	
72	canister, suction	SD009	item	1	
73					
74	tube, suction NG (salem pump)	SD127	item	1	
75	tubing, suction, non-latex (6ft uou)	SD132	item	1	
76	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1	
77	gauze, sterile 4in x 4in	SG055	item	5	
78	tape, surgical paper 1in (Micropore)	SG079	inch	12	
79	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	5	
80	lidocaine 4% soln, topical (Xylocaine)	SH050	ml	1	
81	basin, emesis	SJ010	item	1	
82	denture cup	SJ016	item	1	
83	lubricating jelly (K-Y)(5gm uou)	SJ032	item	4	
84	tongue depressor	SJ061	item	1	
85	cup, drinking	SK018	item	1	
86	<b>Equipment</b>				
87	exam table	E11001		X	
88	surgical lamp	E30009		X	
89	suction machine, Gomco	E30001		X	
90	Eight channel polygraf ID motility function testing application system: Medtronic; model number 08AFTPIDWS; cost \$30,190.00	NEW	item	X	
91	Six channel solid state pressure re-usable catheter: Medtronic; model number POC-30060; cost \$12,800.00	NEW	item	X	
92					

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2005

**Laryngeal Function Studies**

The CPT Editorial Panel revised code 92520 *Laryngeal function studies (ie, aerodynamic testing, and acoustic testing)* to reflect more specifically its current clinical usage and to remove ambiguity by specifying types of testing. Further, with the adoption of code series 92612-92617 [describing flexible fiberoptic evaluation of swallowing and sensory testing with or without physician interpretation/report] there has been concern that 92520 would be utilized inappropriately to report these services.

The specialty society reviewed the survey results for 92520 *Laryngeal function studies (ie, aerodynamic testing, and acoustic testing)* and proposed a work RVU of 0.75 which is lower than the surveyed low outlier (0.80). The response rate was high, however the sample size was small. Therefore a specialty society expert panel convened and recommended a lower value than the survey respondents because the panel felt that the survey respondents overvalued their work. Reference codes 92613 *Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; physician interpretation and report only* (Work RVU=0.71) and 92617 *Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by or video recording; physician interpretation and report only* (Work RVU=0.79) were used because they reflected a comparable amount of work and intensity. In addition, the intra-service time for code 92520 (10 minutes) is comparable to the intra-service times for the reference service codes, 92613 (intra-service time = 10 minutes) and 92617 (intra-service time = 15 minutes). **The RUC recommends a work RVU of 0.75 for code 92520.**

The specialty society clarified that this procedure typically can not be performed in many outpatient centers because of the elaborate laboratory set-up that is used. Code 92520 will typically be billed incident-to a physician.

Practice Expense

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 the intra-service time period. **The revised practice expense inputs are attached and recommended by the RUC.**

**Pre-service time = 10 minutes**

**Intra-service time = 11 minutes**

**Post-service time = 10 minutes**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲92520	B1	<p>Laryngeal function studies (<u>ie, aerodynamic testing, and acoustic testing</u>)</p> <p><u>(For performance of a single test, use modifier 52)</u></p> <p><u>(To report flexible fiberoptic laryngeal evaluation of swallowing and laryngeal sensory testing, see 92611-92617)</u></p> <p><u>(To report other testing of laryngeal function, (eg, electroglottography), use 92700)</u></p>	XXX	0.75

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:92520    Tracking Number:    Global Period: XXX    Recommended Work Relative Value  
Specialty Society RVU: **0.75**

RUC RVU: **0.75**

CPT Descriptor: `

▲ 92520 Laryngeal function studies (ie, aerodynamic testing and acoustic testing)

(For performance of a single test, use modifier 52)

(To report flexible fiberoptic laryngeal evaluation of swallowing and laryngeal sensory testing, see 92611-92617)

(To report other testing of laryngeal function, (eg, electroglottography), use 92700)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 40 year-old elementary school teacher presents with 6 months of hoarseness unresponsive to voice rest and a short course of systemic steroids. Her symptoms began during a viral upper respiratory infection but vocal problems remain long after the other symptoms resolved and she is unable to teach the entire day. Otherwise, her history is unremarkable. Physical examination reveals bowing of the right vocal fold and sluggish movement on phonation. Aerodynamic and acoustic analysis of the patient's voice is obtained to quantify the degree of impairment and form a basis for further testing and therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Read and review related reports and referral information

Description of Intra-Service Work: The patient is taken to the voice laboratory where she vocalizes and speaks into a microphone connected to a computer and an audio recording device. Her voice is recorded and analyzed acoustically by the computer software, then stored. Tests include pitch and loudness of the voice as well as jitter (inconsistency or perturbation of pitch) and shimmer (inconsistency or perturbation of loudness). The computer also analyzes the amount of extraneous noise in her voice (signal-to-noise ratio) and the harmonic frequency distribution (spectral analysis). Other assessments include average airflow, peak airflow, vocal efficiency, and subglottal pressure. A report of the findings is rendered.

Description of Post-Service Work: Contact referring physician to discuss findings

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		02/2005			
Presenter(s):	James Denneny, MD				
Specialty(s):	American Academy of Otolaryngology- Head and Neck Surgery				
CPT Code:	92520				
Sample Size:	20	Resp n:	13	Response:	%
Sample Type:	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
Survey RVW:	0.80	0.90	0.93	1.17	3.50
Pre-Service Evaluation Time:			10.0		

<b>Pre-Service Positioning Time:</b>				<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		5.00	15.00	<b>11.00</b>	25.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b>10.00</b>					
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b>0.0</b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b>0.0</b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
92506	XXX	0.86

CPT Descriptor Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99244	XXX	2.58

CPT Descriptor Office consultation for a new or established patient.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 69.2 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 92520</u>	<u>Key Reference CPT Code: 92506</u>
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	11.00	21.00
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	31.00	21.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.38	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.08
Urgency of medical decision making	2.15	3.08

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.15	2.92
Physical effort required	2.15	2.08

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	1.31	1.46
Outcome depends on the skill and judgment of physician	3.15	2.85
Estimated risk of malpractice suit with poor outcome	1.92	2.15

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.23	2.17
Intra-Service intensity/complexity	2.92	2.83
Post-Service intensity/complexity	2.69	2.50

**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.*

After committee evaluation of survey results and comparison to reference service, AAO-HNS proposes a WRVU of the 25<sup>th</sup> percentile.



Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor:

▲ 92520 Laryngeal function studies (ie, aerodynamic testing and acoustic testing)  
(for performance of a single test, use modifier 52)  
(To report flexible fiberoptic laryngeal evaluation of swallowing and laryngeal sensory testing, see 92611-92617)  
(To report other testing of laryngeal function, (eg, electroglottography), use 92700)

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: XXX

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Initial practice expense information submitted by ASHA for review, AAO-HNS consensus panel reviewed and modified ASHA recommendations based on survey results.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Read and review reports and referral information

Intra-Service Clinical Labor Activities:

The patient is taken to the voice laboratory where she vocalizes and speaks into a microphone connected to a computer and an audio recording device. Her voice is recorded and analyzed acoustically by the computer software, then stored. Tests include pitch and loudness of the voice as well as jitter (inconsistency or perturbation of pitch) and shimmer (inconsistency or perturbation of loudness). The computer also analyzes the amount of extraneous noise in her voice (signal-to-noise ratio) and the harmonic frequency distribution (spectral analysis). Other assessments include average airflow, peak airflow, vocal efficiency, and subglottal pressure. A report of the findings is rendered.

Post-Service Clinical Labor Activities:

Contact referring physician to discuss findings

CPT Code: 92520

Total Staff Time In Office: 35 minutes

Visits in Global Period: 0

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)
L055A	SLP	3	29	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)
SB022	Gloves, non-sterile	1 pair		
SG051	Gauze, non-sterile, 4x4	1		
SD099	Mouthpiece, respiratory	1		
SD130	Tubing, latex	1 foot		
SM012	Disinfectant spray	30 ml		
SK059	Paper, recording (per sheet)	8		
SJ053	Swab-pad, alcohol	2		

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)
	Computerized Speech Lab	\$8,000 (www.kayelemetrics.com)
	Phonatory Function Testing System	\$7,000
E52003	Computer, desktop, w/monitor	
	Printer, laser	
	Computer paper	

	A	B	C	D	E	F	G
1				92520		92526 (CROSSWALK FOR TIME)	
2			CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Laryngeal function studies		Treatment of swallowing dysfunction and/or oral function for feeding	
3	LOCATION			NF	Fac	NF	Fac
4	GLOBAL PERIOD			XXX	XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME	L055A	Speech Pathologist	35	0	79	0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L055A	Speech Pathologist	3	0	5	0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L055A	Speech Pathologist	29	0	71	0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L055A	Speech Pathologist	3	0	3	0
9	PRE-SERVICE						
10	Start: When appointment for service is made						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity: Review/read previous related reports (eg, referral source)	L055A	Speech Pathologist	3		5	
17	End: Patient arrival at office/facility for service						
18	SERVICE PERIOD						
19	Start: Patient arrival at office/facility for service						
20	Pre-service services						
21	Review charts						
22	Greet patient and provide gowning	L055A	Speech Pathologist	2		3	
23	Obtain vital signs						
24	Provide pre-service education/obtain consent	L055A	Speech Pathologist	2		10	
25	Prepare room, equipment, supplies	L055A	Speech Pathologist	5		5	
26	Setup scope (non facility setting only)						
27	Prepare and position patient/ monitor patient/ set up IV	L055A	Speech Pathologist	2			
28	Sedate/apply anesthesia						
29	Intra-service						
30	Assist physician during exam (perform procedure)	L055A	Speech Pathologist	7		45	
31	Post-Service						
32	Monitor pt. following service/check tubes, monitors, drains						
33	Clean room/equipment by physician staff	L055A	Speech Pathologist	3		3	
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L055A	Speech Pathologist	5		5	
39	Other Clinical Activity: Clinician thoroughly analyzes pitch, pitch perturbation, shimmer, harmonic-to-noise ratio; report written	L055A	Speech Pathologist	3			
40	End: Patient leaves office						
41	POST-SERVICE Period						
42	Start: Patient leaves office/facility						
43	Conduct phone calls/call in prescriptions: The referring physician is called and apprised of the findings and recommendations.	L055A	Speech Pathologist	3		3	
44	Other Activity:						
45	End: When appt. for next office visit is made.						

	A	B	C	D	E	F	G
1				92520		92526 (CROSSWALK FOR TIME)	
2		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE		Laryngeal function studies		Treatment of swallowing dysfunction and/or oral function for feeding	
3	LOCATION			NF	Fac	NF	Fac
46	<b>MEDICAL SUPPLIES</b>						
47	gloves, non-sterile	SB022	pair	1		Supplies not crosswalked	
48	gauze, non-sterile 4in x 4in	SG051	item	1			
49	mouthpiece, respiratory	SD099	item	1			
50	tubing, latex	SD130	foot	1			
51	disinfectant spray (Transeptic)	SM012	ml	30			
52	paper, recording (per sheet)	SK059	item	8			
53	swab-pad, alcohol	SJ053	item	2			
54	<b>EQUIPMENT</b>						
55	speech analysis system (incl hardware & software)		See Note 1	X		Equip not crosswalked	
56	phonatory function testing system (incl. hardware & software)		See Note 2	X			
57	computer, desktop, w-monitor	E52003		X			
58	printer, laser, paper			X			
59	Note 1: Kay Elemetrics www.kayelemetrics.com (\$8,000) Computerized Speech Lab (CSL) Model 4500 CSL is an input/output recording device for a PC, which complies with the rigorous specifications and features needed for reliable acoustic measurements. It includes a state-of-the-art PCI hardware interface, using ASIO drivers for low latency (i.e., deterministic responsiveness) between the external module and the host computer, as well as a wealth of features ideal for speech analysis. Unlike systems built around generic, plug-in, multimedia sound cards, which were designed primarily for sound output, CSL, with its fully integrated hardware and software, is well tailored for sound input and measurement in the most exacting speech processing applications. CSL offers input signal-to-noise performance typically 20-30dB superior to generic, plug-in sound cards.			Dedicated equipment			
60	Note 2: Kay Elemetrics www.kayelemetrics.com (\$7,000) Acrophone II Model 6800 A PC-based, hardware/software system for measuring airflow and air pressure parameters intended especially for phonatory function testing. The system calculates some 22 speech/voice aerodynamic parameters derived from sustained vocalizations and other selected tasks.						
61							

AMA/Specialty Society RVS Update Committee  
 Summary of Recommendations  
 February 2005  
**Continuous Glucose Monitoring Interpretation**

The CPT Editorial Panel created a new CPT code 95251 *Ambulatory continuous glucose monitoring of for interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; physician interpretation and report* as a substitute for reporting an Evaluation and Management code for this service. The RUC reviewed survey data from 37 endocrinologists and agreed that the 25<sup>th</sup> percentile of the survey work value (0.85) appeared to be appropriate. The RUC also agreed that this service would require approximately 30 minutes of physician time, including interpretation of over 900 glucose values, overlaid with a patient log of several variables (caloric intake, physical activity, symptoms of hypo- or hyper-glycemia, and other symptoms as they occur). **The RUC recommends a work relative value of 0.85 for CPT code 95251.**

Practice Expense Inputs

All practice expense inputs associated with this service are included in CPT code 95250. Therefore, there are no direct practice expense input recommendations for CPT code 95251.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(e) 95250		<del>Ambulatory continuous glucose monitoring of for up to 72 hours by continuous recording and storage of glucose values from interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; (includes sensor placement, hook-up, calibration of monitor, patient initiation and training, removal of sensor, and printout of recording, disconnection, downloading with printout of data)</del>	XXX	0.00 (PE Inputs Previously Approved)
• 95251	J1	physician interpretation and report  (Do not report 95250, 95251 in conjunction with 99091)  (To report physician review, interpretation and written report associated with code 95250, see Evaluation and Management services codes)	XXX	0.85

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:95251 Tracking Number: J1 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: **0.85**  
RUC RVU: **0.85**

CPT Descriptor: Continuous ambulatory glucose monitoring of interstitial fluid via a subcutaneous sensor for up to 72 hours; physician and interpretation and report -- physician work only (currently reported as an E/M) practice expense reported as CPT 95250.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 45 year-old female with Type I diabetes mellitus has been unable to manage her disease and has had frequent episodes of hypoglycemia symptoms, including a recent hospitalization for ketoacidosis. Continuous ambulatory glucose monitoring is ordered to assist with management of her disease. The 72-hour recording printouts are interpreted and a report is written.

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?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: None

Description of Intra-Service Work: -Interpretation of over 900 glucose values, overlaid with a patient log of several variables (caloric intake, physical activity, symptoms of hypo- or hyper- glycemia, and other symptoms as they occur) reviewing the self blood glucose monitoring measurements.

Description of Post-Service Work: -Writing/dictating report for inclusion in the medical record; other documentation;

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		02/2005			
<b>Presenter(s):</b>	S. Sethu K. Reddy, MD, FACE				
<b>Specialty(s):</b>	American Association of Clinical Endocrinologists				
<b>CPT Code:</b>	95251				
<b>Sample Size:</b>	138	<b>Resp n:</b>	37	<b>Response:</b>	%
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.50	0.85	1.09	1.50	2.50
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	5.00	15.00	30.00	40.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>0.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	

<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99214	XXX	1.09

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires 2 of 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
86077	XXX	0.94

CPT Descriptor 1 Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report - 40 minutes total time

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
92014	XXX	1.10

CPT Descriptor 2 Ophthalmological services; medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits - 39 minutes total time

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99243	XXX	1.72

CPT Descriptor Office consultation for a new or established patient, which requires these three key components: a detailed history, a detailed examination; and medical decision making of low complexity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11      % of respondents: 29.7 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 95251	Key Reference CPT Code: 99214
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	30.00	25.00
Median Immediate Post-service Time	0.00	13.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	30.00	38.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.02	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.22	3.60
Urgency of medical decision making	3.58	3.52

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.06	3.78
Physical effort required	2.76	2.59

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.08	3.79
Outcome depends on the skill and judgment of physician	4.42	4.00
Estimated risk of malpractice suit with poor outcome	3.20	3.44

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.21	2.97
Intra-Service intensity/complexity	4.19	3.91
Post-Service intensity/complexity	3.67	3.34

**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 consultant was hired to help staff with the RUC survey process. Pre-facilitation committee felt that any seemingly E&M work be removed from descriptor. Based on the time, complexity, and using the IWPUT formula resulted in a RVU of 1.15. Although atypical, this code is only for the interpretation and report only and would not preclude an appropriately documented subsequent E&M level visit. The amount of work does relate to analysis of more variables than the usual 24-hour Holter monitoring or 24-hour EEG tracings and most similar to the work of 99214. Since we removed some of the post-service work, we felt that the 25<sup>th</sup> percentile RVU of 0.85 may be more appropriate.



Specialty FP/IM

Frequency 50

Percentage 5.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Complex EMG**

CPT created two new codes for identifying and grading the severity of disorders of nerve and muscle that affect the larynx and diaphragm because the existing codes do not accurately describe the physician work involved in these more difficult electromyographic procedures. Current needle electromyography codes do not appropriately reflect the difficult, time-consuming, risky procedure of laryngeal electromyography and diaphragm electromyography. These procedures are done in sensitive areas. The current RUC evaluations for other electromyography codes, although appropriate for what they define, are not appropriate for these riskier, more difficult electromyographic procedures. These proposed new codes would allow physicians to properly code laryngeal electromyography and diaphragm electromyography. The RUC agreed to maintain the values of the existing codes 95867, 95868, 95870 because the RUC agreed with the presenters who stated that the new services would have accounted for less than one half percent of the volume of the existing codes. Therefore, work neutrality should not apply to this family of codes.

For the new codes, the RUC examined the survey data and agreed with the presenters that that the median survey values appropriately valued the physician work. Both codes were compared to reference code 95860 *Needle electromyography; one extremity with or without related paraspinal areas* (work RVU = 0.96, total time of 34 minutes). While the new codes have total times similar to the reference code, the RUC agreed that the intensity of the new codes was significantly higher and therefore the new codes warranted higher RVUs. **The RUC agreed that a work RVU of 1.57 for code 95865 and 1.25 for 95866 would place the codes in proper rank order.**

Practice Expense

Practice expenses were revised to reflect that the clinical staff assist physicians for two-thirds of the physician intra-service time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
95860		<i>Needle electromyography; one extremity with or without related paraspinal areas</i>	XXX	0.96  (No Change)
▲95867	YY1	cranial nerve supplied muscle(s), unilateral	XXX	0.79  (No Change)
▲95868	YY2	cranial nerve supplied muscle(s), bilateral	XXX	1.18  (No Change)
▲95870	YY3	limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters  (To report a complete study of extremities, see 95860-95864)  (For anal or urethral sphincter, detrusor, urethra, perineum musculature, see 51785-51792)  (For eye muscles, use 92265)	XXX	0.37          (No Change)
●95865	YY4	larynx  (Do not report modifier 50 in conjunction with 9586X)	XXX	1.57
●95866	YY5	hemidiaphragm	XXX	1.25

CPT Code:

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 95865 Tracking Number: YY4 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: 1.57

RUC RVU: 1.57

CPT Descriptor: Needle electromyography; larynx

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 36 year old man complains of a raspy voice after being intubated for a number of days following a drug induced coma. The condition does not improve two months after the hospitalization. His otolaryngologist is uncertain if the cord has a mechanical problem or has sustained damage to its peripheral innervation. He requests EMG for laryngeal muscle assessment.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 3%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the history and notes in particular if there is any history of reaction to local anesthesia -- if this will be used. The indications, risks, and potential complications are explained in detail, the latter including respiratory mucosal irritation, bleeding, and large edema necessitating intubation. In addition, the procedures which may need to be performed in event of respiratory insufficiency (including emergency chest x-ray, airway or endotracheal tube placement, and hospitalization) are discussed. Informed consent is obtained.

Description of Intra-Service Work: The needle electrode is inserted through the skin, then the cricothyroid membrane until muscle activity is located. Placement can be confirmed by phonation of high-pitched vowels. Activation of neck strap muscles without phonation should produce no EMG activity. The muscles being studied are quite small and swallowing or coughing may displace the needle. Localization is often prolonged, particularly in circumstances of vocal fold paresis or paralysis, as phonation to assist localization may not be possible. When the correct muscles are identified, electrodiagnostic properties of the muscle are reviewed including insertion activity, spontaneous activity, and voluntary activity. Motor unit action potentials may be analyzed according to morphology, amplitude, frequency, and recruitment. After the appropriate muscles have been localized and evaluated, the needle is withdrawn, and direct pressure is applied to prevent bleeding.

Description of Post-Service Work: The patient is observed and queried regarding respiratory symptoms. If stridor or dyspnea is reported, the patient is examined. If necessary the resuscitation team is called for consideration of endotracheal intubation. The patient is instructed what to do should respiratory symptoms develop in the hours or days following the laryngeal EMG.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005	
<b>Presenter(s):</b>	Jim Anthony, MD (AAN); Robert Goldberg, DO (AAPMR); Andrea Boon, MD (AANEM); Benn Smith, MD (AANEM); Jim Denny, MD (AAO-HNS)		
<b>Specialty(s):</b>	AAN, AANEM, AAO-HNS, AAPM&R		
<b>CPT Code:</b>	95865		
<b>Sample Size:</b>	45	<b>Resp n:</b>	30
		<b>Response:</b>	66.66 %
<b>Sample Type:</b>	Panel		

CPT Code:

	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.75	1.03	1.57	2.88	5.50
<b>Pre-Service Evaluation Time:</b>			12.5		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	5.00	10.00	15.00	23.75	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>10.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
95860	XXX	0.96

CPT Descriptor Needle electromyography, one extremity with or without related paraspinals

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.

Number of respondents who choose Key Reference Code: 11      % of respondents: 36.6 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 95865</u>	<u>Key Reference CPT Code: 95860</u>
Median Pre-Service Time	12.50	0.00
Median Intra-Service Time	15.00	34.00
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	37.50	34.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.18	3.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.45	2.91
Urgency of medical decision making	3.27	2.91

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.73	3.09
Physical effort required	3.00	2.73
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.18	2.82
Outcome depends on the skill and judgment of physician	4.64	3.45
Estimated risk of malpractice suit with poor outcome	3.45	2.36

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.45	2.73
Intra-Service intensity/complexity	4.27	3.09
Post-Service intensity/complexity	2.91	2.36

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

AAN, AANEM, AAO-HNS, and AAPM&R convened a consensus panel to review survey results. The panel chose to recommend the median RVW. Survey results show the intensity and complexity of the larynx code is much higher than the reference code in all categories, supporting a higher RVW. The intensity of performing a needle EMG of the larynx is also greater than on the diaphragm, so the ranking within the new family of codes is appropriate.



Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 64510: injection, anesthetic agent; stellate ganglion (cervical sympathetic). The reference CPT code does not carry nearly the same risk as laryngeal EMG. Many physicians avoid doing this procedure altogether for fear of the possibility of laryngeal edema and respiratory arrest.

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:95866 Tracking Number: YY5 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: 1.25

RUC RVU: 1.25

CPT Descriptor: Needle electromyography; hemidiaphragm

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 59 year old woman who has a 50 pack year history of smoking develops painless weakness of intrinsic hand muscles on both sides, fasciculations of upper and lower limb muscles, and shortness of breath. Her physical examination shows diffuse weakness of upper more than lower limb muscle groups, widespread fasciculations, and hyperreflexia. The clinician suspects ALS but wishes to know whether her dyspnea is due to COPD or to involvement of the diaphragm in her neuromuscular disorder which might improve with positive pressure assisted ventilation (BiPAP). She refers the patient for EMG/NCS which includes needle EMG examination of the diaphragm.

Percentage of Survey Respondents who found Vignette to be Typical: 63%

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 physician reviews the history and notes in particular if the chest x-ray shows hyperexpansion and flat hemidiaphragms which makes the procedure relatively contraindicated and much more risky. If no recent chest x-ray is available, many physicians will not do the procedure. The indications, risks, and potential complications are explained in detail, the latter including pneumothorax, bleeding, and infection. In addition, the procedure which may need to be performed in event of pneumothorax, including emergency chest x-ray, chest tube placement, respiratory support, and hospitalization, are discussed. Informed consent is obtained.

Description of Intra-Service Work: Ground and reference electrodes are attached. Localization is performed by depressing the patient's abdomen to locate the inferior border of the ninth rib. The EMG needle is inserted at the paramidclavicular line under and beneath the ninth rib. The needle is advanced through the skin and abdominal fascia, through the abdominal wall muscles into the costal insertion of the diaphragm where muscle electrical activity is encountered. The patient may need to temporarily be taken off of the ventilator if he/she is intubated. Electrical activity of the muscle is evaluated both with breathing and during silent periods. In some instances, particularly when the patient is comatose, an assistant may needle to stimulate the phrenic nerve percutaneously to activate motor unit potentials. After the data is collected and analyzed, the needle is withdrawn. In some circumstances, a post-procedure chest x-ray may be desired to exclude pneumothorax, or pneumoperitoneum.

Description of Post-Service Work: The patient is observed and queried regarding respiratory symptoms. If increased dyspnea is reported, the posterior chest is auscultated. If, decreased breath sounds are apparent, urgent chest x-ray is arranged. The patient is instructed what to do should worsening respiratory symptoms develop in the hours or days following the diaphragm EMG.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	04/2005
Presenter(s):	Jim Anthony, MD (AAN); Robert Goldberg, DO (AAPMR); Andrea Boon, MD and Benn Smith, MD (AANEM)
Specialty(s):	AAN, AANEM, AAPMR
CPT Code:	95866

Sample Size: 63	Resp n: 30	Response: 47.61 %			
Sample Type: Panel					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:	0.55	0.96	1.25	1.59	3.30
Pre-Service Evaluation Time:			10.0		
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	30.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>10.00</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
95860	XXX	0.96

CPT Descriptor Needle Electromography, one extremity with or without related paraspinals

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.

Number of respondents who choose Key Reference Code: 11      % of respondents: 36.6 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 95866</u>	<u>Key Reference CPT Code: 95860</u>
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	15.00	34.00
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	34.00
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	3.73	3.36
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	4.18	2.36

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.73	3.27
Physical effort required	4.00	3.09
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.45	2.45
Outcome depends on the skill and judgment of physician	4.55	3.27
Estimated risk of malpractice suit with poor outcome	4.18	2.27

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.45	2.36
Intra-Service intensity/complexity	4.27	3.09
Post-Service intensity/complexity	3.36	2.45

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The societies convened a consensus panel and recommended the median survey RVW of 1.25, slightly lower than the value for the more intense larynx code. Survey results confirm that the intensity and complexity are much higher than for the key reference service, 95860.



CPT Code:

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. CPT code 47000: percutaneous liver biopsy is a closer crosswalk. The reference CPT code does not carry nearly the same risk as diaphragm EMG. Many physicians avoid doing this procedure altogether for fear of the possibility of pneumothorax.

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: Needle electromyography; larynx

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: XXX

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

AAN, AANEM, AAO-HNS, and AAPM&R convened a consensus panel of experts from across the country to develop the recommendations. The panel looked at 95869 as a crosswalk for time, supplies, and equipment. An 8 channel EMG machine is used rather than the 2-4 channel because physicians would only purchase one machine for their office. An 8 channel EMG machine can perform more of the studies that would be typically performed by these physicians.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: none

Intra-Service Clinical Labor Activities:

Greet the patient, confirm correct identity, using name and date of birth. Bring them to the exam room. Explain that the physician will be in shortly to explain the study, and answer any preliminary questions the patient has. Ask the patient to lie down on the bed, and to remove jewelry that may get in the way. Enter the patient's demographic data in to the EMG machine.

Assist with patient positioning, assist with running the EMG machine during needle examination (switching sensitivity, between 50mV and 200mV) to assist physician with examining insertional activity and evaluating motor unit potentials. Enter needle examination findings, if requested by physician. Apply pressure once needle is removed, to prevent bruising.

Take the patient back out to the waiting room, assist with wheelchair if necessary. Remove linen from examination table. Make up examination couch with new linen. Restock supplies for next case, as necessary.

Post-Service Clinical Labor Activities: Follow-up call.

**AMTA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: Needle electromyography; hemidiaphragm

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: XXX

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

AAN, AANEM, and AAPM&R convened a consensus panel of experts from across the country to develop the recommendations. The panel looked at 95869 as a crosswalk for time, supplies, and equipment. An 8 channel EMG machine is used rather than the 2-4 channel because physicians would only purchase one machine for their office. An 8 channel EMG machine can perform more of the studies that would be typically performed by these physicians.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: none

Intra-Service Clinical Labor Activities:

Greet the patient, confirm correct identity, using name and date of birth. Bring patient to the exam room. Ask patient to remove outer garments and to don a gown. Explain that the physician will be in shortly to explain the study, and answer any preliminary questions the patient has. Ask the patient to lie down on the bed. Enter the patient's demographic data in to the EMG machine.

Assist with patient positioning, assist with running the EMG machine during needle examination (switching sensitivity, between 50mV and 200mV) to assist physician with examining insertional activity and evaluating motor unit potentials. Enter needle examination findings, if requested by physician. Apply pressure once needle is removed, to prevent bruising.

Assist the patient with dressing if necessary. Take the patient back out to the waiting room, assist with wheelchair if necessary. Remove linen from examination table. Make up examination couch with new linen. Restock supplies for next case, as necessary.

Post-Service Clinical Labor Activities: Follow-up call.

	A	B	C	D	E	F	G	H	I
1									
2				95865		95866			
3	Meeting Date: April 2005			Needle electromyography: larynx (Do not report modifier 50 in conjunction with 9586X)		Needle electromyography: hemidiaphragm			
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility		
5	GLOBAL PERIOD			XXX		XXX			
6	TOTAL CLINICAL LABOR TIME		L037A	26.0	0.0	26.0	0.0		
7	TOTAL PRE-SERV CLINICAL LABOR TIME		L037A	0.0	0.0	0.0	0.0		
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		L037A	23.0	0.0	23.0	0.0		
9	TOTAL POST-SERV CLINICAL LABOR TIME		L037A	3.0	0.0	3.0	0.0		
10	<b>Start: Following visit when decision for surgery or procedure made</b>								
11	Complete pre-service diagnostic & referral forms								
12	Coordinate pre-surgery services								
13	Schedule space and equipment in facility								
14	Provide pre-service education/obtain consent								
15	Follow-up phone calls & prescriptions								
16	Other Clinical Activity (please specify)								
17	End:When patient enters office/facility for surgery/procedure								
18	<b>Start: When patient enters office/facility for surgery/procedure</b>								
19	Pre-service services								
20	Review charts								
21	Greet patient and provide gowning		L037A	3		3			
22	Obtain vital signs								
23	Provide pre-service education/obtain consent		L037A	3		3			
24	Prepare room, equipment, supplies		L037A	2		2			
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV		L037A	2		2			
27	Sedate/apply anesthesia								
28	Intra-service								
29	Assist physician in performing procedure		L037A	10		10			
30	Post-Service								
31	Monitor pt. following service/check tubes, monitors, drains								
32	Clean room/equipment by physician staff		L037A	3		3			
33	Clean Scope								
34	Clean Surgical Instrument Package								
35	Complete diagnostic forms, lab & X-ray requisitions								
36	Review/read X-ray, lab, and pathology reports								
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
38	Discharge day management 99238 -12 minutes								
39	99239 -15 minutes								
40	Other Clinical Activity (please specify)								
41	End: Patient leaves office								
42	<b>Start: Patient leaves office/facility</b>								
43	Conduct phone calls/call in prescriptions		L037A	3		3			
44	Office visits: Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling, clean room/equip, check supplies; coordinate home or outpatient care								
45	List Number and Level of Office Visits								
46	99211 16 minutes			16					
47	99212 27 minutes			27					
48	99213 36 minutes			36					
49	99214 53 minutes			53					
50	99215 63 minutes			63					
51	Other								
52	Total Office Visit Time								
53	Other Activity (please specify)								
54	End: with last office visit before end of global period								

	A	B	C	D	E	F	G	H	I
2				95865		95866			
3	Meeting Date: April 2005			Needle electromyography; larynx (Do not report modifier 50 in conjunction with 9586X)		Needle electromyography; hemidiaphragm			
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility		
58									
59	pack, minimum multi-specialty visit	SA048	pack	1		1			
60	electrode needle, concentric EMG w-lead	SD049	item	1		1			
61	electrode, ground	SD059	item	1		1			
62	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1			
63	paper, recording (per sheet)	SK059	item	5		5			
64	electrode conductive gel	SJ020	ml	1		1			
65	swab-pad, alcohol	SJ053	item	4		4			
66	gauze, sterile 4in x 4in	SG055	item	4		4			
67	tape, porous-hypoallergenic 2in (Scanpore)	SG077	inch	6		6			
68									
69									
70	table, exam	EF023		1		1			
71	EMG-NCV-EP machine, 2-4 channel	EQ023							
72	EMG-NCV-EP system, 8 channel	EQ024		1		1			

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Education and Training for Patient Self Management**

The CPT Editorial Panel created three new codes to describe educational and training services prescribed by a physician and provided by a qualified, non-physician healthcare professional. There is no physician work associated with these services. The RUC considered recommendations for direct practice expense inputs only. The RUC reviewed inputs for CPT code 98960 *Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient*, 98961 *2-4 patients* and 98962 *5-8 patients*. **The RUC assessed and modified the practice expense inputs, which are attached to this recommendation.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●98960	K1	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	XXX	0.00 (PE Inputs Only)
●98961	K2	2-4 patients	XXX	0.00 (PE Inputs Only)
●98962	K3	5-8 patients	XXX	0.00 (PE Inputs Only)

**AMA/Specialty Society Update Process  
PERC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: Education and training for patient self-management by a qualified, non-physician health care professional, e.g. RD or RN, using a standardized curriculum

[Note: The CPT panel approved this generic code set with the intent it would be used by many qualified health care professionals. While the code is ‘generic,’ there may be instances where the service includes different equipment based on the practitioner’s skill set, the patient/client’s educational objectives/desired outcomes, and the specific nature of the education and training provided.]

The American Dietetic Association (ADA) and the American Association of Clinical Endocrinologists (AACE) compiled this PE summary of recommendations which represents the “typical” clinical labor time, supplies and equipment performed by clinical endocrinologists and dietitians.

*Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:*

Both the American Dietetic Association (ADA) and the American Association of Clinical Endocrinologists (AACE) individually convened expert practice expense panels to collect data for the Education and Training codes. Both groups’ expert panelists represent a variety of practice settings and geographic locations.

Once each group’s data was obtained, ADA and AACE then compiled each group’s respective data obtained from the PE expert panel for clinical labor time, supplies and equipment.

CPT Long Descriptor:

Education and training for patient self-management by a qualified, non-physician health care professional e.g. RD or RN, using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes;

98961	Group 2-4
98962	Group 5-8

[Note: The CPT panel approved this generic code set with the intent it would be used by many qualified health care professionals. While the code is ‘generic,’ there may be instances where the service includes different equipment based on the practitioner’s skill set, the patient/client’s educational objectives/desired outcomes, and the specific nature of the education and training provided.]

The American Dietetic Association (ADA) and the American Association of Clinical Endocrinologists (AACE) compiled this PE summary of recommendations, which represents the “typical” clinical labor time, supplies and equipment performed by registered dietitians and clinical endocrinologists’ staff.

*Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:*

Both the American Dietetic Association (ADA) and the American Association of Clinical Endocrinologists (AACE) individually convened expert practice expense panels to collect data for the Education and Training codes. Both groups’ expert panelists represent a variety of practice settings and geographic locations.

Once each group’s data was obtained, ADA and AACE then compiled each group’s respective data obtained from the PE expert panel for clinical labor time, supplies and equipment.

Please describe the clinical activities of your staff:

**98960 Disease Education Vignette**

Typical Patient: A 35 year-old woman with a symptomatic established illness or disease, e.g. diabetes or asthma, or the desire to delay disease co-morbidities, e.g. cardiovascular co-morbidities, is referred by a physician to a qualified, non-physician health care professional for education/training, eg. RD or RN.

The qualified, non-physician health care professional:

Pre-Service

- Reviews relevant parts of the patient’s medical record
- Reviews the physician referral

Intra-Service

- Assesses the individual’s psychological, social, environmental factors, lifestyle habits, health literacy, and learning styles;
- Using a standardized curriculum, provides education/training to self-manage the illness/disease, or delay the disease co-morbidities, or use a device;
- Answers the patient’s questions as part of the education and training group session

Post-Service

- Establishes a plan for follow-up evaluation and ongoing assessment of outcomes, and communicates to the patient;
- Documents the education/training provided and describes the plan for follow-up

**98961 and 98962 Group Education & Training Vignette**

Typical Patient: A 60 year-old man with a symptomatic established illness or disease, e.g. diabetes or asthma, or the desire to delay disease co-morbidities, e.g. cardiovascular co-morbidities, is referred by a physician to a qualified, non-physician health care professional, e.g. RD or RN, for group education/training.

The qualified, non-physician health care professional:

**Pre-Service**

- Reviews relevant parts of the patient's medical record for all patients involved in the group
- Reviews the physician referral for each patient

**Intra-Service**

- Assesses the groups' psychological, social, environmental factors, lifestyle habits, health literacy, and learning styles;
- Using a standardized curriculum, provides education/training to self-manage the illness/disease, or delay the disease co-morbidities, or use a device;
- Answers the patients' questions as part of the education and training group session

**Post-Service**

- Establishes a plan for follow-up evaluation and ongoing assessment of outcomes, and communicates to each patient in the group;
- Documents the education/training provided and describes the plan for follow-up education/training for each patient in the group.

	A	B	C	D
1				
2				
3				
4				CPT Code
5	RUC April/May 2005			98960 - Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
6	LOCATION	CMS Code	Staff Type	Non Facility
7	GLOBAL PERIOD			
8	TOTAL CLINICAL LABOR TIME	RD (L043B) and RN (L051A)	RD & RN	38.0
9	TOTAL PRE-SERV CLINICAL LABOR TIME	RD (L043B) and RN (L051A)	RD & RN	3.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	RD (L043B) and RN (L051A)	RD & RN	30.0
11	TOTAL POST-SERV CLINICAL LABOR TIME	RD (L043B) and RN (L051A)	RD & RN	5.0
12	PRE-SERVICE			
13	Start: Following visit when decision for surgery or procedure made			
14	Complete pre-service diagnostic & referral forms			3
15	Coordinate pre-surgery services			
16	Schedule space and equipment in facility			
17	Provide pre-service education	RD (L043B) and RN (L051A)		
18	Follow-up phone calls & prescriptions			
19	Other Clinical Activity (please specify)	RD (L043B) and RN (L051A)		
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			
25	Greet patient			
26	Obtain vital signs			
27	Provide pre-service education/obtain consent			
28	Prepare room, equipment, supplies			
29	Setup scope (non facility setting only)			
30	Prepare and position patient/ monitor patient/ set up IV			
31	Sedate/apply anesthesia			
32	Intra-service			
33	Perform education	RD (L043B) and RN (L051A)	RD & RN	30
34	Post-Service			
35	Monitor pt. following service/check tubes, monitors, drains			
36	Clean room/equipment, store equipment/models; media equipment			
37	Clean Scope			
38	Clean Surgical Instrument Package			
39	Complete diagnostic forms, lab & X-ray requisitions: documentation & record outcomes data	RD (L043B) and RN (L051A)	RD & RN	
40	Review/read X-ray, lab, and pathology reports			
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			
42	Discharge day management 99238 - 12 minutes 99239 - 15 minutes			
43	Other Clinical Activity (please specify)			
44	End: Patient leaves office			

	A	B	C	D
4				<b>CPT Code</b>
	RUC April/May 2005			98960 - Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
5				
6	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>
45	<b>POST-SERVICE Period</b>			
46	Start: Patient leaves office/facility			
47	Conduct phone calls/call in prescriptions	RD (L043B) and RN (L051A)	RD & RN	1
48	documentation and recording outcomes			4
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			
58	Other Activity (please specify)			
59	End: with last office visit before end of global period			
60	<b>MEDICAL SUPPLIES</b>	<b>CMS Code</b>	<b>Unit</b>	
61	patient education booklet	SK062	item	1
62				
63				
64				
65	<b>EQUIPMENT</b>	<b>CMS Code</b>	<b>Unit</b>	
66	computer, desktop, with monitor	ED021	1	1
67	printer, laser, paper	ED032	1	1
68	software	EQ187	1	1
69	PC projector (\$1700)	new item- see cost data	1	1
70	equipment and/or models	EQ123	1	1
71	scale	EF016	1	
72				
73				
74				
75				
76				

	A	B	C	E	F
1					
2					
3					
4				<b>CPT Code</b>	
5	RUC Apr/May 2005			98961- Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; group 2-4 (AVERAGE SIZE IS 3)	98962- Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; group 5-8 (AVERAGE SIZE IS 6)
6	LOCATION	CMS Code	Staff Type	Non Facility	Non Facility
7	GLOBAL PERIOD				
8	TOTAL CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	18 (for each individual in the group)	13 (for each individual in the group)
9	TOTAL PRE-SERV CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	3.0	3.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	10.0	5.0
11	TOTAL POST-SERV CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	5.0	5.0
12	<b>PRE-SERVICE</b>				
13	Start: Following visit when decision for surgery or procedure made				
14	Complete pre-service diagnostic & referral forms			3	3
15	Coordinate pre-surgery services				
16	Schedule space and equipment in facility				
17	Provide pre-service education	RD (L043B) and RN (LO51A)			
18	Follow-up phone calls & prescriptions				
19	Other Clinical Activity (please specify)	RD (L043B) and RN (LO51A)			
20	End: When patient enters office/facility for surgery/procedure				
21	<b>SERVICE PERIOD</b>				
22	Start: When patient enters office/facility for surgery/procedure				
23	Pre-service services				
24	Review charts				
25	Greet patient				
26	Obtain vital signs				
27	Provide pre-service education/obtain consent				
28	Prepare room, equipment, supplies				
29	Setup scope (non facility setting only)				
30	Prepare and position patient/ monitor patient/ set up IV				
31	Sedate/apply anesthesia				
32	Intra-service				
33	Perform education	RD (L043B) and RN (LO51A)	RD & RN	10	5
34	Post-Service				
35	Monitor pt. following service/check tubes, monitors, drains				
36	Clean room/equipment, store equipment/models, media equipment				
37	Clean Scope				
38	Clean Surgical Instrument Package				
39	Complete diagnostic forms, lab & X-ray requisitions documentation & record outcomes data	RD (L043B) and RN (LO51A)	RD & RN		
40	Review/read X-ray, lab, and pathology reports				
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
42	Discharge day management 99238 -12 minutes 99239 -15 minutes				
43	Other Clinical Activity (please specify)				
44	End: Patient leaves office				

	A	B	C	E	F
4	RUC April/May 2005			<b>CPT Code</b>	
5				98961- Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum; face-to-face with the patient (could include caregiver/family) each 30 minutes; group 2-4 (AVERAGE SIZE IS 3)	98962- Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; group 5-8 (AVERAGE SIZE IS 6)
6	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Non Facility</b>
45	<b>POST-SERVICE Period</b>				
46	Start: Patient leaves office/facility				
47	Conduct phone calls/call in prescriptions	RD (L043B) and RN (L051A)	RD & RN	1	1
48	documentation and recording outcomes			4	4
49	<i>List Number and Level of Office Visits</i>				
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	<i>Total Office Visit Time</i>				
58	Other Activity (please specify)				
59	End: with last office visit before end of global period				
60	<b>MEDICAL SUPPLIES</b>	<b>CMS Code</b>	<b>Unit</b>		
61	patient education booklet	SK062	item	1	1
62					
63					
64					
65	<b>Equipment</b>	<b>CMS Code</b>	<b>Unit</b>		
66	computer, desktop, with monitor	ED021	1	33%	17%
67	printer, laser, paper	ED032	1	17%	8%
68	software	EQ187	1	33%	17%
69	PC projector (\$1700)	new item- see cost data	1	33%	27%
70	equipment and/or models	EQ123	1	33%	27%
71	scale	EF018	1	7%	3%
72					
73					
74					
75					
76					

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Moderate (Conscious) Sedation**

The CPT Editorial Panel created six new codes to accurately report the two separate families of moderate sedation distinguished by provision of moderate sedation services by the physician who is performing the diagnostic or therapeutic service and supervising an independent trained observer; or moderate sedation services performed by a physician (other than an anesthesiologist) other than the physician performing diagnostic or therapeutic service. These codes would consist of two separate time-based base codes in each family, distinguished by patient age, with a single add-on code in each family to report additional time. These new codes replace CPT codes 99141 *Sedation with or without analgesia (conscious sedation); intravenous, intra-muscular or inhalation*, (work relative value = 0.80) and 99142 *Sedation with or without analgesia (conscious sedation); oral, rectal and/or intranasal* (work relative value = 0.60).

The CPT Editorial Panel and the RUC have reviewed the moderate sedation issue over the past five years. This work included development of an appendix in CPT to identify the services in which moderate sedation is an inherent component. The practice expense refinement has resulted in consistent direct practice expense inputs for the provision of the sedation in each of these codes. CPT instructions note that CPT codes 99143 – 99145 may not be used in addition to the codes listed in the appendix, as the resources utilized in providing these services have already been included in the procedure code. In addition, CPT instructions indicate that 99148 – 99150 may not be reported with the codes listed in the appendix when performed in the non-facility as the resources for this site-of-service are incorporated in the procedure code.

The RUC also continues to advocate that CMS consider a change in payment policy to allow separate payment for conscious sedation, utilizing the stand-alone CPT codes 99143 – 99150, when this service is provided in conjunction with a procedure where conscious sedation is not an inherent component. We welcome the opportunity to retrospectively review utilization data once these codes are active to review data regarding the procedure codes that are routinely reported with moderate sedation codes. The RUC understands that 99143 – 99150 will be reported with codes for procedures where conscious sedation is not inherently a part of the procedure. This is to be taken into consideration in reviewing the relative value recommendation for these new moderate sedation codes. The provision of sedation would not be the normal course of action and that implies a different intensity of work for these services than would be the case when it is inherent to the procedure.

The RUC first reviewed the code family describing the provision of moderate sedation services by a physician other than the physician performing the diagnostic or therapeutic service:

**99149**

The RUC reviewed the specialty societies' recommendations to the RUC for 99149 *Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; first 30 minutes intra-service time.* The specialty societies reviewed the survey time data and felt that the RVU value reflected in the survey data was over-valued. Therefore, the specialty societies recommended using a building block methodology. This methodology included using the surveyed pre, intra and post service times, 15, 20 and 15 minutes respectively.

The RUC agreed that the pre-service work was comparable to 99241 *Office consultation for a new or established patient (23 minutes total time, Work RVU=0.64).* The RUC agreed with the specialty society recommendation to consider the majority of the intra-service time as related to monitoring. This monitoring time was felt to be similar in intensity to the anesthesia intensity level 2 (0.031) approved for 19 anesthesia services utilized in the previous Five-Year Review. The RUC agreed that five minutes of elevated intensity was appropriate for the induction period. Although the RUC was comfortable with the time allotted for post-service time, 15 minutes, the RUC felt that using the full value for 99241 in the pre-service work would lead to a duplication in the post-service time work (as 99241 includes 4 minutes of post-service time). Therefore the RUC recommended that 4 minutes of time at the usual post-service IWP/UT of 0.0224 be removed from the specialty societies recommended post-service time work value. This time change was reflected in the following building block methodology:

Pre-service median time	15 minutes Pre-service reference code: 99241	0.64
Intra-service time	20 minutes: 5 minutes for induction (0.057) 15 minutes of monitoring (0.031)	0.29 0.47
Post-service median time	11* minutes of post-service intensity (0.0224) (*15 minutes less 4 minutes of post-service time already built into the 99241 code)	0.25
	<b>Total</b>	<b>1.65 RVUs</b>

The RUC reviewed this methodology and felt that it accurately captured the intensity and complexity of this service **The RUC recommends a work RVU of 1.65 for 99149.**

**99148**

The specialty societies’ recommendation for this procedure 99148 *Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time* was based on the extrapolation of the relationship between “under age five” and the “five and over” central venous access codes (36555-36571). The specialty society determined the relative relationship between the pediatric and non-pediatric central venous access codes to be approximately 1.065. The specialty society applied this scaling factor to the 99149, 1.65 work relative value, which results in a work RVU recommendation of 1.75 work RVUs for 99148.

RUC recommended Work RVU for 99149	1.64
Specialty Society Scaling Factor from central venous access code age differentiation	x 1.065
Specialty Society Recommended Work RVU of 99148	1.75

The RUC reviewed this methodology and felt that it accurately captured the intensity and complexity of this service **The RUC recommends a work value of 1.75 for 99148.**

**99150**

The specialty societies’ recommendation for this procedure 99150 *Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; each additional 15 minutes intra-service time* or *Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; each additional 15 minutes intra-service time* includes multiplying the 15 minutes of intra-service time the same intensity utilized for monitoring time in the base code (0.031).

Specialty Society Recommended Intra-Service Time	15 Minutes
Monitoring intensity as described in 99149	0.031
Specialty Society Recommended Work RVU	0.47

The RUC reviewed this methodology and felt that it accurately captured the intensity and complexity of this service. **The RUC recommends a work relative value of 0.47 for CPT code 99150.**

**99144**

The RUC discussed 99144 *Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time.* The RUC felt that there should be a reduction in the intensity associated with the pre and post-service times of this code. The specialty society agreed that the intensity of the pre and post service time should be reduced by 50% (from 0.0224 to 0.0112) to account for the duplicative work associated when this service is performed with another procedural code by the same provider. However, the specialty society did state that they tried to account for this duplication by decreasing the surveyed pre-service time of 15 minutes to 10 minutes. As the intensity decrease will now account for this duplication, the specialty society requests that the surveyed pre-service time of 15 minutes be reinstated. In addition, the specialty societies explained that the intra-service work for the new code should reflect a 50% reduction in the intra-service work calculated for 99149 (RUC Approved work relative value for intra-service = 0.76) to account for the multiple procedures performed by a single provider, resulting in an intra-service work RVU of 0.38. Therefore, the following times and intensities were used to develop the RUC’s recommendation of 0.66 work relative value for 99144.

Pre-Service	15 minutes x 0.0112	0.168
Intra-Service	(5 minutes x 0.057 + 15 minutes x 0.031) x 0.50	0.380
Post Service	10 minutes x 0.0112	0.112
	Total	0.66

**The RUC recommends a work relative value of 0.66 work for 99144.**

**99143**

The RUC discussed 99143 *Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time.* The specialty societies based their work recommendation for this code on the extrapolation of the relationship between the “under age five” and “the five and over” central venous access codes (36555-36571). The specialty society determined the relative relationship between the pediatric and non-pediatric central venous access codes to be approximately 1.065.

The specialty society applied this scaling factor to the newly recommended work RVU of 99144, 0.66 RVU which results in a work RVU recommendation of 0.70 for 99143. The RUC agrees that this is appropriate as it is also the mean of the work relative values from the codes that previously were utilized to report this service 99141 (work relative value = .80) and 99142 (work relative value = 0.60).

Facilitation Committee Recommended Work RVU for 99144	0.66
Specialty Society Scaling Factor from central venous access code age differentiation	x 1.065
Facilitation Committee Recommended Work RVU for 99143	0.70

**The RUC recommends a work relative value of 0.70 for 99143.**

**99145**

The RUC discussed 99145 *Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; each additional 15 minutes intra-service time.* The specialty societies agreed that this procedure should be crosswalked to 99150 however, they felt that to account for the multiple procedures being performed by a single provider the intensity associated with 99150, 0.031, should be reduced by 50% resulting in an intensity of 0.0155. This new value should be applied to the 15 minute increment of intra-service time for this procedure resulting in a work relative value of 0.23.

Specialty Society Recommended Intra-Service Time	15
50% reduction of the Intensity of Intra-Service Work of 99150	0.0155
Facilitation Committee Recommended Work RVU for 99145	0.23

**The RUC recommends a work relative value of 0.23 for 99145.**

**Practice Expense:**

The practice expense inputs were reviewed by the RUC. Modifications were made to the specialty societies' recommendations to reflect PEAC standards for conscious sedation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p><i>Services involving administration of anesthesia ...</i></p> <p><i>The reporting of anesthesia services is appropriate ...</i></p> <p><i>Items used by all physicians in reporting their services ...</i></p> <p>To report <u>moderate (conscious) sedation with or without analgesia (conscious sedation)</u> provided by a physician also performing the service for which conscious sedation is being provided, see codes <u>99143-99145 99141, 99142</u>. <u>When any physician, other than the physician performing the procedure, provides anesthesia services as specified in CPT guidelines (conscious sedation or otherwise), the Anesthesia codes should be reported.</u> (For the procedures listed in Appendix G <u>when a second physician other than the healthcare professional performing the diagnostic or therapeutic services, provides moderate (conscious) sedation in the facility setting, the second physician reports the associated moderate sedation procedure/service 99148-99150; when these services are performed by the second physician in the non-facility setting, codes 99148-99150 would not be reported.</u>) Moderate sedation does not include minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care (00100-01999).</p> <p><i>To report regional or general anesthesia provided by...</i></p>				
<p><b>Medicine</b></p> <p><b><u>Moderate (Conscious) Sedation</u></b></p> <p><b><u>Sedation With or Without Analgesia (Conscious Sedation)</u></b></p>				
<p><del>Sedation with or without analgesia (conscious sedation) is used to achieve a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and ability to respond to stimulation or verbal commands. Conscious sedation includes performance and documentation of pre and post sedation evaluations of the patient, administration of the sedation and/or analgesic agent(s), and monitoring of cardiorespiratory function (ie, pulse oximetry, cardiorespiratory monitor, and blood pressure). The use of these codes requires the presence of an independent trained observer to assist the physician in monitoring the patient's level of consciousness and physiological status.</del></p> <p><u>Moderate (conscious) sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and</u></p>				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p><u>spontaneous ventilation is adequate. Cardiovascular function is usually maintained.</u></p> <p><u>Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care (00100-01999).</u></p> <p><u>When providing moderate sedation, the following services are included and not reported separately:</u></p> <ol style="list-style-type: none"> <li>1. <u>Assessment of the patient (not included in intra service time)</u></li> <li>2. <u>Establishment of IV access and fluids to maintain patency, when performed</u></li> <li>3. <u>Administration of agent(s)</u></li> <li>4. <u>Maintenance of sedation</u></li> <li>5. <u>Monitoring of oxygen saturation, heart rate and blood pressure</u></li> <li>6. <u>Recovery (not included in intra service time)</u></li> </ol> <p><u>Intra-service time starts with the administration of the sedation agent(s), requires continuous face to face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.</u></p> <p><u>Do not report 99143-99150 in conjunction with 94760–94762.</u></p> <p><u>Do not report 99143–99145 in conjunction with codes listed in Appendix G. Do not report 99148–99150 w in conjunction ith codes listed in Appendix G when performed in the non-facility setting.</u></p> <p><u>When a second physician other than the healthcare professional performing the diagnostic or therapeutic services, provides moderate sedation in the facility setting (eg hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility) for the procedures listed in Appendix G, the second physician reports 99148-99150. However, for the circumstances in which these services are performed by the second physician in the non-facility setting (eg, physician office, freestanding imaging center), codes 99148-99150</u></p>				

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<del>are nor reported</del>				
<del>(If the sedation with or without analgesia (conscious sedation) is administered in support of a procedure provided by another physician, see Anesthesia section)</del>				
D 99141		<del>Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation (94760-94762 may not be reported in addition to 99141)</del>	XXX	N/A
D 99142		<del>oral, rectal and/or intranasal (94760-94762 may not be reported in addition to 99142) (99141, 99142 have been deleted. To report, see 99143, 99144, 99145)</del>	XXX	N/A
Ø●99143	FF1	Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time	XXX	0.70
Ø●99144	FFF2	age 5 years or older; first 30 minutes intra-service time	XXX	0.66
+●99145	FF3	each additional 15 minutes intra-service time (List separately in addition to code for primary service)  (Use 99145 in conjunction with 99143, 99144)	ZZZ	0.23

<b>CPT Code (•New)</b>	<b>Tracking Number</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
Ø•99148	FF4	Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time	XXX	1.75
Ø•99149	FF5	age 5 years or older; first 30 minutes intra-service time	XXX	1.65
+•99150	FF6	each additional 15 minutes intra-service time (List separately in addition to code for primary service)  (Use 99150 in conjunction with 99148, 99149)	ZZZ	0.47

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:99143 Tracking Number: FFF1 Global Period: XXX

Specialty Society RVU: **0.85**RUC RVU: **0.70**

CPT Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 2-year old patient undergoes a procedure that requires moderate sedation to complete safely and with minimal emotional trauma. The physician will supervise and direct an independent trained observer who will assist in monitoring the patient's level of consciousness and physiologic status throughout the procedure.

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?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The procedural/sedating physician performs and documents a thorough patient assessment to assure that moderate sedation can be safely provided outside of an operating room setting. This assessment includes a review of the patient's current and past medical history (eg, concurrent acute illness or chronic diseases, current medications, allergy history, immunization status, prior medical and surgical history, response to any previous sedative or analgesic agents, etc.) The timing of the patient's last meal must also be determined. A physical exam is completed with an emphasis on underlying pathology that might negatively impact the induction or recovery from the sedative. Based upon this assessment, and the sedation and/or analgesia requirements of the procedure, the physician must then determine the appropriate pharmacologic agent(s) to be used, including dosing and route of administration. The sedation process, including the risks and benefits, are explained to the parent(s) or legal guardian and consent is obtained. The patient is verbally prepared for the procedure and the appropriate monitoring equipment (heart rate, respiration, pulse oximetry, intermittent blood pressure) is connected to the patient. The physician confirms that the independent observer has assured the availability and the appropriate functioning of oxygen, suctioning equipment, artificial airways, masks, and resuscitation bags.

Description of Intra-Service Work: The physician supervises the administration and induction of the sedating agent, with or without an analgesic, initiated by the independent trained observer. The patient is assessed continuously until an effective and safe level of moderate sedation and/or analgesia is achieved. Additional doses of sedating and/or analgesic agent(s) are ordered by the physician as needed. The physician's intra-service time ends when the procedure is complete, the patient is physiologically stable, and face-to-face physician time is no longer required.

Description of Post-Service Work: Upon completion of the procedure, the independent observer continues to monitor the patient. The physician returns and re-assesses the patient until the patient reaches a pre-sedation level of consciousness. The physician then establishes if pre-determined discharge criteria have been met. These assessments and the final assessment are documented in the procedural records and discharge instructions are provided to the parent(s) or legal guardian

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Steven Krug, MD; Charles Mick, MD; Lanny Garvar, DMD; Timothy Shahbazian, DDS

<b>Specialty(s):</b>	American Academy of Pediatrics, American College of Emergency Physicians, North American Spine Society, American Association of Oral and Maxillofacial Surgeons				
<b>CPT Code:</b>	99143				
<b>Sample Size:</b>	196	<b>Resp n:</b>	42	<b>Response:</b> 21.42 %	
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	2.00	3.00	3.97	5.00
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	5.00	25.00	30.00	37.50	67.50
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>10.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u> 99291	<u>Global</u> XXX	<u>Work RVU</u> 3.99
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CPT Descriptor Critical care, evaluation and management of the critically ill or injured patient; first 30-74 minutes

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u> 92012	<u>Global</u> XXX	<u>Work RVU</u> 0.67
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CPT Descriptor 1 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

<u>MPC CPT Code 2</u> 90862	<u>Global</u> XXX	<u>Work RVU</u> 0.95
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CPT Descriptor 2 Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

<u>Other Reference CPT Code</u> 99284	<u>Global</u> XXX	<u>Work RVU</u> 1.95
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CPT Descriptor Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 23.8 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 99143</b>	<b>Key Reference CPT Code: 99291</b>
Median Pre-Service Time	15.00	15.00
Median Intra-Service Time	30.00	45.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>55.00</b>	<b>75.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.57	3.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.11	3.46
Urgency of medical decision making	3.63	3.80

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.24	3.74
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Physical effort required	3.14	2.91
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.29	3.83
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Outcome depends on the skill and judgment of physician	4.46	4.03
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Estimated risk of malpractice suit with poor outcome	4.54	3.74
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.86	3.03
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Intra-Service intensity/complexity	4.03	3.74
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Post-Service intensity/complexity	2.83	2.65
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**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.*

Please see attached revised rationale.



Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99213

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:99144 Tracking Number: FFF2 Global Period: XXX

Specialty Society RVU: **0.80**RUC RVU: **0.66**

CPT Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient 5 years of age or older presents with a complaint necessitating performance of some procedure or service (i.e., the "supported procedure"), in support for which moderate sedation is deemed clinically appropriate. The treating physician will perform both the supported procedure and the moderate sedation service.

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: The sedation process, including risks and benefits, is explained to the patient, family, and/or legal guardian, and consent is obtained. The physician performs and documents a patient assessment to assure that moderate sedation can be safely provided outside of an operating room setting. This assessment involves a medical history review (e.g., current medications, allergies, prior medical and surgical history, response to any previous sedative or analgesic agents, time since the most recent meal, etc.), as well as a physical exam with emphasis on underlying pathology that might negatively impact the induction with or recovery from sedating agents. Based upon the patient's age, presenting problem(s), medical history, examination, and the type of sedation-supported procedure and its projected duration, the physician determines the appropriate sedating agent(s), route of administration, and respective dosage to be used. The patient is verbally prepared for the sedation procedure. The physician directs that monitoring technology be implemented as needed, and that an independent trained observer be available to assist the physician in monitoring the patient's level of consciousness and physiological status. The availability and appropriate functioning of any materiel necessary for cardiorespiratory intervention are confirmed.

Description of Intra-Service Work: The physician supervises the administration and induction of the sedating agent, with or without an analgesic, initiated by the independent trained observer. The patient is observed until a safe and effective level of moderate sedation is achieved. The physician, assisted by the independent trained observer, continually assesses the patient's level of consciousness and physiological status throughout performance of the supported procedure. Additional doses of sedating agent are ordered by the physician, as needed to maintain the achieved level of sedation for the supported procedure.

Description of Post-Service Work: Upon completion of the supported procedure, the independent trained observer continues to monitor the patient. If there are any untoward reactions resulting from conscious sedation, the physician determines the appropriate patient care management. The physician reassesses the patient's clinical condition to assure that the patient has returned to the pre-sedation level of consciousness. This assessment is documented in the medical record, and discharge instructions are provided for the patient, family, and/or legal guardian

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Steven Krug, MD; Charles Mick, MD; Lanny Garvar, DMD; Timothy Shahbazian, DDS

<b>Specialty(s):</b>	American College of Emergency Physicians, North American Spine Society, American Association of Oral and Maxillofacial Surgeons, American Academy of Pediatrics				
<b>CPT Code:</b>	99144				
<b>Sample Size:</b>	376	<b>Resp n:</b>	66	<b>Response:</b> 17.55 %	
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.33	1.93	2.40	3.90	7.98
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	4.00	15.00	20.00	30.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>10.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99291	XXX	3.99

CPT Descriptor Critical care, evaluation and management of the critically ill or injured patient; first 30-74 minutes

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
92012	XXX	0.67

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
90862	XXX	0.95

CPT Descriptor 2 Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99284	XXX	1.95

CPT Descriptor Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 21.2 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 99144</u>	<u>Key Reference CPT Code: 99291</u>
Median Pre-Service Time	15.00	15.00
Median Intra-Service Time	20.00	45.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	45.00	75.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.56	3.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	3.41
Urgency of medical decision making	3.85	3.74

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.88	3.78
Physical effort required	3.33	3.38

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.32	3.73
Outcome depends on the skill and judgment of physician	4.27	3.88
Estimated risk of malpractice suit with poor outcome	4.61	3.91

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.21	4.09
Intra-Service intensity/complexity	4.09	3.74
Post-Service intensity/complexity	3.08	3.03

**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.*

Please see attached revised rationale.

**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. Moderate sedation is provided in support of another procedure.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99141-99142

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

- Specialty ACEP                      How often? Commonly
- Specialty AAMOS                      How often? Commonly
- Specialty NASS                      How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1789000  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty ACEP	Frequency 250000	Percentage	%
Specialty AAOMS	Frequency 1519000	Percentage	%
Specialty NASS	Frequency 20000	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 268,350  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty ACEP	Frequency 37500	Percentage	%
Specialty AAOMS	Frequency 227850	Percentage	%
Specialty NASS	Frequency 3000	Percentage	%

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99213

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:99145 Tracking Number: FFF3 Global Period: ZZZ

Specialty Society RVU: **0.27**

**RUC RVU: 0.23**

CPT Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient 5 years of age or older presents with a complaint necessitating performance of some procedure or service (i.e., the "supported procedure"), in support for which moderate sedation is deemed clinically appropriate. The treating physician will perform both the supported procedure and the moderate sedation service.

Percentage of Survey Respondents who found Vignette to be Typical:

Is conscious sedation inherent to this procedure?      Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: The physician, assisted by the independent trained observer, continually assesses the patient's level of consciousness and physiological status throughout performance of the supported procedure. Additional doses of sedating agent are ordered by the physician, as needed to maintain the achieved level of sedation for the supported procedure.

Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Steven Krug, MD; Charles Mick, MD; Lanny Garvar, DMD; Timothy Shahbazian, DDS				
<b>Specialty(s):</b>	American College of Emergency Physicians, North American Spine Society, American Association of Oral and Maxillofacial Surgeons, American Academy of Pediatrics				
<b>CPT Code:</b>	99145				
<b>Sample Size:</b>	0	<b>Resp n:</b>	0	<b>Response:</b>	%
<b>Sample Type:</b>					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>					
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>			15.00		
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>0.00</u>				

<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0				
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0			
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00				
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).



**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	<input type="text"/>	<input type="text"/>
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	<input type="text"/>	<input type="text"/>
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Urgency of medical decision making	<input type="text"/>	<input type="text"/>
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	<input type="text"/>	<input type="text"/>
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Physical effort required	<input type="text"/>	<input type="text"/>
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	<input type="text"/>	<input type="text"/>
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Outcome depends on the skill and judgment of physician	<input type="text"/>	<input type="text"/>
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Estimated risk of malpractice suit with poor outcome	<input type="text"/>	<input type="text"/>
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**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	<input type="text"/>	<input type="text"/>
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Intra-Service intensity/complexity	<input type="text"/>	<input type="text"/>
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Post-Service intensity/complexity	<input type="text"/>	<input type="text"/>
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**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.*

Please see attached revised rationale.

**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) 99141-99142

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty                      How often?

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty                      Frequency 0                      Percentage                      %

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?

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99212

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:99148 Tracking Number: FFF4 Global Period: XXX

**Recommended Work Relative Value**Specialty Society RVU: **1.84**RUC RVU: **1.75**

CPT Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 3-year old patient undergoes a procedure that requires moderate sedation to complete safely and with minimal emotional trauma. The physician performing the procedure requests that the sedation be delivered and monitored by a second physician.

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?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The sedating physician first performs and documents a thorough patient assessment to assure that moderate sedation can be safely provided outside of an operating room setting. This assessment includes a detailed review of the patient's current and past medical history (eg, historical factors necessitating the procedure, concurrent acute illness or chronic diseases, current medications, allergy history, immunization status, prior medical and surgical history, and response to any previous sedative or analgesic agents, etc). The timing of the patient's last meal must also be determined. A physical exam is completed with an emphasis on underlying pathology that might negatively impact the induction or recovery from the sedative. Based upon this assessment, and the sedation and/or analgesia requirements of the procedure, the sedating physician must then determine the appropriate pharmacologic agent(s) to be used, including dosing and route of administration. The sedation process, including the risks and benefits, are explained to the parent(s) or legal guardian and consent is obtained. The patient is verbally prepared for the procedure and the appropriate monitoring equipment (heart rate, respiration, pulse oximetry, intermittent blood pressure) is connected to the patient. The availability and the appropriate functioning of oxygen, suctioning equipment, artificial airways, masks, and resuscitation bags are confirmed.

Description of Intra-Service Work: The sedating agent(s) with or without an analgesic agent is administered and the patient is assessed continuously until an effective and safe level of moderate sedation and/or analgesia is achieved. The patient is closely monitored by the sedating physician and additional doses of sedating and/or analgesic agent(s) are delivered as needed. The sedating physician's intra-service time ends when the procedure is complete, the patient is physiologically stable, and face-to-face time with the sedating physician is no longer required.

Description of Post-Service Work: Upon completion of the sedation and when the patient is physiologically stable, patient monitoring is returned to the procedural physician and/or clinical staff. The sedating physician returns and re-assesses the patient until the patient reaches a pre-sedation level of consciousness. The sedating physician then establishes if pre-determined discharge criteria have been met. These assessments and the final assessment are documented in the procedural records and post-sedation instructions are provided to the parent(s) or legal guardian. This information is then communicated to the procedural physician.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Steven Krug, MD; Charles Mick, MD; Lanny Garvar, DMD; Timothy Shahbazian, DDS

<b>Specialty(s):</b>	American Academy of Pediatrics, American College of Emergency Physicians, North American Spine Society, American Association of Oral and Maxillofacial Surgeons				
<b>CPT Code:</b>	99148				
<b>Sample Size:</b>	71	<b>Resp n:</b>	31	<b>Response:</b> 43.66 %	
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.20	1.96	3.00	3.62	5.55
<b>Pre-Service Evaluation Time:</b>			20.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	10.00	30.00	30.00	45.00	95.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>15.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99291	XXX	3.99

CPT Descriptor Critical care, evaluation and management of the critically ill or injured patient; first 30-74 minutes

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
92004	XXX	1.67

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
71275	XXX	1.92

CPT Descriptor 2 Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99284	XXX	1.95

CPT Descriptor Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 32.2 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 99148</u>	<u>Key Reference CPT Code: 99291</u>
Median Pre-Service Time	20.00	15.00
Median Intra-Service Time	30.00	45.00
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	65.00	75.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.79	4.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	4.03
Urgency of medical decision making	4.10	4.14

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.38	4.10
Physical effort required	3.31	3.31

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.52	4.24
Outcome depends on the skill and judgment of physician	4.76	4.28
Estimated risk of malpractice suit with poor outcome	4.86	4.31

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.69	3.31
Intra-Service intensity/complexity	4.45	4.21
Post-Service intensity/complexity	3.24	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.*

Please see attached revised rationale.



Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99284

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:99149 Tracking Number: FFF5 Global Period: XXX

Recommended Work Relative Value

Specialty Society RVU: 1.73

RUC RVU: 1.64

CPT Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; first 30 minutes intra-service time

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient 5 years of age or older presents with a complaint necessitating performance of some procedure or service (i.e., the "supported procedure"), in support for which moderate sedation is deemed clinically appropriate. One health care professional will perform the supported procedure, while a different physician will provide the moderate sedation service.

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: The sedation process, including risks and benefits, is explained to the patient, family, and/or legal guardian, and consent is obtained. The physician providing sedation performs and documents a patient assessment to assure that moderate sedation can be safely provided outside of an operating room setting. This assessment involves a medical history review (e.g., current medications, allergies, prior medical and surgical history, response to any previous sedative or analgesic agents, time since the most recent meal, etc.), as well as a physical exam with emphasis on underlying pathology that might negatively impact the induction with or recovery from sedating agents. Based upon the patient's age, presenting problem(s), medical history, examination, and the type of sedation-supported procedure and its projected duration, the physician determines the appropriate sedating agent(s), route of administration, and respective dosage to be used. The patient is verbally prepared for the sedation procedure. The physician directs that monitoring technology be implemented as needed. The availability and appropriate functioning of any materiel necessary for cardiorespiratory intervention are confirmed.

Description of Intra-Service Work: Administration of the sedating agent, with or without an analgesic, is initiated. The patient is observed until a safe and effective level of moderate sedation is achieved. The physician continuously face-to-face assesses the patient's level of consciousness and physiological status throughout performance of the supported procedure. Additional doses of sedating agent are ordered by the physician, as needed to maintain the achieved level of sedation for the supported procedure.

Description of Post-Service Work: If, following cessation of continuous face-to-face assessment of the patient's level of consciousness and physiological status, there are any untoward reactions resulting from sedation, the physician providing sedation determines the appropriate patient care management. The physician reassesses the patient's clinical condition to assure that the patient has returned to the pre-sedation level of consciousness. This assessment is documented in the medical record, and discharge instructions are provided for the patient, family, and/or legal guardian.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Steven Krug, MD; Charles Mick, MD; Lanny Garvar, DMD; Timothy Shahbazian, DDS
<b>Specialty(s):</b>	American College of Emergency Physicians, North American Spine Society, American Association of Oral and Maxillofacial Surgeons, American Academy of Pediatrics

CPT Code: 99149					
Sample Size: 251	Resp n: 51	Response: 20.31 %			
Sample Type: Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:	0.33	1.78	2.45	3.70	7.98
Pre-Service Evaluation Time:			15.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	5.00	15.00	20.00	30.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>11.00</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>
99284	XXX	1.95

CPT Descriptor Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
92004	XXX	1.67

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
71275	XXX	1.92

CPT Descriptor 2 Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99291	XXX	3.99

CPT Descriptor Critical care, evaluation and management of the critically ill or injured patient; first 30-74 minutes

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 14      % of respondents: 27.4 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 99149</b>	<b>Key Reference CPT Code: 99284</b>
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	20.00	0.00
Median Immediate Post-service Time	11.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>46.00</b>	<b>0.00</b>
Other time if appropriate		42.00

**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	3.65	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	3.62
Urgency of medical decision making	4.02	3.66

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.96	3.80
Physical effort required	3.33	3.44

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.53	3.82
Outcome depends on the skill and judgment of physician	4.41	3.98
Estimated risk of malpractice suit with poor outcome	4.82	4.41

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.49	3.34
Intra-Service intensity/complexity	4.31	3.94
Post-Service intensity/complexity	3.27	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.*

Please see attached revised rationale.

**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. N/A

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Using the appropriate anesthesia 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 ACEP                      How often? Commonly

Specialty NASS                      How often? Sometimes

Specialty                              How often?

Estimate the number of times this service might be provided nationally in a one-year period? 41000  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty ACEP                      Frequency 40000                      Percentage                      %

Specialty NASS                      Frequency 1000                      Percentage                      %

Specialty                              Frequency 0                      Percentage                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
6,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty ACEP                      Frequency 6000                      Percentage                      %

Specialty NASS                      Frequency 500                      Percentage                      %

Specialty                              Frequency 0                      Percentage                      %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale. 99284

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

**CPT Long Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time**

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: **XXX**

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**After discussion and analysis by an expert panel consisting of representatives from AAP, ACEP, NASS, and AAOMS, the PEAC standard conscious sedation direct practice expense inputs were crosswalked to codes 99143-991450.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **Two minutes to initiate sedation (PEAC standard)**

Intra-Service Clinical Labor Activities: **Clinical labor time equal to the physician intra service time for monitoring during the procedure (PEAC standard) and 15 minutes of follow-up monitoring for each hour monitored following the procedure (PEAC standard)**

Post-Service Clinical Labor Activities: **N/A**

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:99150 Tracking Number: FFF6 Global Period: ZZZ

**Recommended Work Relative Value**  
Specialty Society RVU: **0.47**

**RUC RVU: 0.47**

CPT Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey:

Percentage of Survey Respondents who found Vignette to be Typical:

Is conscious sedation inherent to this procedure?      Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code?

Description of Pre-Service Work:

Description of Intra-Service Work: The patient is closely monitored by the sedating physician and additional doses of sedating and/or analgesic agent(s) are delivered as needed. The sedating physician's intra-service time ends when the procedure is complete, the patient is physiologically stable, and face-to-face time with the sedating physician is no longer required.

Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Steven Krug, MD; Charles Mick, MD; Lanny Garvar, DMD; Timothy Shahbazian, DDS				
<b>Specialty(s):</b>	American Academy of Pediatrics, American College of Emergency Physicians, North American Spine Society, American Association of Oral and Maxillofacial Surgeons				
<b>CPT Code:</b>	99150				
<b>Sample Size:</b>	0	<b>Resp n:</b>	0	<b>Response:</b>	0.00 %
<b>Sample Type:</b>					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>					
<b>Pre-Service Evaluation Time:</b>				0.0	
<b>Pre-Service Positioning Time:</b>				0.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0	
<b>Intra-Service Time:</b>				15.00	
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>0.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	

<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x <b>0.00</b> 99239x <b>0.00</b>
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x <b>0.0</b> 12x <b>0.0</b> 13x <b>0.0</b> 14x <b>0.0</b> 15x <b>0.0</b>

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).



**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	<input type="text"/>	<input type="text"/>
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	<input type="text"/>	<input type="text"/>
--	----------------------	----------------------

Urgency of medical decision making	<input type="text"/>	<input type="text"/>
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	<input type="text"/>	<input type="text"/>
--------------------------	----------------------	----------------------

Physical effort required	<input type="text"/>	<input type="text"/>
--------------------------	----------------------	----------------------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	<input type="text"/>	<input type="text"/>
---	----------------------	----------------------

Outcome depends on the skill and judgment of physician	<input type="text"/>	<input type="text"/>
--	----------------------	----------------------

Estimated risk of malpractice suit with poor outcome	<input type="text"/>	<input type="text"/>
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**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	<input type="text"/>	<input type="text"/>
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Intra-Service intensity/complexity	<input type="text"/>	<input type="text"/>
------------------------------------	----------------------	----------------------

Post-Service intensity/complexity	<input type="text"/>	<input type="text"/>
-----------------------------------	----------------------	----------------------

**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.*

Please see attached revised rationale.

**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. N/A

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Using the appropriate anesthesia 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                                      How often?
- Specialty                                      How often?
- Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

- Specialty                      Frequency 0                      Percentage                      %
- 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?

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99213

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs

CPT Long Descriptor: **Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time**

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: **XXX**

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**After discussion and analysis by an expert panel consisting of representatives from AAP, ACEP, NASS, and AAOMS, the PEAC standard conscious sedation direct practice expense inputs were crosswalked to codes 991443-991450.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **Two minutes to initiate sedation (PEAC standard)**

Intra-Service Clinical Labor Activities: **Clinical labor time equal to the physician intra service time for monitoring during the procedure (PEAC standard) and 15 minutes of follow-up monitoring for each hour monitored following the procedure (PEAC standard)**

Post-Service Clinical Labor Activities: **N/A**

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
ZZZ Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: **Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)**

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: **ZZZ**

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:

**After discussion and analysis by an expert panel consisting of representatives from AAP, ACEP, NASS, and AAOMS, the PEAC standard conscious sedation direct practice expense inputs were crosswalked to codes 99143-991450.**

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities: **Clinical labor time equal to the physician intra service time for monitoring during the procedure (PEAC standard) and 15 minutes of follow-up monitoring for each hour monitored following the procedure (PEAC standard)**

	A	B	C	D	E	F	G	H	I
1									
2	<b>TAB C (REVISED 04/30/05)</b>			<b>CPT Code: 99143</b>		<b>CPT Code: 99144</b>		<b>CPT Code: 99145</b>	
	Meeting Date: April 2005 RUC			<b>Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time</b>		<b>Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time</b>		<b>Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time</b>	
3									
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>								
6	<b>TOTAL CLINICAL LABOR TIME</b>	L051A	RN	47.00	0.00	47.00	0.00	15.00	0.00
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			0.00	0.00	0.00	0.00	0.00	0.00
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			47.00	0.00	47.00	0.00	15.00	0.00
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			0.00	0.00	0.00	0.00	0.00	0.00
10	<b>PRE-SERVICE</b>								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity. Initiate sedation			0	0	0	0	0	0
18	End: When patient enters office/facility for surgery/procedure								
19	<b>SERVICE PERIOD</b>								
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	L051A	RN	2	0	2	0	0	0
30	<b>Intra-service</b>								
31	Clinical staff time equal to physician intra-service time	L051A	RN	30	0	30	0	15	0
32	<b>Post-Service</b>								
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. 15 minutes of follow-up monitoring for each hour monitored following the procedure	L051A	RN	15.00	0.00	15.00	0.00	0.00	0.00
42	End: Patient leaves office								
43	<b>POST-SERVICE PERIOD</b>								
44	Start: Patient leaves office/facility								
45	Conduct phone calls/call in prescriptions								

	A	B	C	D	E	F	G	H	I
2	<b>TAB C (REVISED 04/30/05)</b> Meeting Date: April 2005 RUC			<b>CPT Code: 99143</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time		<b>CPT Code: 99144</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time		<b>CPT Code: 99145</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time	
3									
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
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	0	0
56	Other Activity (please specify)								
57	End: with last office visit before end of global period								

	A	B	C	D	E	F	G	H	I
2	<b>TAB C (REVISED 04/30/05)</b> Meeting Date: April 2005 RUC			<b>CPT Code: 99143</b> <b>Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time</b>		<b>CPT Code: 99144</b> <b>Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time</b>		<b>CPT Code: 99145</b> <b>Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time</b>	
3									
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
58	<b>MEDICAL SUPPLIES</b>	<b>CMS Code</b>	<b>Unit</b>						
59	Conscious Sedation Package (Previously Approved by PEAC)			1		1			
60									
61									
62									
63	<b>EQUIPMENT</b>	<b>CMS Code</b>	<b>Unit</b>						
64	Pulse oximeter with printer	EQ211		1		1		1	
65	IV infusion pump	EQ032		1		1		1	
66	Oxygen system, portable	EQ192		1		1		1	
67	Cardio-respiratory monitor			1		1		1	
68									
69									
70									
71									
72									

	A	B	C	J	K	L	M	N	O
1									
2	<b>TAB C (REVISED 04/30/05)</b> Meeting Date: April 2005 RUC			<b>CPT Code: 99148</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time	<b>CPT Code: 99149</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; first 30 minutes intra-service time	<b>CPT Code: 99150</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time			
3									
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>								
6	<b>TOTAL CLINICAL LABOR TIME</b>	L051A	RN	N/A	0.00	N/A	0.00	N/A	0.00
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			N/A	0.00	N/A	0.00	N/A	0.00
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			N/A	0.00	N/A	0.00	N/A	0.00
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			N/A	0.00	N/A	0.00	N/A	0.00
10	<b>PRE-SERVICE</b>								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity: Initiate sedation			0	0	0	0	0	0
18	End: When patient enters office/facility for surgery/procedure								
19	<b>SERVICE PERIOD</b>								
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	L051A	RN	0	0	0	0	0	0
30	Intra-service								
31	Clinical staff time equal to physician Intra-service time	L051A	RN	0	0	0	0	0	0
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. 15 minutes of follow-up monitoring for each hour monitored following the procedure	L051A	RN	0.00	0.00	0.00	0.00	0.00	0.00
42	End: Patient leaves office								
43	<b>POST-SERVICE PERIOD</b>								
44	Start: Patient leaves office/facility								
45	Conduct phone calls/call in prescriptions								

	A	B	C	J	K	L	M	N	O
2	<b>TAB C (REVISED 04/30/05)</b> Meeting Date: April 2005 RUC			<b>CPT Code: 99148</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; under 5 years of age; first 30 minutes intra-service time	<b>CPT Code: 99149</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; age 5 years or older; first 30 minutes intra-service time	<b>CPT Code: 99150</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time			
3									
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
46	<i>Office visits. Greet patient, escort to room, provide gowning, interval history &amp; vital signs and chart; assemble previous test reports/results, assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies, coordinate home or outpatient care</i>								
47	<i>List Number and Level of Office Visits</i>								
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	<i>Total Office Visit Time</i>			0	0	0	0	0	0
56	Other Activity (please specify)								
57	<b>End: with last office visit before end of global period</b>								

	A	B	C	J	K	L	M	N	O
2	<b>TAB C (REVISED 04/30/05)</b> Meeting Date: April 2005 RUC			<b>CPT Code: 99148</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time		<b>CPT Code: 99149</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; first 30 minutes intra-service time		<b>CPT Code: 99150</b> Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time	
3									
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
58	<b>MEDICAL SUPPLIES</b>	<b>CMS Code</b>	<b>Unit</b>						
59	Conscious Sedation Package (Previously Approved by PEAC)								
60									
61									
62									
63	<b>EQUIPMENT</b>	<b>CMS Code</b>	<b>Unit</b>						
64	Pulse oximeter with printer	EQ211							
65	IV infusion pump	EQ032							
66	Oxygen system, portable	EQ192							
67	Cardio-respiratory monitor								
68									
69									
70									
71									
72									

**Tab C: Moderate Sedation  
99148-99150 (FFF4-FFF6)**

**Background: April 1997 RUC Rationale For Codes 99141-99142**

*The RUC considered two new CPT codes for conscious sedation; 99141, Sedation with or without analgesia (conscious sedation); intravenous, intra-muscular or inhalation, and 99142, oral, rectal and/or intranasal. The RUC agreed that conscious sedation represents the lowest end of the spectrum of anesthesia services and the only comparable codes would be anesthesia codes. However, the intra service portion for the sedation alone is not as intense as an anesthesia service because the physician's attention is devoted to the principal procedure and the pre and post work for conscious sedation is more similar to an evaluation and management service.*

*The RUC chose to evaluate 99141 and 99142 by assigning what was believed to be appropriate intra-service work per-unit of time (IWPUT) for the pre-, intra-, and post-service periods. When reviewing intra-service work, the RUC recommends 50% of the accepted anesthesia intra-work intensity,  $.5(.017) = .0085$ , and 20 minutes of intra-service work. Half of the anesthesia work intensity was selected because physicians do not spend all their time and effort on anesthesia, in that they are involved with the primary service. Twenty minutes of intra-service time is supported by the pediatric survey data and adequately distinguishes the provision of sedation from the primary procedure.*

*For both pre and post-service work the RUC recommends assigning an IWPUT equivalent to an evaluation and management service (0.027) and assuming 10 minutes for both pre and post time. The RUC arrived at 10 minutes of work because it is supported in the survey data which show median time in excess of 10 minutes and because it was felt that some of the pre and post-work for the primary service overlaps with work for conscious sedation. It was expressed that the survey results of 1.80 and 2.40 did not recognize the overlap of time with the primary procedure.*

*The resulting calculation is:  $10(.027) + 20(.0085) + 10(.027) = 0.71$  RVUs. The RUC viewed the value of 0.71 RVUs as a middle range. The value was adjusted up for 99141 to 0.80 and down for 99142 to 0.60. This adjustment compensated for the varying levels of difficulty associated with the two routes for administration of the sedation.*

**April 2005 Moderate Sedation Revised Rationale**

A coalition of diverse specialties who perform moderate sedation for a wide spectrum of indications met and reviewed the survey data.

**99149 (FFF5)**

We believe the median survey times are correct, but the median recommended work RVU is too high. The most commonly selected reference code was 99284 (by 27.4%) of respondents. We do not think this is a good choice because there is no RUC time data for this code. 99149 is a sedation code and the most appropriate reference code should come from this section of CPT. We reviewed anesthesia codes and selected eight anesthesia codes for which intravenous sedation (monitored anesthesia care or deep sedation) is often administered. In many situations, the anesthesiologist performing these codes is providing the sedation for the same index procedure that a non-anesthesiologist would use 99149.

CPT Code	Long Descriptor	Time Source	Anes Base Units	Pre-Time	Intra-Time	Post-Time	Pre- & Post-Times	Total Time	RUC Meeting Date	Vignette	RUC Review
00142	Anesthesia for procedures on eye; lens surgery	No data	4								NO
00635	Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture	RUC time	4	15	42.5	15	27.5	70	October 2000	Yes	YES
00640	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine	RUC time 2003	3	15	27.5	10			Feb02	Yes	YES
01112	Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest	No data	5	15					October 2000		YES
01820	Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones	No data	3								NO
01905	Anesthesia for myelography, diskography, vertebroplasty	RUC time	5	15	60	15	30	90	April 2001	Yes	YES
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position	RUC time 2003	3	15	30	10			Feb02	Yes	YES
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position	RUC time 2003	5	15	30	10			Feb02	Yes	YES

Our expert panel believes that anesthesia codes 01991 and 01992 are much better reference codes to use for comparison. They were recently reviewed by the RUC and typically the procedures for which the anesthesia is required and level of anesthesia administered are similar to the survey code. Our survey times are similar to that of these codes.

	Moderate Sedation Code 99149	Anesthesia Code 01991	Anesthesia Code 01992
Pre-service time	15	15	15
Intra-service time	20	30	30
Post-service time	15	10	10
	4 base units	3 base units	5 base units

The values for these codes are 3 and 5 anesthesia base units, respectively. Code 01992 is strictly for prone procedures and is typically more complex. We believe 4 base units, an average of these two codes best represents the spectrum of cases for which 99149 will be used. Anesthesia coding

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also includes a time factor (one base unit for each 15 minute of “continuous hands on care”). We have added two time units for 99149 for a total of 6 base units. Anesthesia base units can be converted to RVUs using the following formula:

$$\text{RVUs} = \text{anesthesia units} \times (\text{anesthesia CF/fee CF}) \times 0.7805 \text{ (anesthesia work fraction)}$$

$$6 \text{ base units} \times (17.76/37.8975) \times 0.7805 = \underline{2.19 \text{ RVUs}}$$

**Alternate methodology**

We have also applied the same building block methodology used by anesthesia during the previous Five-Year Review.

Pre-service median time Pre-service reference code: 99241	15 minutes	0.64
Intra-service time	20 minutes:	
	5 minutes of Anesthesia Induction Level of Intensity (0.057)	0.29
	15 minutes of Anesthesia Intensity Level 2 (0.031)	0.47
Post-service median time	11* minutes of Anesthesia Intensity Level 1 (0.0224) (*15 minutes less 4 minutes of post-service time already built into the 99241 code)	0.25
	<b>Total</b>	<b>1.65 RVUs</b>

Our multispecialty expert panel believes that the RVU value based upon evaluation of anesthesia base units is too high for 99149. This does, however, identify an upper limit for a very similar service. The patients who receive sedation from anesthesiologists may have additional comorbidities that may increase the complexity of the service provided.

Therefore, we have opted to recommend the building block methodology to arrive at the lower recommendation of 1.65RVUs for 99149.

**99148 (FFF4)**

99148 is a similar service to 99149 but performed on patients under age five. We believe that the median survey times for this code are correct. The increased pre- and intra-service times are explained by the needs of younger patients and their parents.

We have calculated a work recommendation for 9919X4 based on extrapolation of the relationship between the “under age five” and “age five and over” central venous access codes. We determined the relative relationship between the pediatric and the non-pediatric central venous access codes to be 1.065. Applying this scaling factor to 99148 results in a work recommendation of 1.76.

$$1.65 \times 1.065 = \underline{1.76 \text{ RVUs}}$$

4/29/05

**99150 (FFF6)**

99150 is an add-on code for each additional 15-minute increment of intra-service time. We believe that there is physician work in this code due additional medical decision making and the need for additional dosing of sedation agents and/or use of reversal agents.

We have calculated a work recommendation for 99150 by multiplying 15 minutes by Anesthesia Intensity Level 2 (0.031).

15 minutes x 0.031 = 0.47 RVUs

## AMA/Specialty RVS Update Committee

### Deletion of Inpatient Follow-up Consultations and Confirmatory Consultations

#### Staff Note

At the November 2004 CPT Editorial Panel Meeting, the Panel acted to delete the inpatient follow-up consultation (CPT code 99261-99263) and the confirmatory consultation (CPT codes 99271-99275) services for *CPT 2006*. The services previously reported by these codes will now be reported by subsequent hospital visit codes (99231-99233) or other evaluation and management codes, as appropriate.

In analysis conducted in preparation for the CPT Editorial Panel meeting, it was estimated that the total impact of this coding change for Medicare would be approximately \$30,000,000. The increase in the total work relative values for the subsequent hospital visit codes is less than 1%. If a work neutrality adjustment was implemented to the subsequent hospital visit codes, it would be minimal, as follows:

	<u>2005 Work RVU</u>	<u>Work RVU with aje</u>	<u>Change</u>
99231	0.64	0.64	0.00
99232	1.06	1.05	0.01
99233	1.51	1.50	0.01

At the February 2005 RUC meeting, the RUC briefly discussed the work neutrality implications of deleting the inpatient follow-up and confirmatory consultation CPT codes in CPT with cross-references to report other existing CPT codes. The RUC understands that CMS will have the work neutrality impact analysis complete by the April RUC meeting. The RUC agreed to discuss this issue at that time.

CMS staff have reviewed this issue and responded as follows:

*I reviewed the proposed changes and do not see any reason to apply a budget neutrality factor to these services. The increase in total WRVUs is so small that a budget neutrality adjustment is not warranted.*

It appears that the CPT analysis may have overestimated the true impact and CMS does not view this to be a budget neutrality issue. The RUC, therefore, does not need to take any further action on this issue.

**E-Mail Communication between AMA and CMS staff regarding budget neutrality related to deleted inpatient and confirmatory consultation codes.**

>>> "Rick Ensor" <[Frederick.ENSOR@cms.hhs.gov](mailto:Frederick.ENSOR@cms.hhs.gov)> 3/22/2005 12:21:24 PM  
>>>

I reviewed the proposed changes and do not see any reason to apply a budget neutrality factor to these services. The increase in total WRVUs is so small that a budget neutrality adjustment is not warranted.

Rick Ensor  
Health Insurance Specialist  
Division of Practitioner Services

>> "Sherry Smith" <[Sherry\\_Smith@ama-assn.org](mailto:Sherry_Smith@ama-assn.org)> 03/17/05 05:19PM >>>  
\*\* High Priority \*\*

Rick and Gaysha

I'm not sure if Doctor Simon let you know about this and I just remembered it. So, I apologize that I did not send this to you earlier.

Attached are several document regarding CPT's decision to delete a number of E/M codes in 2006. This will involve some referencing to report other E/M codes, some of which have higher work rvus than the deleted codes.

In preparation for the Cpt Editorial Panel, the CPT staff did budget impact calculations that showed that the budget impact would be minimal. The RUC reviewed this information in February to determine whether it wanted to recommend that the work neutrality be applied to the family of E/M services or to the Conversion Factor. The RUC requested, and Doctor Simon agreed, that CMS look at the budget impact to the family of E/M services and share this with the RUC in April so the RUC could make a more informed decision.

Would you be able to take at look at this and let me know your results by April 1st?

Thank you!!

Excerpt from the November 2004 CPT Editorial Panel Meeting Minutes:

**Tab D7: E/M Elimination of Inpatient Follow-up Consultations and Confirmatory Consultations**

**Issue #1**

The Panel accepted this recommendation to delete the Follow-up Inpatient Consultation codes 99261-99263 and recommended that these services be reported with the Subsequent Hospital Care codes 99231-99233 or Subsequent Care Nursing Facility codes 99311-99313.

**Evaluation and Management Consultations**

**~~Follow-Up Inpatient Consultations~~**

~~Follow-up consultations are visits to complete the initial consultation OR subsequent consultative visits requested by the attending physician.~~

~~A follow-up consultation includes monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status.~~

~~If the physician consultant has initiated treatment at the initial consultation, and participates thereafter in the patient's management, the codes for subsequent hospital care should be used (99231-99233).~~

~~The following codes are used to report follow-up consultations provided to hospital inpatients or nursing facility residents only. For consultative services provided in other settings, the codes for office or other outpatient consultations should be reported (99241-99245).~~

~~99261 Follow-up inpatient consultation for an established patient, which requires at least two of these three key components:~~

- ~~• a problem focused interval history;~~
- ~~• a problem focused examination;~~
- ~~• medical decision making that is straightforward or of low complexity.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit~~

~~99262 Follow-up inpatient consultation for an established patient which requires at least two of these three key components:~~

- ~~• an expanded problem focused interval history;~~
- ~~• an expanded problem focused examination;~~
- ~~• medical decision making of moderate complexity.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit~~

99263 Follow up inpatient consultation for an established patient which requires at least two of these three key components:

- ~~• a detailed interval history;~~
- ~~• a detailed examination;~~
- ~~• medical decision making of high complexity.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.~~

(99261-99263 have been deleted. For follow up inpatient consultation, see Subsequent Hospital Care codes (99231-99233)).

## Issue #2

The Panel accepted this recommendation to delete the Confirmatory Consultation codes 99271-99275 and recommended that, depending upon the site of service, that these services be reported with the consultation or non-consultation E/M codes that are appropriate to the setting of care and consistent with the definition of 'consultation'.

### **Evaluation and Management Consultations Confirmatory Consultations New or Established Patient**

~~The following codes are used to report the evaluation and management services provided to patients when the consulting physician is aware of the confirmatory nature of the opinion sought (eg, when a second/third opinion is requested or required on the necessity or appropriateness of a previously recommended medical treatment or surgical procedure):~~

~~Confirmatory consultations may be provided in any setting.~~

~~A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice only. Any services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care. If a confirmatory consultation is required, eg, by a third party payor, the modifier '32', mandated services, should also be reported. (See also Consultation notes, page 14). Typical times have not yet been established for this subcategory of services.~~

(99271-99275 have been deleted. For confirmatory consultation, see the appropriate E/M service code for the setting and type of service (eg, consultation))

99271 ~~Confirmatory consultation for a new or established patient, which requires these three key components:~~

- ~~• a problem focused history;~~
- ~~• a problem focused examination;~~
- ~~• and straightforward medical decision making.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the presenting problem(s) are self limited or minor.~~

99272 ~~Confirmatory consultation for a new or established patient, which requires these three key components:~~

- ~~• an expanded problem focused history;~~
- ~~• an expanded problem focused examination;~~
- ~~• and straightforward medical decision making.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the presenting problem(s) are of low severity.~~

99273 ~~Confirmatory consultation for a new or established 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.~~

99274 ~~Confirmatory consultation for a new or established patient, which requires these three key components:~~

- ~~• a comprehensive history;~~
- ~~• a comprehensive examination;~~
- ~~• and medical decision making of moderate complexity.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the presenting problem(s) are of moderate to high severity.~~

99275

~~Confirmatory consultation for a new or established patient, which requires these three key components:~~

- ~~• a comprehensive history;~~
- ~~• a comprehensive examination;~~
- ~~• and medical decision making of high complexity.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the presenting problem(s) are of moderate to high severity.~~

**American Medical Association  
CPT Editorial Panel  
Sheraton/Bal Harbour  
Miami, FL  
November 4-7, 2004**

**Old Business:** I\_2119PA\_V2\_Elimination of Inpatient Follow-up and  
Confirmatory Consultation codes - Clinical Examples  
Update

**Date of Request:**

**Requester:** Douglas Wood, MD (Clinical Examples Task Force)

**Advisors Contacted:** All Advisors

**Literature Supplement:** Yes

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**Background:**

At the August 2004 Editorial Panel meeting, the Panel deferred the request to delete 99260-99263 for reporting follow-up consultation to the CPT Advisory Committee for discussion at the Annual Meeting in November. In addition, the Panel deferred the request to delete 99271-99275 for reporting confirmatory consultation to the CPT Advisory Committee for discussion at the Annual Meeting in November. The Panel accepted a recommendation to rescind its November 2002 action to accept the new E/M descriptors based on the use of Clinical Examples to guide code selection. The Panel decided to reconsider and resubmit to the CPT/HCPAC Advisors the Panel's November 2002 actions on changes to the codes, descriptors and guidelines for the Follow-up Inpatient Consultations (99261 - 99263), the Confirmatory Consultations (99271 - 99275), and the Nursing Facility Services (99301 - 99316). The Panel modified this recommendation by excluding the Nursing Facility Services codes, as the American Geriatric Society, in conjunction with other specialty societies, is interested in revising the Nursing Facility Services codes to incorporate the concepts of the 2002 action while not relying upon the reference code method of selection.

The information included below is provided in follow-up to those recommendations. To allow a comparison of the financial impact of the deletion of these sets of codes, a spreadsheet display of the fiscal impact of deletion of codes 99261-99263 and 99271-99275 has been included. In addition, the minutes from the August meeting has also been included.

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## Issue:

- 1) Should the CPT Editorial Panel delete the Follow-up Inpatient Consultations (99261 - 99263) codes and allow use of the Subsequent Hospital Care codes 99231-99233 in their place?
- 2) Should the CPT Editorial Panel delete the Confirmatory Consultation (99271 - 99275) codes and allow replacement use of Outpatient Services codes 99201-99215 and Hospital Inpatient Care codes 99221-99233?

## Evaluation and Management Consultations Follow-Up Inpatient Consultations

~~Follow-up consultations are visits to complete the initial consultation OR subsequent consultative visits requested by the attending physician.~~

~~A follow-up consultation includes monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status.~~

~~If the physician consultant has initiated treatment at the initial consultation, and participates thereafter in the patient's management, the codes for subsequent hospital care should be used (99231—99233).~~

~~The following codes are used to report follow-up consultations provided to hospital inpatients or nursing facility residents only. For consultative services provided in other settings, the codes for office or other outpatient consultations should be reported (99241—99245).~~

These codes have been deleted. To report these services, use the appropriate subsequent hospital care code.

~~99261 — Follow-up inpatient consultation for an established patient, which requires at least two of these three key components:~~

- ~~▲ a problem focused interval history;~~
- ~~▲ a problem focused examination;~~
- ~~▲ medical decision making that is straightforward or of low complexity.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit~~

~~99262 — Follow-up inpatient consultation for an established patient which requires at least two of these three key components:~~

- ~~▲ an expanded problem focused interval history;~~
- ~~▲ an expanded problem focused examination;~~
- ~~▲ medical decision making of moderate complexity.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

*Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit*

~~99263 ————— Follow-up inpatient consultation for an established patient which requires at least two of these three key components:~~

- ~~▲ a detailed interval history;~~
- ~~▲ a detailed examination;~~
- ~~▲ medical decision-making of high complexity.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.~~

**Evaluation and Management  
Consultations  
Confirmatory Consultations  
New or Established Patient**

*The following codes are used to report the evaluation and management services provided to patients when the consulting physician is aware of the confirmatory nature of the opinion sought (eg, when a second/third opinion is requested or required on the necessity or appropriateness of a previously recommended medical treatment or surgical procedure).*

~~Confirmatory consultations may be provided in any setting.~~

~~A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice only. Any services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care. If a confirmatory consultation is required, eg, by a third party payor, the modifier '32', mandated services, should also be reported. (See also Consultation notes, page 14). Typical times have not yet been established for this subcategory of services.~~

**These codes have been deleted. Report these services using the appropriate outpatient or inpatient E/M code.**

~~99271 ————— Confirmatory consultation for a new or established patient, which requires these three key components:~~

- ~~▲ a problem focused history;~~
- ~~▲ a problem focused examination;~~
- ~~▲ and straightforward medical decision-making.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the presenting problem(s) are self limited or minor.~~

99272

~~Confirmatory consultation for a new or established patient, which requires these three key components:~~

- ~~• an expanded problem focused history;~~
- ~~• an expanded problem focused examination;~~
- ~~• and straightforward medical decision making.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the presenting problem(s) are of low severity.~~

99273

~~Confirmatory consultation for a new or established 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.~~

99274

~~Confirmatory consultation for a new or established patient, which requires these three key components:~~

- ~~• a comprehensive history;~~
- ~~• a comprehensive examination;~~
- ~~• and medical decision making of moderate complexity.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the presenting problem(s) are of moderate to high severity.~~

99275

~~Confirmatory consultation for a new or established patient, which requires these three key components:~~

- ~~• a comprehensive history;~~
- ~~• a comprehensive examination;~~
- ~~• and medical decision making of high complexity.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the presenting problem(s) are of moderate to high severity~~

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## Rationale:

This material is a continuation of issues previously requested by the Clinical Examples Task force. The original decision to eliminate these codes came from the E/M Workgroup as an addendum recommendation to the changes suggested regarding use of Clinical Examples to determine E/M code level. The original argument for deletion of these codes stemmed from the belief that these codes were redundant, as other E/M codes (eg, Hospital Outpatient Services, Office visits) could be used in replacement of these codes.

Upon review, members of the Clinical Examples Task Force later felt it necessary to request an additional review of the requested deletions by the Advisory Committee. The Panel review this information with Advisory Committee comments in August 2004, and subsequently decided to allow more discussion during the November Advisory Committee meeting to allow as many specialties the ability to comment regarding the suggested deletions. The Panel could then make a more informed decision regarding retaining or deleting the codes in question.

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**Clinical Vignette:**

Does not apply.

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**Advisors' Comments:**

<p><b>Donald W. Aaronson, MD</b> American Academy of Allergy, Asthma and Immunology No response received.</p>
<p><b>H. Christopher Alexander, III, MD</b> American College of Physicians-American Society of Internal Medicine <b>Does not support change.</b></p>
<p><b>Louis F. Alfano, MD</b> American Society of Abdominal Surgeons No response received.</p>
<p><b>Grant P. Bagley, MD</b> American Academy of Pharmaceutical Physicians No response received.</p>
<p><b>Stephen N. Bauer, MD</b> College of American Pathologists No response received.</p>
<p><b>David I. Berland, MD</b> American Academy of Child and Adolescent Psychiatry No response received.</p>
<p><b>Albert Bothe, Jr., MD</b> American College of Surgeons No response received.</p>

<p><b>Robert L. Bree, MD</b> Society for Radiologists in Ultrasounds No response received.</p>
<p><b>Joel V. Brill, MD</b> American Gastroenterological Association</p> <p>4Supports change as proposed. 4Does not support change. 4Supports change with amendment. 4No comment. 4No response received. "Comment here."</p>
<p><b>Kenneth P. Brin, MD</b> American College of Cardiology No response received.</p>
<p><b>Daniel E. Buffington, PharmD, MBA</b> X12 Pharmacy Advisory Panel No response received.</p>
<p><b>Boyd Buser, DO</b> American Osteopathic Association No response received.</p>
<p><b>Robert B. Cameron, MD,</b> American College of Gastroenterology No response received.</p>
<p><b>Jeffery B. Carter, MD, DMD</b> American Dental Association No response received.</p>
<p><b>Mark V. Connelly, MD</b> American Academy of Facial Plastic and Reconstructive Surgery No response received.</p>
<p><b>Jeffrey Cozzens, MD</b> American Association of Neurological Surgeons No response received.</p>
<p><b>John P. Crow, MD</b> American Pediatric Surgical Association No response received.</p>
<p><b>Jeffrey A. Dann, MD</b> American Urological Association, Inc. No response received.</p>
<p><b>Leslie F. Davidson, M.S.Ed, OTR/L</b> American Occupational Therapy Association No response received.</p>
<p><b>Richard A. Dickey, MD</b> Endocrine Society No response received.</p>

<b>Debra L. Doyle, MS, CGC</b> National Society of Genetic Counselors No response received.
<b>Charles Drueck, MD</b> American Society of General Surgeons No response received.
<b>Richard Duszak, Jr., MD</b> American College of Radiology No response received.
<b>David A. Ellington, MD</b> American Academy of Family Physicians Does not support change. "The elimination of inpatient follow up codes will increase the incidence of reported concurrent care with corresponding problems with reimbursement for appropriate care."
<b>David B. Flannery, MD</b> American College of Medical Genetics No response received.
<b>Samuel A. Fleishman, MD</b> American Academy of Sleep Medicine No response received.
<b>Eduardo M. Fraifeld, MD</b> American Academy of Pain Medicine No response received.
<b>L. Neal Freeman, MD</b> American Society of Ophthalmic Plastic and Reconstructive Surgery No response received.
<b>Richard E. Fulton, MD</b> Radiologic Society of North America No response received.
<b>Bob W. Gayler, MD</b> Association of University Radiologists No response received.
<b>Elizabeth Genovese, MD</b> American College of Occupational and Environmental Medicine No response received.
<b>Robert W. Gillespie, MD</b> American Burn Association No response received.
<b>Arvind K. Goyal, MD, MPH</b> American Association of Public Health Physicians No response received.
<b>Joel Grossman, MD</b> American College of Medical Quality No response received.
<b>Gary N. Gross, MD</b> American College of Allergy, Asthma and Immunology No comment.

<b>Richard J. Hamburger, MD</b> Renal Physicians Association No response received.
<b>Robert H. Haralson III MD</b> American Orthopaedic Association No response received.
<b>M. Bradford Henley, MD</b> American Academy of Orthopaedic Surgeons No response received.
<b>David C. Hoak, MD</b> American Society of Cytopathology No response received.
<b>Stephen Hoffmann, MD</b> American Thoracic Society No response received.
<b>R. Wayne Holland, Ed.D.</b> American Speech and Language Hearing Association No response received.
<b>R. Patrick Jacob, MD</b> Congress of Neurological Surgeons No response received.
<b>Raymond V. Janevicius, MD</b> American Society of Plastic Surgeons No response received.
<b>Jodi Kaigh, MD</b> American Association of Gynecologic Laparoscopists No response received.
<b>David Keepnews, PhD, JD, RN</b> American Nurses Association No response received.
<b>James H. Kelly, MD</b> Triological Society No response received.
<b>Michael J. King, DPM</b> American Podiatric Medical Association Supports change as suggested.
<b>Katharine L. Krol, MD,</b> Society of Interventional Radiology No response received.
<b>Francis P. Lagattuta, MD</b> North American Spine Society v
<b>Stephen S. Lane, MD</b> American Society of Cataract and Refractive Surgery No response received.

<b>James M. Levett, MD</b> American Association for Thoracic Surgery No response received.
<b>Craig S. Little, DC</b> American Chiropractic Association No response received.
<b>Virginia LiVolsi, MD</b> United States and Canadian Academy of Pathology No response received.
<b>Robert Lloyd, MD</b> American College of Rheumatology No response received.
<b>Whitney W. Lowe,</b> American Massage therapy Association No response received.
<b>David A. Margolin, MD</b> American Society of Colon and Rectal Surgeons No response received.
<b>Lawrence P. Martinelli, MD</b> Infectious Diseases Society of America No comment.
<b>Geraldine McGinty, MD</b> American Roentgen Ray Society No response received.
<b>Kenneth A. McKusick, MD</b> Society of Nuclear Medicine No response received.
<b>Klaus Mergener, MD</b> American Society for Gastrointestinal Endoscopy No response received.
<b>Wendell B. Milliman, ND</b> American Association of Naturopathic Physicians No response received.
<b>William Mitchell, MD</b> North American Spine Society No response received.
<b>Richard A. Molteni, MD</b> American Academy of Pediatrics No response received.
<b>Mircea A. Morariu, MD</b> American Society of Neuroimaging No response received.
<b>Douglas C. Morrow, OD</b> American Optometric Association No response received.
<b>Robert A. Murray, MD</b> American Society of Neuroradiology No comment.
<b>Daniel J. Nagle, MD</b> American Society for Surgery of the Hand No response received.
<b>Keith S. Naunheim, MD</b> Society of Thoracic Surgeons

No response received.
<b>Harvey L. Nisenbaum, MD</b> American Institute of Ultrasound in Medicine No response received.
<b>Fred T. Nobrega, MD</b> American College of Preventive Medicine No response received.
<b>Marc Nuwer, MD, PhD</b> American Academy of Neurology & American Clinical Neurophysiology Society <u>Supports change as suggested</u>
<b>Pennell Painter, PhD</b> American Association for Clinical Chemistry No response received.
<b>Walter J. Pedowitz, MD</b> American Orthopaedic Foot and Ankle Society No response received.
<b>William C. Penley, MD</b> American Society of Clinical Oncology No response received.
<b>Steve G. Peters, MD</b> American College of Chest Physicians No response received.
<b>Pamela K. Phillips, MD</b> American Society for Dermatologic Surgery No response received.
<b>H. J. Przybylo, MD</b> American Society of Anesthesiologists No response received.
<b>Antonio Puente, PhD</b> American Psychological Association No response received.
<b>John Queenan, Jr., MD</b> American Society for Reproductive Medicine No response received.
<b>Paul A. Raslavicus, MD</b> National Association of Medical Examiners No response received.
<b>Satti Sethu-Kumar Reddy MD,</b> American Association of Clinical Endocrinologists No response received.

<b>Michael X. Repka, MD</b> American Academy of Ophthalmology No response received.
<b>Susan Rinaldo-Gallo, RRT, Med</b> American Association for Respiratory Care No response received.
<b>Paul Rockar, Jr., PT</b> American Physical Therapy Association No response received.
<b>Kyle W. Ruffing, MD</b> American Association of Electrodiagnostic Medicine No response received.
<b>George A. Sample, MD</b> Society of Critical Care Medicine No response received.
<b>Peter L. Sawchuk, MD</b> American College of Emergency Physicians No comment.
<b>Chester W. Schmidt, Jr., MD</b> American Psychiatric Association No response received.
<b>Alan E. Seyfer, MD</b> American Society of Maxillofacial Surgeons No response received.
<b>Paresh C. Shah, MD</b> Society of American Gastrointestinal Endoscopic Surgeons No response received.
<b>Anton N. Sidawy, MD</b> International Society for Cardiovascular Surgery No response received.
<b>Michael J. Sillers, MD</b> American Academy of Otolaryngology Head and Neck Surgery No response received.
<b>Samuel M. Silver, MD, PhD</b> American Society of Hematology No response received.
<b>Charles B. Slonim, MD, FACS</b> Contact Lens Association of Ophthalmologists No response received.
<b>Nelda Spyles, ACSW, LCSW</b> National Association of Social Workers No response received.
<b>Michael L. Steinberg, MD</b> American Society for Therapeutic Radiology and Oncology No response received.
<b>Dennis L. Stone, MD</b> American Medical Directors Association No response received.
<b>Stephen P. Stone, MD</b> Society for Investigative Dermatology No response received.

<p><b>J. Craig Strafford, MD</b> American College of Obstetricians and Gynecologists No response received.</p>
<p><b>Mark S. Synovec, MD</b> American Society of Clinical Pathologists No response received.</p>
<p><b>Claire Tibiletti, MD</b> International Spinal Injection Society No response received.</p>
<p><b>Susan K. Turney, MD</b> American Medical Group Association No response received.</p>
<p><b>Thomas J. Weatherall, Jr., MD</b> American College of Radiation Oncology No response received.</p>
<p><b>Paul R. Weiss, MD</b> American Society for Aesthetic Plastic Surgery No response received.</p>
<p><b>Jane White, PhD</b> American Dietetic Association No response received.</p>
<p><b>Allan S. Wirtzer, MD</b> American Academy of Dermatology No response received.</p>
<p><b>Harold R. Wright, MD</b> American Academy of Otolaryngic Allergy No response received.</p>
<p><b>Robert A. Zorowitz, MD, MBA</b> American Geriatric Society Supports change as proposed.</p> <p>“The original concept of the Confirmatory Consultation as a “second opinion” has not been supported as particularly useful in the medical literature. As a geriatrician, I often saw patients for “second opinions,” but the work was, frankly, identical to the analogous new outpatient E&amp;M codes. Furthermore, many of these patients tended to remain in the practice, retrospectively indicating that the first encounter was really an Outpatient Service. Thus, I support elimination of these codes.</p> <p>Regarding the follow-up consultation:</p> <p>I haven’t seen too many subspecialty consultations that do not lead to concurrent care. It is proper that these use the inpatient E&amp;M codes. When a consultant “signs off” a case and is then asked to evaluate a new problem, the inpatient consultation codes are quite appropriate. Thus I support elimination of the follow-up consultation codes, since such visits can be handled more accurately by the other existing codes.”</p>

## Ballot for Issue

- 1) Should the CPT Editorial Panel delete the Follow-up Inpatient Consultations (99261 - 99263) codes and allow use of the Subsequent Hospital Care codes 99231-99233 in there place?
- 2) Should the CPT Editorial Panel delete the Confirmatory Consultation (99271 - 99275) codes and allow replacement use of Outpatient Services codes 99201-99215 and Hospital Inpatient Care codes 99221-99233?

### Evaluation and Management Consultations Follow-Up Inpatient Consultations

~~Follow up consultations are visits to complete the initial consultation OR subsequent consultative visits requested by the attending physician.~~

~~A follow up consultation includes monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status.~~

~~If the physician consultant has initiated treatment at the initial consultation, and participates thereafter in the patient's management, the codes for subsequent hospital care should be used (99231-99233).~~

~~The following codes are used to report follow up consultations provided to hospital inpatients or nursing facility residents only. For consultative services provided in other settings, the codes for office or other outpatient consultations should be reported (99241-99245).~~

These codes have been deleted. To report these services, use the appropriate subsequent hospital care code.

~~99261 Follow up inpatient consultation for an established patient, which requires at least two of these three key components:~~

- ~~▲ a problem focused interval history;~~
- ~~▲ a problem focused examination;~~
- ~~▲ medical decision making that is straightforward or of low complexity.~~

~~Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit~~

~~99262 Follow up inpatient consultation for an established patient which requires at least two of these three key components:~~

- ~~▲ an expanded problem focused interval history;~~
- ~~▲ an expanded problem focused examination;~~
- ~~▲ medical decision making of moderate complexity.~~

*Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.*

*Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit*

~~99263 — Follow up inpatient consultation for an established patient which requires at least two of these three key components:~~

- ~~▲ a detailed interval history;~~
- ~~▲ a detailed examination;~~
- ~~▲ medical decision making of high complexity.~~

*Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.*

*Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.*

**Evaluation and Management  
Consultations  
Confirmatory Consultations  
New or Established Patient**

*The following codes are used to report the evaluation and management services provided to patients when the consulting physician is aware of the confirmatory nature of the opinion sought (eg, when a second/third opinion is requested or required on the necessity or appropriateness of a previously recommended medical treatment or surgical procedure).*

*Confirmatory consultations may be provided in any setting.*

*A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice only. Any services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care. If a confirmatory consultation is required, eg, by a third party payor, the modifier '32', mandated services, should also be reported. (See also Consultation notes, page 14). Typical times have not yet been established for this subcategory of services.*

**These codes have been deleted. Report these services using the appropriate outpatient or inpatient E/M code.**

~~99271 — Confirmatory consultation for a new or established patient, which requires these three key components:~~

- ~~▲ a problem focused history;~~
- ~~▲ a problem focused examination;~~
- ~~▲ and straightforward medical decision making.~~

*Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.*

*Usually, the presenting problem(s) are self limited or minor.*

99272

*Confirmatory consultation for a new or established patient, which requires these three key components:*

- ▲ an expanded problem focused history;*
- ▲ an expanded problem focused examination;*
- ▲ and straightforward medical decision making.*

*Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.*

*Usually, the presenting problem(s) are of low severity.*

99273

*Confirmatory consultation for a new or established 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.*

99274

*Confirmatory consultation for a new or established patient, which requires these three key components:*

- ▲ a comprehensive history;*
- ▲ a comprehensive examination;*
- ▲ and medical decision making of moderate complexity.*

*Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.*

*Usually, the presenting problem(s) are of moderate to high severity.*

99275

*Confirmatory consultation for a new or established patient, which requires these three key components:*

- ▲ a comprehensive history;*
- ▲ a comprehensive examination;*
- ▲ and medical decision making of high complexity.*

*Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.*

~~Usually, the presenting problem(s) are of moderate to high severity~~

Accept  Reject  Modify Proposal

T  D (Review date for deferred issue \_\_\_\_-\_\_\_\_-\_\_\_\_)  R

Rationale:

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Continuing Neonatal Intensive Care Services**

The CPT Editorial Panel has recognized that the physician work involved in the provision of neonatal intensive care services is different from that typically provided to older infants, children and adults. Physician services in neonatal and pediatric intensive care units are provided by full time physicians who are hospital based. They care for patients of various maturity, birth weight, gestational age and level of critical/intensive care. All of these patients require intensive monitoring and oversight, however, not all of these patients qualify for critical care services as currently defined by CPT but all require frequent visits, team appraisals, laboratory and imaging studies, physical exams and communication with parents and family. These codes will bridge the gap and complete the neonatal critical and intensive care codes for neonates with present body weight of 2501-5000 grams.

The RUC reviewed the specialty society's survey results for 99300 *Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)* and determined that the reference code 99299 *Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)* (Work RVU=2.50) was reasonable. When comparing the surveyed code to reference code, it was determined that both codes had the same intra-service times, 30 minutes. In addition, the surveyed code and the reference code had similar intensity and complexity measures. Therefore, the specialty society recommends the survey median of 2.40 work RVUs which reflects an appropriate difference for a slightly higher weight patient. The RUC reviewed the survey data and agrees with the specialty society's recommendations. **The RUC recommends 2.40 work RVUs for 99300.**

**Practice Expense**

As this procedure is performed in the facility setting only, no practice expense inputs are recommended.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Codes 99298, 99299, 99300 are used to report services subsequent to the day of admission provided by a physician directing the continuing intensive care of the low birth weight (LBW, 1500-2500 grams present body weight) infant, or very low birth weight (VLBW, less than 1500 grams present body				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p><del>weight) infant, or normal weight newborn (2501-5000 grams present body weight) who no longer do not</del> meets the definition of critically ill but continue to require intensive observation, frequent interventions, and other intensive services. They represent subsequent day(s) of care and may be reported only once per day, per patient. Low birth weight services are reported for those neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and interventions only available in an intensive care setting. The level and frequency of services required for the LBW and the VLBW infant exceed those available in less intensive hospital areas or medical floors. Codes 99298, 99299, 99300 represent subsequent day(s) of care and may be reported only once per calendar day, per patient and are global 24-hour codes with the same services bundled as outlined under codes 99293-99296.</p> <p>For additional instructions, see descriptions listed for 99298, 99299, 99300</p>				
▲ 99298		<p>Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)</p> <p>Infants with present body weight less than 1500 grams who are <del>not</del> longer critically ill but continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring and constant observation by the health care team under direct physician supervision.</p>	XXX	2.75  (No Change)
▲ 99299		<p>Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)</p> <p>Infants with present body weight of 1500-2500 grams who are <u>not</u> critically ill but continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring, and constant observation by the health care team under direct physician supervision.</p>	XXX	2.50  (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●99300	AAA1	<p>Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)</p> <p>Infants with present body weight of 2501-5000 grams who are not critically ill but continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring, and constant observation by the health care team under direct physician supervision</p>	XXX	2.40

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:99300 Tracking Number: AAA3 Global Period: XXX

Specialty Society RVU: **2.40**RUC RVU: **2.40**

CPT Descriptor: Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 3500-gram neonate is recovering from bacteremia and pneumonia following intrapartum acquisition of Group B strep organisms from his mother. He had severe pneumonia, pulmonary hypertension, neutropenia, thrombocytopenia, and septic shock requiring prolonged mechanical ventilation including nitric oxide, oscillatory ventilation, surfactant and large pressor doses to maintain perfusion and blood pressure. He is now on low flow nasal cannula oxygen; his umbilical lines have been removed and a PIC line is being placed to complete antibiotic therapy and for use in providing bridging parenteral nutrition until he is tolerating all enteral feeds.

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? 43%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: In the morning, the patient's chart is reviewed and the flowsheet viewed and discussed with the bedside nurse. The online laboratory results are obtained from yesterday as well as early morning values that are back in the chart. Any recent radiographs are reviewed through the PACS system available in the intensive care unit. His CBC is reviewed to assure continued recovery of the low platelet and neutrophil count.

Description of Intra-Service Work: The patient is then examined with particular attention to overall cardiovascular stability, neurological function, pulmonary status post extubation, and gastrointestinal function. Comprehensive evaluations of these organ systems are completed. The PIC line site is carefully evaluated for any signs of cellulitis. The lungs are carefully evaluated for any evidence of post extubation atelectasis. The GI tract is evaluated for any sign of mucosal or transmural injury leading to feeding intolerance, malabsorption or perforation. The patient is evaluated neurologically to determine if physical therapy or occupational therapy would be indicated. The patient is visited throughout the day and evening to assure that the patient continues to tolerate feedings and that there has been no change in the patient's pulmonary, cardiovascular or neurological function.

Description of Post-Service Work: The results of the history, laboratory and imaging work is discussed at bedside with the resident, nurse practitioner, bed side primary nurse, nutritionist, social worker, and respiratory therapist. The plan of care is agreed to and discussions around the opportunity to back transport the patient to the home nursery and/or the potential home care needs for the child are conducted. After bedside rounds, the patient's condition and plans are discussed with the parents and extended family. Later in the day, any obtained laboratory work or medical imaging studies are checked and any additional orders are completed.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Gilbert I. Martin, MD, FAAP and Richard A. Molteni, MD, FAAP
<b>Specialty(s):</b>	American Academy of Pediatrics
<b>CPT Code:</b>	99300

<b>Sample Size:</b> 65	<b>Resp n:</b> 53	<b>Response:</b> 81.53 %			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.80	2.30	2.40	2.50	3.00
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	15.00	25.00	30.00	40.00	70.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>15.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99299	XXX	2.50

CPT Descriptor Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99298	XXX	2.75

CPT Descriptor 1 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99433	XXX	0.62

CPT Descriptor 2 Subsequent hospital care, for the evaluation and management of a normal newborn, per day

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
N/A		

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 52      % of respondents: 98.1 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 99300	Key Reference CPT Code: 99299
Median Pre-Service Time	15.00	10.00
Median Intra-Service Time	30.00	30.00
Median Immediate Post-service Time	15.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	60.00	55.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.53	3.46
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	3.58
Urgency of medical decision making	3.44	3.42

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.42	3.46
Physical effort required	3.15	3.14

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.65	3.62
Outcome depends on the skill and judgment of physician	3.75	3.68
Estimated risk of malpractice suit with poor outcome	4.13	3.81

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.29	3.29
Intra-Service intensity/complexity	3.68	3.67
Post-Service intensity/complexity	3.28	3.27

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel consisting of members of the American Academy of Pediatrics (AAP) Section on Perinatal Pediatrics and Committee on Coding and Nomenclature reviewed the survey results. Based on the consistency of the survey data, they recommend the survey median of 2.40 work RVUs.



Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/Specialty Society RVS Update Committee  
 Summary of Recommendations  
 April 2005  
**Nursing Facilities Services**

The CPT Editorial Panel replaced the existing family of codes for nursing facility services (CPT codes 99301 – 99313) with a new family of codes, representing a greater range in the complexity of medical decision making. The Panel specifically created CPT Code 99310 (BBB7) *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention to describe a new higher level visit in the subsequent visit family of codes.*

A survey was conducted for this new family of codes. Unfortunately, the specialty was not able to include important, relevant reference services (such as hospital visits) because many of the Evaluation and Management services are currently under review in the Five-Year Review of the RBRVS. The RUC reviewed the resulting data and found it to be unacceptable and does not recommend a new survey until the specialty is able to include other Evaluation and Management services, such as the hospital visit codes on a reference service list.

The specialty societies presented an alternative approach to value the new nursing facility services based on a crosswalk from the existing nursing facility services, with new work described for the new comprehensive subsequent visit code 99310 (BBB7). The specialty society indicated that they plan to re-survey these services after the hospital visit work relative values are considered stable and may be used as reference services. The specialties presented, and the RUC agreed, to the following relative values:

Current Nursing Facility (CPT Code (To be deleted in 2006))	2005 Work RVU	New Nursing Facility (CPT Code (Tracking #))	Recommended Work RVU
99301	1.20	99304 (BBB1)	1.20
99302	1.61	99305 (BBB2)	1.61
99303	2.01	99306 (BBB3)	2.01
99311	0.60	99307 (BBB4)	0.60
99312	1.00	99308 (BBB5)	1.00
99313	1.42	99309 (BBB6)	1.42
		99310 (BBB7)	1.77
99301	1.20	99318 (BBB8)	1.20

New CPT code 99310 (BBB7) describes a visit with at least two of these three key components: comprehensive history, comprehensive examination, or medical decision making of high complexity. This mirrors the elements required in a 99215 *Level 5 Established Patient Office Visit* (work rvu = 1.77) and the RUC recommends that this is an appropriate crosswalk for the new nursing facility service.

The RUC acknowledges that the valuation of 99310 (BBB7) represents new physician work not currently captured in this family of services. The committee agreed that there is compelling evidence that patient population has changed for these services as this new comprehensive code relates to patients who would have previously been routinely hospitalized. The committee also notes that there has been a shift in patient acuity as referenced in studies discussed in the attached letter.

The surveyed physician time should be used as an interim approach until the specialties re-survey these services. It is acknowledged that this time, and in particular the post-service time may be inappropriate as there was confusion regarding the current heading of “day of procedure” preceding the time data questions in the RUC survey. The committee recommends that an asterisk be placed on these services so that the time data for these services are not used for any other validation purposes. In addition, the committee recommended that this time data be re-examined, along with the new survey time, when these codes are reviewed again in the future. The RUC will recommend that CPT refrain from including intra-service time in CPT for these services until after a new survey is reviewed.

#### Practice Expense

The direct practice expense inputs for nursing facility services were reviewed by the RUC in March and April 2004. Therefore, the RUC did not agree with the specialty society’s recommendation to increase the clinical staff time for these services. The RUC recommended practice expense inputs represent the current practice expense related to the current nursing facility services and are attached to this recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>The following codes are used to report evaluation and management services to patients in Nursing Facilities (formerly called Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs) or Long Term Care Facilities (LTCFs)).</p>				
<p>These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential treatment center (a facility or a distinct part of a facility for psychiatric care, which provides a 24-hour therapeutically planned and professionally staffed group living and learning environment). If procedures such as medical psychotherapy are provided in addition to evaluation and management services, these should be reported in addition to the evaluation and management services provided.</p>				
<p>Nursing facilities that provide convalescent, rehabilitative, or long term care are required to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity using a Resident Assessment Instrument (RAI). All RAIs include the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs) and utilization guidelines. The MDS is the primary screening and assessment tool; the RAPs trigger the identification of potential problems and provide guidelines for follow-up assessments.</p>				
<p>Physicians have a central role in assuring that all residents receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the residents' physical and psychosocial functioning. <u>This role includes providing input in the development of the Minimum Data Set and a multi-disciplinary plan of care, as required by regulations pertaining to the care of nursing facility residents.</u></p>				
<p>Two <u>major</u> subcategories of nursing facility services are recognized: <u>Comprehensive Initial Nursing Facility Assessments Care</u> and Subsequent Nursing Facility Care. Both subcategories apply to new or established patients. <del>Comprehensive Assessments may be performed at one or more sites in the assessment process: the hospital, observation unit, office, nursing facility, domiciliary / non-nursing facility or patient's home.</del></p>				
<p>For definitions of key components and commonly used terms, please see Evaluation and Management Service Guidelines.</p>				
<p><b><u>Comprehensive Initial Nursing Facility Assessments Care</u></b>  <b>New or Established Patient</b></p>				
<p>When the patient is admitted to the nursing facility in the course of an encounter in another site of service (eg, hospital emergency department, physician's office), all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial nursing facility care when performed on the same date as the admission or readmission. The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the nursing facility setting.</p>				
<p>Hospital discharge or observation discharge services performed on the same date of nursing facility admission or readmission may be reported separately. For a patient discharged from inpatient status on the same date of nursing facility admission or readmission, the hospital discharge services should be reported with codes 99238, 99239 as appropriate. For a patient discharged from observation status on the same date of nursing facility admission or readmission, the observation care discharge services should be reported with code 99217. For a patient admitted and discharged from observation or inpatient status on the same date, see codes 99234 - 99236.</p>				
<p>(For nursing facility care discharge, see 99315, 99316)</p>				
<p><del>More than one comprehensive assessment may be necessary during an inpatient confinement.</del></p>				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 99301		<p><del>Evaluation and management of which requires these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> a detailed interval history;</del></li> <li><del><input type="checkbox"/> a comprehensive examination; and</del></li> <li><del><input type="checkbox"/> medical decision making that is straightforward or of low complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required. Physicians typically spend 30 minutes at the bedside and on the patient's facility floor or unit.</del></p>	XXX	N/A
D 99302		<p><del>Evaluation and management of a new or established patient involving a nursing facility assessment, which requires these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> a detailed interval history;</del></li> <li><del><input type="checkbox"/> a comprehensive examination; and</del></li> <li><del><input type="checkbox"/> medical decision making of moderate to high complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status.</del></p> <p><del>The creation of a new medical plan of care is required. Physicians typically spend 40 minutes at the bedside and on the patient's facility floor or unit.</del></p>	XXX	N/A

D 99303		<p><del>Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility, which requires these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> a comprehensive history;</del></li> <li><del><input type="checkbox"/> a comprehensive examination; and</del></li> <li><del><input type="checkbox"/> medical decision making of moderate to high complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>The creation of a medical plan of care is required. Physicians typically spend 50 minutes at the bedside and on the patient's facility floor or unit.</del></p>	XXX	N/A
●99304	BBB1	<p>Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a detailed or comprehensive history;</li> <li><input type="checkbox"/> a detailed or comprehensive examination; and</li> <li><input type="checkbox"/> medical decision making that is straightforward or of low complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the problem(s) requiring admission are of low severity.</p>	XXX	1.20
●99305	BBB2	<p>Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a comprehensive history;</li> <li><input type="checkbox"/> a comprehensive examination; and</li> <li><input type="checkbox"/> medical decision making of moderate complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the problem(s) requiring admission are of moderate severity.</p>	XXX	1.61

●99306	BBB3	<p>Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a comprehensive history;</li> <li><input type="checkbox"/> a comprehensive examination; and</li> <li><input type="checkbox"/> medical decision making of high complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the problem(s) requiring admission are of high severity.</p>	XXX	2.01
<p><b><i>Subsequent Nursing Facility Care New or Established Patient</i></b>  <b>The following codes are used to report the services provided to residents of nursing facilities who do not require a comprehensive assessment, and/or who have not had a major, permanent change of status.</b></p> <p><b>All levels include reviewing the medical record, noting changes in the resident's status since the last visit, and reviewing and signing orders.</b></p> <p><b>All levels of subsequent nursing facility care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status, (ie, changes in history, physical condition and response to management) since the last assessment by the physician.</b></p>				
D 99311		<p><del>Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> a problem focused interval history;</del></li> <li><del><input type="checkbox"/> a problem focused examination;</del></li> <li><del><input type="checkbox"/> medical decision making that is straightforward or of low complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.</del></p>	XXX	N/A

D 99312		<p><del>Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> an expanded problem focused interval history;</del></li> <li><del><input type="checkbox"/> an expanded problem focused examination;</del></li> <li><del><input type="checkbox"/> medical decision making of moderate complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.</del></p>	XXX	N/A
D 99313		<p><del>Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> a detailed interval history;</del></li> <li><del><input type="checkbox"/> a detailed examination;</del></li> <li><del><input type="checkbox"/> medical decision making of moderate to high complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.</del></p>	XXX	N/A

●99307	BBB4	<p>Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a problem focused interval history;</li> <li><input type="checkbox"/> a problem focused examination;</li> <li><input type="checkbox"/> straightforward medical decision making</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the patient is stable, recovering or improving.</p>	XXX	0.60
●99308	BBB5	<p>Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> an expanded problem focused interval history;</li> <li><input type="checkbox"/> an expanded problem focused examination;</li> <li><input type="checkbox"/> medical decision making of low complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the patient is responding inadequately to therapy or has developed a minor complication.</p>	XXX	1.00

●99309	BBB6	<p>Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a detailed interval history;</li> <li><input type="checkbox"/> a detailed examination;</li> <li><input type="checkbox"/> medical decision making of moderate complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the patient has developed a significant complication or a significant new problem.</p>	XXX	1.42
●99310	BBB7	<p>Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a comprehensive interval history;</li> <li><input type="checkbox"/> a comprehensive examination; and</li> <li><input type="checkbox"/> medical decision making of high complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.</p>	XXX	1.77
<p><b><i>Nursing Facility Discharge Services</i></b>  <i>The nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician for the final nursing facility discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent by the physician on that date is not continuous. Instructions are given for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.</i></p>				
99315		<i>Nursing facility discharge day management; 30 minutes or less</i>	XXX	1.13  (No Change)

99316		<i>more than 30 minutes</i>	XXX	1.50 (No Change)
<b>Other Nursing Facility Services</b>				
●99318	BBB8	<p>Evaluation and management of a patient involving an annual nursing facility assessment which requires these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a detailed interval history;</li> <li><input type="checkbox"/> a comprehensive examination; and</li> <li><input type="checkbox"/> medical decision making that is of low to moderate complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the patient is stable, recovering or improving.</p> <p>(Do not report 99318 on the same date of service as other nursing facility services codes)</p>	XXX	1.20

April 4, 2005

Roseanne Eagle  
American Medical Association  
515 N. State Street  
Chicago, IL 60610

Dear Ms. Eagle:

On behalf of the American Medical Directors Association (AMDA), I am pleased to submit the enclosed RUC Summary Forms for Work and Practice Expense for the Nursing Facility codes as part of the RUC review process at its April meeting. In this transmittal memo, we will provide “compelling evidence” that the existing values for these services are not appropriate. As indicated in more detail below, we believe that the physician work involved in providing these services has increased over the past several years.

We also believe that the 2005 CPT codes used to describe these services are inadequate, and we recently submitted a set of coding change recommendations to the American Medical Association’s CPT Editorial Panel that was approved by the Panel during its February 2005 meeting. Please note the changes that we recommended and that were approved are generally consistent with the changes recommended in 2002 by the AMA’s E/M Workgroup to the CPT Editorial Panel.

In brief, the CPT Editorial Panel made the following changes to the Nursing Facility Services section of CPT:

- Revised the structure of the current Comprehensive Nursing Facility Assessment codes to create three levels of service for admissions, consistent with the structure of the three levels of service for admission in the Initial Hospital Care section of CPT;
- Added a fourth level of service to the Subsequent Nursing Facility Care codes to allow the reporting of a comprehensive level of care (comprehensive history, comprehensive exam, high complexity decision making; and,
- Added a new code in a new subsection (Other Nursing Facility Care) to allow the reporting of a comprehensive annual assessment.

### **Compelling Evidence that Physician Work has Increased**

As evidence for the need for revised work RVUs for the nursing facility services, we provide the following data and excerpts from the indicated published sources:

#### **Centers for Medicare and Medicaid Services *Nursing Home Compendium, 2001***

The *Compendium* includes data on all residents in Medicare- and Medicaid-certified nursing homes in the United States. The source of these data is the Minimum Data Set (MDS). In 2001,

40.1 percent of nursing home residents were 85 years of age or older. In 2001, “[m]ore than one third of nursing home residents required extensive assistance with at least four of the five Activities of Daily Living (ADL) that were examined (bed mobility, transferring, dressing, eating and toileting)...From 1998 to 2001...there was a steady increase in residents with four or more ADL impairments.” From 1999 to 2001, the proportion of nursing home residents with 4 or more ADL impairments went from 35.4 percent to 37.1 percent. “The median pressure ulcer prevalence across all nursing homes increased steadily from 7.1 to 7.9 percent from 1998 to 2001.” By the fourth quarter of 2001, it had reached 8.1 percent. “The prevalence of tube feeding has been fairly steady, at 4.2-4.4 percent, since the beginning of 1999.”

Note: Data for 2001 come from just over 16,600 nursing homes in the United States and cover more than 3 million nursing home residents.

**Pillemer K, Lachs MS. Symposium: “The Crisis in Long Term Care”: The Crisis in the Long-Term Care Workforce.” *Journal of Health Care Law & Policy* 2002;4:294-307.**

“...the long-term care population is becoming more disabled and complex to care for. The emphasis throughout the 1990s on transferring elderly people from acute to long-term care settings has had a major impact on nursing homes in particular. This trend toward earlier discharge means that more residents have acute illnesses from which they have not completely recovered at the time they are transferred to long-term care facilities. One of the results of this trend is that nursing homes are now using more complicated technologies that were previously used only in hospitals.”

“...many nursing home residents are identical to the patients who would have [been] cared for in the hospital as a resident a decade ago. They arrive with all manner of inpatient technology— intravenous lines, complex surgical wounds, tracheotomies, and mechanical ventilators in some facilities.”

“This change in the mixture of nursing home residents—what we would call the ‘acuitization of long-term care’—can challenge and even overwhelm staff. Over the past decade the prevalence of nursing home residents with several or more impairments in activities of daily living (such as eating, bathing, and dressing) has risen substantially.”

“Three major forces—all economic—have led to the ‘acuitization of the nursing home: 1) managed care, 2) the current prevailing mechanism of hospital reimbursement for inpatient care of older persons (diagnosis related groups or DRGs), and 3) reimbursement formulas for nursing homes which favor high acuity patients.”

**Nelson KJ, Coulston AM, Sucher KP, Tseng RY. Prevalence of malnutrition in the elderly admitted to long term care facilities. *J Am Diet Assoc* 1993;93:459-61.**

“Nutritionally compromised nursing home patients have a greater risk of developing fevers, infections, and pressure sores, and have a higher mortality rate...In 100 patients admitted consecutively to a skilled nursing facility, the prevalence of malnutrition was 39%. The

strongest predictor of decreased nutritional status was route of admission...Patients admitted from acute-care facilities were more malnourished than those admitted from home.”

[Note: National Nursing Home Survey results show that the proportion of nursing home residents whose residence prior to admission was a hospital went from 40.5 percent in 1995 to 46.3 percent in 1999, the last year for which data are available.]

We believe that the recognition by the AMA’s E/M Workgroup to the CPT Editorial Panel and the CPT Editorial Panel itself that the current CPT codes for Nursing Facility Services are inadequate and not descriptive of the services provided in nursing facilities, coupled with published documentation that physician work in nursing facilities has changed over the past several years, constitutes a compelling argument that the existing nursing facility values are no longer rational or appropriate for the new nursing facility codes. We look forward to working with the RUC to assure the proper valuation of these services.

Sincerely,

Dennis Stone, MD, CMD  
AMDA Advisor to the RUC

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:99304 Tracking Number: BBB1 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 1.20

RUC RVU: 1.20

**CPT Descriptor:**

Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components:

- a detailed or comprehensive history;
- a detailed or comprehensive examination; and
- medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of low severity.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Admission visit for an 80 year old Alzheimer's patient with associated bowel and bladder incontinence, plus controlled glaucoma, hypertension and moderate osteoarthritis who is no longer able to be maintained at an Assisted Living Facility and is requiring nursing facility placement. He is presently on a topical eye medication, a mild analgesic and a cholinesterase inhibitor but no psychotropics.

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: includes preparing to see the patient, procuring and reviewing previous medical records and communicating with facility professionals as appropriate.

Description of Intra-Service Work: includes a detailed history of dietary and fluid intake, a review of his chronic but stable vision, mild hearing loss, general arthritis, chronic constipation, a medication review, and a gathering of health history from his wife, the previous Assisted Living staff and his previous medical care providers. A detailed physical exam is performed. VS are noted. The skin is carefully expected for ulceration/pre-ulceration. Oral hygiene is noted. Cardiovascular, pulmonary, abdominal and GU exams are performed with special attention to evidence of obstructive urinary retention and fecal impaction. The patient's ability to communicate and gait safety is assessed.

Description of Post-Service Work: includes follow-up telephone calls with the facility regarding diagnostic findings, post-service coordination of care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discussion with family and/or surrogate decision maker regarding preferred intensity of care/DNR is also included in post-service work.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	Dr. Dennis Stone
<b>Specialty(s):</b>	Long Term Care Facilities
<b>CPT Code:</b>	99304

<b>Sample Size:</b> 500	<b>Resp n:</b> 48	<b>Response:</b> %			
<b>Sample Type:</b> Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	2.35	2.56	2.56	3.50
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	10.00	20.00	30.00	30.00	50.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>10.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99234	XXX	2.56

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:

- a detailed or comprehensive history;
- a detailed or comprehensive examination; and
- medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 32      % of respondents: 66.6 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 99304	Key Reference CPT Code: 99234
Median Pre-Service Time	10.00	10.00
Median Intra-Service Time	30.00	60.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>50.00</b>	<b>85.00</b>

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.71	2.62
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.06	2.74
--	------	------

Urgency of medical decision making	2.29	2.46
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.81	2.71
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Physical effort required	2.58	2.58
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.79	2.59
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Outcome depends on the skill and judgment of physician	2.83	2.74
--	------	------

Estimated risk of malpractice suit with poor outcome	3.08	2.61
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.40	2.40
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Intra-Service intensity/complexity	2.88	2.94
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Post-Service intensity/complexity	2.46	2.40
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**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: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are 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) 99301 - Evaluation and management of a new or established patient involving an annual nursing facility assessment, which requires these three key components:

- a detailed interval history;
- a comprehensive examination; and
- medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required. Physicians typically spend 30 minutes at the bedside and on the patient's facility floor or unit.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine	How often? Commonly
Specialty Family Practice	How often? Commonly
Specialty Nurse Practitioners	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 87500  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Internal Medicine	Frequency 29000	Percentage	%
Specialty Family Practice	Frequency 24000	Percentage	%
Specialty Nurse Practitioners	Frequency 8500	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 75,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Internal Medicine	Frequency 26000	Percentage	%
Specialty Family Practice	Frequency 21000	Percentage	%
Specialty Nurse Practitioners	Frequency 7000	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. 99301

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**

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**Recommended Work Relative Value**

CPT Code:99305 Tracking Number: BBB2 Global Period: XXX

Specialty Society RVU: 1.61

RUC RVU: 1.61

CPT Descriptor: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of moderate severity.

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: SNF admission for an 88-year-old, cognitively intact patient who suffered a hip fracture from a mechanical fall while living at home. While in the hospital for treatment of the fracture, he developed a UTI and a Stage II heel pressure ulcer. Prior to the fracture he was known to have multiple health problems including controlled CHF and HTN, chronic constipation, BPH, osteoarthritis, old CVA and depression. He was also known to have peripheral perfusion compromise.

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: includes preparing to see the patient, procuring and reviewing the hospital records, labs and diagnostic findings, and communicating with facility professionals as appropriate

Description of Intra-Service Work: includes a review of the patient's intake and hydration status, the post-op course and initial rehabilitation results, the recent urosepsis and the development of the pressure ulcer plus an evaluation of the status of the patient's multiple chronic health problems. A comprehensive physical exam is performed to assess the recent surgical site, the potential return of function, the need for the continued indwelling catheter, and the status of the pressure sore. Additionally, an examination of the patient's vision and hearing (especially in relation to rehab potential), overall cardio-vascular status in regard to stamina, plus a general abdominal, GU, mental status and neurological examination is performed and documented. A multi-disciplinary plan of care is developed which includes PT and OT services, initiation of a pressure wound care program, adjustments in diet, weaning off catheter, re-titration of medications, evaluation of dietary and fluid intake and monitoring for mental status changes due to changes in environment.

Description of Post-Service Work: includes follow-up telephone calls with the patient's orthopedist and with the facility regarding diagnostic findings, post-service coordination of care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discussion with family and/or surrogate decision maker regarding preferred intensity of care/DNR is also included in post-service work.

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**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	Dr. Dennis Stone					
<b>Specialty(s):</b>	Long Term Care Facilities					
<b>CPT Code:</b>	99305					
<b>Sample Size:</b>	500	<b>Resp n:</b>	48	<b>Response:</b>	%	
<b>Sample Type:</b> Convenience						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		1.00	3.07	3.41	3.41	4.00
<b>Pre-Service Evaluation Time:</b>				15.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		5.00	25.00	30.00	45.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>15.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99235	XXX	3.41

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 33      % of respondents: 68.7 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 99305</u>	<u>Key Reference CPT Code: 99235</u>
Median Pre-Service Time	15.00	10.00
Median Intra-Service Time	30.00	75.00
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
<b>Median Total Time</b>	<b>60.00</b>	<b>100.00</b>

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.54	3.41
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.48
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Urgency of medical decision making	3.40	3.41
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.35	3.30
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Physical effort required	3.29	3.11
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.60	3.49
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Outcome depends on the skill and judgment of physician	3.60	3.33
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Estimated risk of malpractice suit with poor outcome	3.77	3.31
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	2.87
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Intra-Service intensity/complexity	3.74	3.70
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Post-Service intensity/complexity	3.38	3.33
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99302 - Evaluation and management of a new or established patient involving a nursing facility assessment, which requires these three key components:

- a detailed interval history;
- a comprehensive examination; and
- medical decision making of moderate to high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status. The creation of a new medical plan of care is required. Physicians typically spend 40 minutes at the bedside and on the patient's facility floor or unit.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine                      How often? Commonly

Specialty Family Practice                      How often? Commonly

Specialty Nurse Practitioners                      How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 665000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Internal Medicine                      Frequency 301000                      Percentage 45.26 %

Specialty Family Practice                      Frequency 170000                      Percentage 25.56 %

Specialty Nurse Practitioners	Frequency 40000	Percentage 6.01 %
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Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 578,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Internal Medicine	Frequency 262000	Percentage 45.32 %
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Specialty Family Practice	Frequency 148000	Percentage 25.60 %
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Specialty Nurse Practitioners	Frequency 35000	Percentage 6.05 %
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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. 99302

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:99306 Tracking Number: BBB3 Global Period: XXX

Recommended Work Relative Value

Specialty Society RVU: 2.01

RUC RVU: 2.01

CPT Descriptor: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of high severity.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: SNF admission of a 72-year-old diabetic patient who previously lived at the same NF is now being admitted post hospitalization for aspiration pneumonitis, blood sugars running in the 300+ range, CHF and delirium associated with on-going history of dementia. She also suffers from chronic atrial fibrillation, constipation, and stress incontinence, and a recent vertebral compression fracture associated with osteoporosis. She returns on IV hydration, antibiotics, O2 and new psychotropics and she requires continued titration of her diabetes and diuretic regimen, control of her pain which is reducing her inspiratory effort, rehabilitation of swallowing and respiratory function and a stabilizing of cardiovascular and mental status.

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: includes preparing to see the patient, procuring and reviewing the hospital records, labs and diagnostic findings, and communicating with facility professionals as appropriate.

Description of Intra-Service Work: includes a comprehensive history including a review of the hospital records, labs and diagnostic findings, the patient's intake and hydration status plus a review of the sliding scale insulin and psychotropic regimen. Additionally there is a discussion with the patient's formal and informal care providers regarding a symptom review of the patient's multiple, still unstable, health problems. The comprehensive physical exam involved assessment of current status of cardio-pulmonary function, swallowing and mobility function, and cognitive function. Lab review includes assessing oxygenation, hydration, white count, cardiac rhythm and glucose level trends. Orders are initiated for oxygen, IV fluids, antibiotics, pain control, and rehabilitation and diagnostic testing to assess status. Also, included in the multi-disciplinary plan of care is PT, RT and Speech services, titration off insulin sliding scale, adjustments in diet and hydration, re-titration of psychotropic and analgesic medications, and monitoring for mental status changes.

Description of Post-Service Work: includes follow-up telephone calls with the facility regarding diagnostic findings, post-service coordination of care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discussion with family and/or surrogate decision maker regarding preferred intensity of care/DNR is also included in post-service work.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Dr. Dennis Stone				
<b>Specialty(s):</b>	Long Term Care Facilities				
<b>CPT Code:</b>	99306				
<b>Sample Size:</b>	500	<b>Resp n:</b>	48	<b>Response:</b>	%
<b>Sample Type:</b>	Convenience				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Survey RVW:</b>		1.00	3.89	4.26	4.35
<b>Pre-Service Evaluation Time:</b>				15.0	
<b>Pre-Service Positioning Time:</b>				0.0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0	
<b>Intra-Service Time:</b>		15.00	30.00	40.00	57.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>20.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99236	XXX	4.26

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 33      % of respondents: 68.7 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 99306</u>	<u>Key Reference CPT Code: 99236</u>
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	40.00	110.00
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
<b>Median Total Time</b>	<b>75.00</b>	<b>110.00</b>

Other time if appropriate		
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**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.71	4.43
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.65	4.30
--	------	------

Urgency of medical decision making	4.38	4.30
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.35	4.20
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Physical effort required	4.06	3.87
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.65	4.43
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Outcome depends on the skill and judgment of physician	4.56	4.43
--	------	------

Estimated risk of malpractice suit with poor outcome	4.32	3.96
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.76	3.56
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Intra-Service intensity/complexity	4.65	4.49
------------------------------------	------	------

Post-Service intensity/complexity	4.33	4.31
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**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: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are 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) 99303 - Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate to high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

The creation of a medical plan of care is required. Physicians typically spend 50 minutes at the bedside and on the patient's facility floor or unit.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine                      How often? Commonly

Specialty Family Practice                      How often? Commonly

Specialty Nurse Practitioners                      How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1337000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Internal Medicine                      Frequency 658000                      Percentage 49.21 %

Specialty Family Practice                      Frequency 302000                      Percentage 22.58 %

Specialty Nurse Practitioner

Frequency 86000

Percentage 6.43 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,162,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Internal Medicine

Frequency 572000

Percentage 49.22 %

Specialty Family Practice

Frequency 262000

Percentage 22.54 %

Specialty Nurse Practitioners

Frequency 75000

Percentage 6.45 %

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. 99203.

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:99307 Tracking Number: BBB4 Global Period: XXX

**Recommended Work Relative Value**Specialty Society RVU: **0.60****RUC RVU: 0.60**

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- a problem focused interval history;
- a problem focused examination;
- straightforward medical decision making

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 88 year old demented, non-diabetic patient with a previously evaluated Stage IV sacral pressure sore with peripheral, localized inflammation is seen in follow-up to evaluate the wound's response to present plan of care.

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: includes preparing to see the patient, a record review of previously attempted interventions and communicating with facility professionals, as appropriate. The suggestions of the facility dietitian and consultant pharmacist are reviewed

Description of Intra-Service Work: includes an interval history that reveals on-going poor dietary intake and urinary incontinence in a patient who cannot cooperate in pressure relief activities because of cognitive impairment. It also includes a focused physical exam that reveals an improving lesion with no peripheral inflammation and no evidence of systemic involvement. The topical regimen is altered, a new nutritional program is ordered and a support surface is authorized.

Description of Post-Service Work: includes follow-up telephone calls with facility staff with coordination of care, and documentation as indicated associated with delivery of care to this patient until the next face-to-face physician encounter.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	Dr. Dennis Stone		
<b>Specialty(s):</b>	Long Term Care Facilities		
<b>CPT Code:</b>	99307		
<b>Sample Size:</b>	500	<b>Resp n:</b> 48	<b>Response:</b> %
<b>Sample Type:</b>	Convenience		

	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
<b>Survey RVW:</b>	0.55	0.76	1.00	1.20	3.00
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	10.00	10.00	15.00	30.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>5.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99347	XXX	0.76

CPT Descriptor Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a problem focused interval history;
- a problem focused examination;
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 32      % of respondents: 66.6 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 99307	Key Reference CPT Code: 99347
Median Pre-Service Time	5.00	5.00
Median Intra-Service Time	10.00	15.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	20.00	30.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.25	2.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.31	2.20
Urgency of medical decision making	2.10	2.13

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.47	2.39
Physical effort required	2.21	2.28

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.44	2.24
Outcome depends on the skill and judgment of physician	2.52	2.33
Estimated risk of malpractice suit with poor outcome	2.94	2.48

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.71	1.70
Intra-Service intensity/complexity	2.33	2.30
Post-Service intensity/complexity	1.96	1.93

**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.*

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**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.

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**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99311 - Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

- a problem focused interval history;
- a problem focused examination;
- medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine                      How often? Commonly

Specialty Family Practice                      How often? Commonly

Specialty Nurse Practitioners                      How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 6868000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Internal Medicine                      Frequency 2336000                      Percentage 34.01 %

Specialty Family Practice                      Frequency 1792000                      Percentage 26.09 %

Specialty Nurse Practitioners	Frequency 647000	Percentage 9.42 %
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Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 5,972,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Internal Medicine	Frequency 2031000	Percentage 34.00 %
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Specialty Family Practice	Frequency 1558000	Percentage 26.08 %
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Specialty Nurse Practitioners	Frequency 562000	Percentage 9.41 %
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Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99311

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:99308 Tracking Number: BBB5 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 1.00

RUC RVU: 1.00

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- an expanded problem focused interval history;
- an expanded problem focused examination;
- medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: NF visit for evaluation and management of an acute urinary tract infection in a 35 year old male with multiple sclerosis with indwelling catheter presenting with new intermittent hematuria and fever.

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: includes preparing to see the patient, a record review, and communication with other facility professionals, as appropriate.

Description of Intra-Service Work: includes an expanded history review including intake and hydration information, discussion of the suprapubic – localizing discomfort and muscle spasm and a psychosocial review of the patient's coping with his underlying disease. An expanded physical examination notes no evidence of dehydration, further gross hematuria or focal neurological findings but increased depression is detected. After necessary labs are ordered, he is treated for the UTI started on an anti-depressant.

Description of Post-Service Work: includes discussion with facility social services and activities programming, follow-up telephone calls with the nursing facility regarding titration of anti-depressant, review of confirming diagnostic lab data and follow-up on antibiotic effectiveness, plus all coordination of care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	Dr. Dennis Stone		
<b>Specialty(s):</b>	Long Term Care Facilities		
<b>CPT Code:</b>	99308		
<b>Sample Size:</b>	500	<b>Resp n:</b> 48	<b>Response:</b> %
<b>Sample Type:</b>	Convenience		

	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
<b>Survey RVW:</b>	0.76	1.26	1.50	1.70	3.50
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	5.00	14.30	15.00	20.00	30.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>10.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99348	XXX	1.26

CPT Descriptor Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- an expanded problem focused interval history;
- an expanded problem focused examination;
- medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 32      % of respondents: 66.6 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 99308</b>	<b>Key Reference CPT Code: 99348</b>
Median Pre-Service Time	5.00	10.00
Median Intra-Service Time	15.00	30.00
Median Immediate Post-service Time	10.00	56.00
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	96.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.88	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.92	2.83
Urgency of medical decision making	2.85	2.83

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.94	2.80
Physical effort required	2.77	2.80

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.27	3.07
Outcome depends on the skill and judgment of physician	3.31	3.07
Estimated risk of malpractice suit with poor outcome	3.40	2.98

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.21	2.17
Intra-Service intensity/complexity	2.96	2.91
Post-Service intensity/complexity	2.62	2.43

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

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**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.

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**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99312 - Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

- an expanded problem focused interval history;
- an expanded problem focused examination;
- medical decision making of moderate low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine                      How often? Commonly

Specialty Family Practice                      How often? Commonly

Specialty Nurse Practitioners                      How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 10701000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Internal Medicine                      Frequency 4196000                      Percentage 39.21 %

Specialty Family Practice                      Frequency 2374000                      Percentage 22.18 %

Specialty Nurse Practitioners	Frequency 1329000	Percentage 12.41 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,305,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Internal Medicine	Frequency 3649000	Percentage 39.21 %
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Specialty Family Practice	Frequency 2064000	Percentage 22.18 %
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Specialty Nurse Practitioners	Frequency 1155000	Percentage 12.41 %
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Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99312

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:99309 Tracking Number: BBB6 Global Period: XXX

Specialty Society RVU: 1.42

RUC RVU: 1.42

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination;
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 72-year-old patient with COPD, HTN, PVD, GERD, chronic constipation, bladder stress incontinence, osteoarthritis, osteoporosis, dementia and hypothyroidism on 9+ medications is seen for interval disease management of her chronic health issues and also to evaluate the status of a recent URI, increased constipation, new behavioral changes and a skin tear that have occurred since the last medical visit.

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: includes preparing to see the patient, reviewing the telephone orders associated of the recently reported URI, the changes in the dietary, bowel and psychotropic regimens and the treatment of the non-infected skin tear all reported by telephone by nursing staff since last medical visit. Also includes communicating with facility professionals, as appropriate.

Description of Intra-Service Work: includes a detailed interval history review of each involved organ system that has an acute or active medical problem. This includes the status of the recent URI complicating her underlying COPD, any associated cardio-vascular complication or decline, the status of the GERD, bowel and bladder function, and the recent change in mental status associated with the patient's dementia. Also included in the history is a) a review of the patient's multiple medications for indication and efficacy; b) recent lab and diagnostic data ordered to evaluate her recent respiratory compromise; and, c) the updated nursing plan of care. A detailed physical exam reveals a "frailer" more confused patient, with normal vitals, resting comfortably in bed with a dry oral mucosa, "clear" lung fields, regular rhythm with no change in her AS murmur, no pedal edema, a vaguely tender abdomen, no lateralizing neurological signs and a non-inflamed skin tear.

Description of Post-Service Work: includes evaluation of additional diagnostic testing to determine hydration and pulmonary status and further changes in patient's psychotropic regimen, follow-up telephone calls with the facility staff, all coordination of care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	04/2005
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<b>Presenter(s):</b>	Dr. Dennis Stone				
<b>Specialty(s):</b>	Long Term Care Facilities				
<b>CPT Code:</b>	99309				
<b>Sample Size:</b>	500	<b>Resp n:</b>	48	<b>Response:</b>	%
<b>Sample Type:</b>	Convenience				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
<b>Survey RVW:</b>	1.10	2.02	2.27	2.54	4.00
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	10.00	18.80	20.00	30.00	50.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>10.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99349	XXX	2.02

CPT Descriptor Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination;
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 29      % of respondents: 60.4 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 99309	Key Reference CPT Code: 99349
Median Pre-Service Time	10.00	10.00
Median Intra-Service Time	20.00	40.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	40.00	65.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.94	3.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.79	3.80
Urgency of medical decision making	3.73	3.59

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.81	3.65
Physical effort required	3.75	3.50
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.04	3.80
Outcome depends on the skill and judgment of physician	4.08	3.91
Estimated risk of malpractice suit with poor outcome	3.98	3.50

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.06	2.96
Intra-Service intensity/complexity	3.70	3.49
Post-Service intensity/complexity	3.34	3.22

**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.*

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**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.

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**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99313 - Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination;
- medical decision making of moderate to high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine                      How often? Commonly

Specialty Nurse Practitioners                      How often? Commonly

Specialty Family Practice                      How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 2293000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Internal Medicine                      Frequency 804000                      Percentage 35.06 %

Specialty Nurse Practitioners                      Frequency 471000                      Percentage 20.54 %

Specialty Family Practice	Frequency 387000	Percentage 16.87 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,994,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Internal Medicine	Frequency 699000	Percentage 35.05 %
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Specialty Nurse Practitioners	Frequency 410000	Percentage 20.56 %
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Specialty Family Practice	Frequency 337000	Percentage 16.90 %
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Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99313

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:99310 Tracking Number: BBB7 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 1.77

RUC RVU: 1.77

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- a comprehensive interval history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 69-year-old, long time resident of a NF with a long history of multi-infarct dementia, non-insulin dependent diabetes mellitus, hypertension, and chronic renal insufficiency develops an acute decline in mental status with decreased intake and vague right sided weakness. The family requests that she not be transferred to the hospital but receive treatment at the facility. Her BP blood pressure is 188/102, pulse 92/regular and respirations are 20/min off O2. Physical examination reveals a dry mucosa and decreased skin turgor, no cyanosis, reduced lung sounds, no pedal or sacral edema, a soft, non-distended abdomen and a slight right hemiparesis leg > arm. Lab values drawn just prior to visit reveal blood glucose 352, Na 152, BUN 78, Creatinine 2.8, Hct 32, Hb10.1, a WBC of 18.0, O2 sat of 87% on room air and a portable CXR that "cannot rule out" a LLL pneumonia.

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: includes preparing to see the patient, reviewing the medical record and previously ordered diagnostic lab and communication with facility professionals as appropriate.

Description of Intra-Service Work: includes a comprehensive history including evaluation of hydration and intake, ability to swallow, cardiopulmonary status, abdominal bowel and bladder function, mental status, and sensori-motor function .

The multi-factorial etiologies and their impact on multiple, additional co-morbidities require a comprehensive physical examination involving virtually every organ system. The resultant multidisciplinary care planning includes IV hydration and antibiotic therapy, nursing instructions regarding monitoring of respiratory, mental, functional and diabetic status, a respiratory therapy and physical therapy assessment with treatment as indicated and further lab monitoring to track effectiveness of treatment.

Description of Post-Service Work: includes evaluation of additionally ordered lab and diagnostic testing, telephone calls with the facility to adjust interventions as indicated, discussion with family regarding updating end of life issues, coordination of all care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)

04/2005

<b>Presenter(s):</b>	Dr. Dennis Stone				
<b>Specialty(s):</b>	Long Term Care Facilities				
<b>CPT Code:</b>	99310				
<b>Sample Size:</b>	500	<b>Resp n:</b>	48	<b>Response:</b>	%
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.70	3.00	3.10	3.50	4.50
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	10.00	18.80	20.00	40.00	70.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>15.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99350	XXX	3.03

CPT Descriptor Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a comprehensive interval history;
- a comprehensive examination;
- medical decision making of moderate to high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 34      % of respondents: 70.8 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 99310</b>	<b>Key Reference CPT Code: 99350</b>
Median Pre-Service Time	10.00	15.00
Median Intra-Service Time	20.00	72.00
Median Immediate Post-service Time	15.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	45.00	107.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.77	4.58
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.62	4.44
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Urgency of medical decision making	4.83	4.72
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.55	4.32
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Physical effort required	4.15	4.14
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.83	4.69
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Outcome depends on the skill and judgment of physician	4.72	4.67
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Estimated risk of malpractice suit with poor outcome	4.32	4.02
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.81	3.71
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Intra-Service intensity/complexity	4.68	4.49
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Post-Service intensity/complexity	4.36	4.24
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**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.*

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**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.

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**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 9930X7 is a new code, and has not been previously reported. It is, however, based on 99313

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine                      How often? Commonly

Specialty Nurse Practitioners                      How often? Commonly

Specialty Family Practice                      How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 1147000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Internal Medicine                      Frequency 402000                      Percentage 35.04 %

Specialty Nurse Practitioners                      Frequency 236000                      Percentage 20.57 %

Specialty Family Practice                      Frequency 194000                      Percentage 16.91 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 997,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Internal Medicine                      Frequency 350000                      Percentage 35.10 %

Specialty Nurse Practitioners                      Frequency 205000

Percentage 20.56 %

Specialty Family Practice                              Frequency 169000

Percentage 16.95 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99302

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**

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CPT Code:99318 Tracking Number: BBB8 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 1.20

RUC RVU: 1.20

CPT Descriptor: Evaluation and management of a patient involving an annual nursing facility assessment which requires these three key components:

- a detailed interval history;
- a comprehensive examination; and
- medical decision making that is of low to moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving.

(Do not report 99318 on the same date of service as other nursing facility services codes)

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Annual nursing facility history and physical and MDS/RAI evaluation for a two-year nursing facility resident who is an 84-year-old female with multiple chronic health problems, including: stable controlled hypertension, chronic constipation, osteoarthritis, and moderated stable dementia.

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: includes preparing to see the patient, procuring previous medical records over the past year and communicating with facility professionals as appropriate.

Description of Intra-Service Work: includes a detailed review of the interval history for the occurrence and resolution of intercurrent episodes of illness or injury and for signs and symptoms of progression of the chronic conditions that justify continued nursing facility services. A review of systems may include an assessment of dietary and fluid intake with note of any dental concerns or changes in appetite; a review of worsening sensory impairments, such as vision or hearing loss; changes in functional level, especially related to mobility or continence, that might be amenable to therapy; a medication review with attention to the accumulation of therapies no longer needed and that screening tests for toxicity, side-effects and efficacy have been performed; and a review of any noted behavioral changes or changes in affect. Also included is a review of compliance with routine specialty follow-up care and that health maintenance measures have been provided. Social history includes the relationship of the family with the patient, the staff and the facility. A comprehensive physical exam is performed. VS are noted, including a review of the patient's weight over the previous year. The skin is carefully inspected for ulceration. Evidence of sensory impairments and the status of oral hygiene is noted. Cardiovascular, pulmonary, abdominal and GU exams are performed with special attention to evidence of urinary retention and fecal impaction. The patient's ability to communicate and gait safety is assessed. Short form evaluations of interval changes in cognitive functioning and a screen for affective changes may be performed, as indicated. Assessment is made of the patient's and family's goals for care and their preferences for medical interventions, in light of the prognosis derived from the review of the chart, the interval history and physical examination.

Description of Post-Service Work: includes follow-up telephone calls with the family and the facility regarding diagnostic findings, post-service coordination of care, documentation, and interaction with facility health professionals associated

with delivery of care to this patient until the next face-to-face physician encounter. A reassessment of the advance directives and updates of contact information for surrogate decision makers is included in the post service work.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	Dr. Dennis Stone				
<b>Specialty(s):</b>	Long Term Care Facilities				
<b>CPT Code:</b>	99318				
<b>Sample Size:</b>	500	<b>Resp n:</b>	48	<b>Response:</b> 9.60 %	
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	1.80	2.06	2.50	4.00
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	2.00	20.00	25.00	30.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>10.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99397	XXX	1.71

CPT Descriptor Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient;65 years and over.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 37.5 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 99318</u>	<u>Key Reference CPT Code: 99397</u>
Median Pre-Service Time	10.00	5.00
Median Intra-Service Time	25.00	35.00
Median Immediate Post-service Time	10.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	45.00	50.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.77	4.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.62	4.44
Urgency of medical decision making	4.83	4.72

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.55	4.32
Physical effort required	4.15	4.14

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.83	4.69
Outcome depends on the skill and judgment of physician	4.72	4.67
Estimated risk of malpractice suit with poor outcome	4.32	4.02

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.89	2.78
Intra-Service intensity/complexity	3.45	3.45
Post-Service intensity/complexity	3.09	2.92

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**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) 993X2 is a new code. However, it does contain elements of 99301.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine                      How often? Commonly

Specialty Family Practice                      How often? Commonly

Specialty Nurse Practitioners                      How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 260000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Internal Medicine                      Frequency 89000                      Percentage 34.23 %

Specialty Family Practice                      Frequency 78000                      Percentage 30.00 %

Specialty Nurse Practitioners                      Frequency 25000                      Percentage 9.61 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 226,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Internal Medicine                      Frequency 77000                      Percentage 34.07 %

Specialty Family Practice                      Frequency 68000                      Percentage 30.08 %

Specialty Nurse Practitioners                      Frequency 22000                      Percentage 9.73 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99301

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/Specialty Society Update Process  
PERC Summary of Recommendation  
XXX Global Period  
Facility and Nonfacility Direct Inputs**

**CPT Long Descriptors:**

**99304** - Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components:

- a detailed or comprehensive history;
- a detailed or comprehensive examination; and
- medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of low severity.

**99305** - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of moderate severity.

**99306** - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of high severity.

**99307** - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- a problem focused interval history;
- a problem focused examination;
- straightforward medical decision making

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving.

**99308** - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- an expanded problem focused interval history;
- an expanded problem focused examination;
- medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication.

**99309** - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination;
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem.

**99310** Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- a comprehensive interval history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

**99318** - Evaluation and management of a patient involving an annual nursing facility assessment which requires these three key components:

- a detailed interval history;
- a comprehensive examination; and
- medical decision making that is of low to moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving.

(Do not report 99318 on the same date of service as other nursing facility services codes)

Sample Size: 500 Response Rate: (%) 9.6% Global Period: XXX

Geographic Practice Setting %: Rural 42% Suburban: 29% Urban: 31%

Type of Practice %: 27% Solo Practice  
33% Single Specialty Group  
23% Multispecialty Group  
17% Medical School Faculty Practice Plan

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

In March 2003 the American Medical Directors Association (AMDA) conducted a nationwide Practice Expense survey of its membership involving CPT codes 99301, 99302, and 99303 (evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility); and 99311, 99312, and 99313 (subsequent nursing facility care, per day, for the evaluation and management of a new or established patient), establishing a time basis for those codes. During the recent revisions of the Nursing Facility CPT codes, those six old codes have been deleted and replaced with eight new codes: three codes for Initial Nursing Facility Care (99304-99306), four codes for Subsequent Nursing Facility Care (99307-99310), and one code for an annual patient assessment (99318).

Due to the similarity between the inputs and data of the March 2003 Practice Expense survey and those required by the Practice Expense portion of the current coding revisions process, the March 2003 data was used as a basis when AMDA convened an RVS Committee to determine proper time measurements for the revised codes. The RVS Committee consisted of seven physicians who are medical directors of long term care facilities: Dr. Dennis Stone of Louisville, Kentucky; Dr. Charles Crecelius of St. Louis, Missouri; Dr. Leonard Gelman of Ballston Spa, New York; Dr. George Taler of Washington, D.C.; Dr. Arthur Snow of Shawnee Mission, Kansas; Dr. Robert Zorowitz of Riverdale, New York; and Dr. David MacRae of Mobile, Alabama. The RVS Committee met in New Orleans in March, and then later via conference call, to discuss Practice Expense recommendations.

**Please describe the clinical activities of your staff:**

**Pre-Service Clinical Labor Activities:**

99304 - Includes preparing to see the patient, procuring and reviewing previous medical records and communicating with facility professionals as appropriate.

99305 - Includes preparing to see the patient, procuring and reviewing the hospital records, labs and diagnostic findings, and communicating with facility professionals as appropriate.

99306 - Includes preparing to see the patient, procuring and reviewing the hospital records, labs and diagnostic findings, and communicating with facility professionals as appropriate

99307 - Includes preparing to see the patient, a record review of previously attempted interventions and communicating with facility professionals, as appropriate. The suggestions of the facility dietitian and consultant pharmacist are reviewed.

99308 - Includes preparing to see the patient, a record review, and communication with other facility professionals, as appropriate.

99309 - Includes preparing to see the patient, reviewing the telephone orders associated of the recently reported URI, the changes in the dietary, bowel and psychotropic regimens and the treatment of the non-infected skin tear all reported by telephone by nursing staff since last medical visit. Also includes communicating with facility professionals, as appropriate.

99310 - Includes preparing to see the patient, reviewing the medical record and previously ordered diagnostic lab and communication with facility professionals as appropriate.

99318 - Includes preparing to see the patient, procuring previous medical records over the past year and communicating with facility professionals as appropriate.

**Intra-Service Clinical Labor Activities:**

None listed.

**Post-Service Clinical Labor Activities:**

99304 - includes follow-up telephone calls with the facility regarding diagnostic findings, post-service coordination of care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discussion with family and/or surrogate decision maker regarding preferred intensity of care/DNR is also included in post-service work.

99305 - includes follow-up telephone calls with the patient's orthopedist and with the facility regarding diagnostic findings, post-service coordination of care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discussion with family and/or surrogate decision maker regarding preferred intensity of care/DNR is also included in post-service work.

99306 - Includes follow-up telephone calls with the facility regarding diagnostic findings, post-service coordination of care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discussion with family and/or surrogate decision maker regarding preferred intensity of care/DNR is also included in post-service work.

99307 - Includes follow-up telephone calls with facility staff with coordination of care, and documentation as indicated associated with delivery of care to this patient until the next face-to-face physician encounter.

99308 - Includes discussion with facility social services and activities programming, follow-up telephone calls with the nursing facility regarding titration of anti-depressant, review of confirming diagnostic lab data and follow-up on antibiotic effectiveness, plus all coordination of care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

99309 - Includes evaluation of additional diagnostic testing to determine hydration and pulmonary status and further changes in patient's psychotropic regimen, follow-up telephone calls with the facility staff, all coordination of care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

99310 - Includes evaluation of additionally ordered lab and diagnostic testing, telephone calls with the facility to adjust interventions as indicated, discussion with family regarding updating end of life issues, coordination of all care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

99318 - Includes follow-up telephone calls with the family and the facility regarding diagnostic findings, post-service coordination of care, documentation, and interaction with facility health professionals associated with delivery of care to this patient until the next face-to-face physician encounter. A reassessment of the advance directives and updates of contact information for surrogate decision makers is included in the post service work.

	CMS Code	99304		99305		99306		99307		99308		99309		99310		99318	
		Initial nursing facility care, per day, for the evaluation and management of a patient, straightforward or low complexity.	Initial nursing facility care, per day, for the evaluation and management of a patient, moderate complexity.	Initial nursing facility care, per day, for the evaluation and management of a patient, high complexity.	Initial nursing facility care, per day, for the evaluation and management of a patient, high complexity.	Initial nursing facility care, per day, for the evaluation and management of a patient, high complexity.	Initial nursing facility care, per day, for the evaluation and management of a patient, high complexity.	Subsequent nursing facility care, per day, for the evaluation and management of a patient, straightforward medical decision making.	Subsequent nursing facility care, per day, for the evaluation and management of a patient, low complexity.	Subsequent nursing facility care, per day, for the evaluation and management of a patient, moderate complexity.	Subsequent nursing facility care, per day, for the evaluation and management of a patient, high complexity.	Subsequent nursing facility care, per day, for the evaluation and management of a patient, high complexity.	Subsequent nursing facility care, per day, for the evaluation and management of a patient, high complexity.	Subsequent nursing facility care, per day, for the evaluation and management of a patient, high complexity.	Subsequent nursing facility care, per day, for the evaluation and management of a patient, high complexity.	Subsequent nursing facility care, per day, for the evaluation and management of a patient, high complexity.	Subsequent nursing facility care, per day, for the evaluation and management of a patient, high complexity.
LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
<b>GLOBAL PERIOD</b>		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
<b>TOTAL CLINICAL LABOR TIME- RN/LPN/MTA</b>	L037D	14.0	14.0	14.0	14.0	14.0	14.0	11.0	11.0	17.0	17.0	21.0	21.0	27.0	27.0	14.0	14.0
<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>		3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	6.0	6.0	6.0	6.0	9.0	9.0	3.0	3.0
<b>TOTAL SERVICE PERIOD CLINICAL LABOR</b>		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>TOTAL POST-SERV CLIN LABOR TIME</b>		11.0	11.0	11.0	11.0	11.0	11.0	8.0	8.0	11.0	11.0	15.0	15.0	18.0	18.0	11.0	11.0
<b>Start: Prior to visit to nursing facility patient.</b>																	
Schedule space and equipment in facility																	
Review/read x-ray, lab, and pathology reports										3	3	3	3	3	3		
Coordinate home or outpatient care																	
Coordinate/modify rehab, speech, respiratory care																	
Phone calls between visits with patient, family, pharmacy		3	3	3	3	3	3	3	3	3	3	3	3	6	6	3	3
Coordinate ancillary services: podiatry, optometry, dentist, psych.																	
Monitor patient/notify physician of change in condition																	
Respond to consultant pharmacist or nutritionist reviews & recommendations																	
<b>End: When patient enters office/facility for surgery/procedure</b>																	
<b>Start: When patient enters office/facility for surgery/procedure</b>																	
<b>Pre-service services</b>																	
Review charts																	
Greet patient and provide gowning																	
Obtain vital signs																	
Provide pre-service education/obtain consent																	
Prepare room, equipment, supplies																	
Sedate/apply anesthesia																	
<b>Intra-service</b>																	
Assist physician in performing procedure																	
<b>Post-Service</b>																	
Monitor pt. following service/check tubes, monitors, drains																	
Complete diagnostic forms, lab & X-ray requisitions																	
Review/read X-ray, lab, and pathology reports																	
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions																	
Discharge day management 99238 -12 minutes																	
Other Clinical Activity (please specify)																	
<b>End: Patient leaves office</b>																	

LOCATION	CMS Code	99304		99305		99306		99307		99308		99309		99310		99318	
		Non Facility	Facility														
<b>Start: Patient leaves office/physician leaves patient's bedside or facility</b>																	
Schedule space and equipment in facility																	
Review/read x-ray, lab, and pathology reports		2	2	2	2	2	2	1	1	2	2	3	3	3	3	2	2
Coordinate home or outpatient care														0	0	0	0
Coordinate/modify rehab, speech, respiratory care																	
Phone calls between visits with patient, family, pharmacy dentist, psych.		3	3	3	3	3	3	3	3	3	3	3	3	6	6	3	3
Monitoring patient/notifying physician of change in condition		3	3	3	3	3	3	3	3	3	3	6	6	6	6	3	3
Respond to consultant pharmacist or nutritionist reviews and recommendations		3	3	3	3	3	3	1	1	3	3	3	3	3	3	3	3
<i>List Number and Level of Office Visits</i>																	
99211 16 minutes	16																
99212 27 minutes	27																
99213 36 minutes	36																
99214 53 minutes	53																
99215 63 minutes	63																
Other																	
<b>Total Office Visit Time</b>		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Activity (please specify)																	
<b>End: with last office visit before end of global period</b>																	
None																	
None																	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Domiciliary Care Services**

When CPT Editorial Panel convened an E&M workgroup to evaluate potential changes in CPT descriptors, a review of all the E&M codes was conducted. Several coding changes were proposed. Restructuring of the nursing facility codes was recommended as was deletion of the domiciliary care codes. The CPT Editorial Panel considered the work and practice expense of the domiciliary codes to be identical to the Home Visit codes (CPT codes 99341-99350) and felt it would be less confusing for providers to use a single family of codes to describe these services. When this was proposed, objections were raised by the Centers for Medicare and Medicaid Services (CMS) because the definition of a domiciliary facility did not include a private home. Because of this administrative restriction, restructuring of the domiciliary codes was proposed. The domiciliary codes were revised to have a structure identical to the home visit codes. Following this, the home care physicians were asked to survey these codes. The previous valuations of these codes by CMS were arbitrarily assigned as 67% of the home visit codes.

The RUC agreed to the following:

1. Home Visits and Domiciliary Care Services are analogous services with essentially identical physician work and practice expense.
2. Domiciliary Care Services codes were developed to address a CMS administrative problem since CMS would not allow deletion of these codes.
3. The equivalence of the home visit and domiciliary codes constitutes compelling evidence that CMS used a flawed assumption by assigning the domiciliary codes 67% of the value of the home visit codes. Further compelling evidence is outlined in the attached letter prepared by the presenting specialty societies.
4. The survey results were hopelessly flawed and would not be useful in accurately capturing the physician work involved in these services (i.e. the vignettes were not felt to be typical by 50% or more of respondents; intra-service times did not correlate with similar level home visit codes).

Therefore, the RUC recommends the following:

1. Discard the survey data and crosswalk the physician work and practice expense values for analogous Home Visit code levels, as CPT had originally proposed.

2. A note should be included in the RUC Database describing the straight crosswalk from the home visit codes.
3. Recommend to CPT that the typical times used for domiciliary visits in the CPT book should be identical to the times used for home visits.

**The RUC recommends the following physician work relative values and physician time:**

Code	Description	Work RVUs	CPT Times	Domiciliary Care Codes	Recommended Domiciliary Care Code Work RVU	Recommended Domiciliary Care Code Time
99341	Home visit, new patient	1.01	20	99324	1.01	20
99342	Home visit, new patient	1.52	30	99325	1.52	30
99343	Home visit, new patient	2.27	45	99326	2.27	45
99344	Home visit, new patient	3.03	60	99327	3.03	60
99345	Home visit, new patient	3.78	75	99328	3.78	75
99347	Home visit, est patient	0.76	15	99334	0.76	15
99348	Home visit, est patient	1.26	25	99335	1.26	25
99349	Home visit, est patient	2.02	40	99336	2.02	40
99350	Home visit, est patient	3.03	60	99337	3.03	60

**Practice Expense:**

The RUC recommends a straight cross-walk of the practice expense inputs of the Domiciliary Care codes to the Home visit codes as described in the table above. These practice expense inputs are attached to this recommendation.



CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p><b>Domiciliary Care Services</b>            The following codes are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. <u>These codes are also intended to report evaluation and management services in an assisted living facility.</u></p>				
D 99321		<p><del>Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> a problem focused history;</del></li> <li><del><input type="checkbox"/> a problem focused examination; and</del></li> <li><del><input type="checkbox"/> medical decision making that is straightforward or of low complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>Usually, the presenting problem(s) are of low severity.</del></p>	XXX	N/A
D 99322		<p><del>Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> an expanded problem focused history;</del></li> <li><del><input type="checkbox"/> an expanded problem focused examination; and</del></li> <li><del><input type="checkbox"/> medical decision making of moderate complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>Usually, the presenting problem(s) are of moderate severity.</del></p>	XXX	N/A

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 99323		<p><del>Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> a detailed history;</del></li> <li><del><input type="checkbox"/> a detailed examination; and</del></li> <li><del><input type="checkbox"/> medical decision making of high complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>Usually, the presenting problem(s) are of high complexity.</del></p>	XXX	N/A
•99324	CCC1	<p>Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a problem focused history;</li> <li><input type="checkbox"/> a problem focused examination; and</li> <li><input type="checkbox"/> straightforward medical decision making</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.</p>	XXX	1.01

●99325	CCC2	<p>Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> an expanded problem focused history;</li> <li><input type="checkbox"/> an expanded problem focused examination; and</li> <li><input type="checkbox"/> medical decision making of low complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.</p>	XXX	1.52
●99326	CCC3	<p>Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a detailed history;</li> <li><input type="checkbox"/> a detailed examination; and</li> <li><input type="checkbox"/> medical decision making of moderate complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.</p>	XXX	2.27

●99327	CCC4	<p>Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a comprehensive history;</li> <li><input type="checkbox"/> a comprehensive examination; and</li> <li><input type="checkbox"/> medical decision making of moderate complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.</p>	XXX	3.03
●99328	CCC5	<p>Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a comprehensive history;</li> <li><input type="checkbox"/> a comprehensive examination; and</li> <li><input type="checkbox"/> medical decision making of high complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.</p>	XXX	3.78



D 99331	<p><del>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> a problem focused interval history;</del></li> <li><del><input type="checkbox"/> a problem focused examination;</del></li> <li><del><input type="checkbox"/> medical decision making that is straightforward or of low complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>Usually, the patient is stable, recovering or improving.</del></p>	XXX	N/A
D 99332	<p><del>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> an expanded problem focused interval history;</del></li> <li><del><input type="checkbox"/> an expanded problem focused examination;</del></li> <li><del><input type="checkbox"/> medical decision making of moderate complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>Usually, the patient is responding inadequately to therapy or has developed a minor complication.</del></p>	XXX	N/A

D 99333		<p><del>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:</del></p> <ul style="list-style-type: none"> <li><del><input type="checkbox"/> a detailed interval history;</del></li> <li><del><input type="checkbox"/> a detailed examination;</del></li> <li><del><input type="checkbox"/> medical decision making of high complexity.</del></li> </ul> <p><del>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.</del></p> <p><del>Usually, the patient is unstable or has developed a significant complication or a significant new problem.</del></p>	XXX	N/A
●99334	CCC6	<p>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a problem focused interval history;</li> <li><input type="checkbox"/> a problem focused examination;</li> <li><input type="checkbox"/> straightforward medical decision making</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.</p>	XXX	0.76

●99335	CCC7	<p>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> an expanded problem focused interval history;</li> <li><input type="checkbox"/> an expanded problem focused examination;</li> <li><input type="checkbox"/> medical decision making of low complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.</p>	XXX	1.26
●99336	CCC8	<p>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a detailed interval history;</li> <li><input type="checkbox"/> a detailed examination;</li> <li><input type="checkbox"/> medical decision making of moderate complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.</p>	XXX	2.02

●99337	CCC9	<p>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> a comprehensive interval history;</li> <li><input type="checkbox"/> a comprehensive examination; and</li> <li><input type="checkbox"/> medical decision making of moderate to high complexity.</li> </ul> <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.</p>	XXX	3.03
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April 4, 2005

Sherry Smith  
Roseanne Eagle  
Todd Klemp  
American Medical Association  
515 N. State Street  
Chicago, IL 60610

Dear Ms. Smith, Ms. Eagle, and Mr. Klemp,

On behalf of the American Academy of Home Care Physicians (AAHCP), and under the sponsorship of the American Geriatrics Society, I am pleased to submit the enclosed RUC Summary Forms for Work and Practice Expense for the revision of the Domiciliary Care codes as part of the RUC review process at its April meeting. In this transmittal memo, I will provide the “compelling evidence” arguments for adoption of these code recommendations, summarize the recommendations and discuss the results of our survey process.

### **1. Compelling Evidence and Work Neutrality**

AAHCP believes that increases in the current work values for the domiciliary codes is warranted for three principal reasons: (1) the work associated with these services has increased over the past decade; (2) these services were never properly evaluated; and (3) the amount of work involved is comparable to that provided to home patients and currently reported by CPT codes 99341-99350—but the domiciliary codes currently have work values that are, on average, less than 65 percent of those assigned to comparable levels of home services.

#### ***Physician work has increased over the past decade.***

Prior to 1990, congregate living was described primarily as “board and care”, in which residents had a single or semi-private room, were generally “looked after” in a social context and received “family-style” meals, but little to no other supportive services. State Departments of Health licensed some families to take small numbers of elders too frail to live alone into their homes under a foster care arrangement and established group homes (GH) for residents with chronic mental conditions and developmental disabilities. This was the scenario in which CPT Codes 99321-99333 were described and valued.

Both the nature of LTC facilities and the characteristics of the residents changed dramatically over the past decade. The “oldest-old” are the fastest growing segment of our society. Assisted living facilities (ALF) were established to allow residents a more home-like environment than usually

available in a nursing facility (NF)—and physicians were told to report E/M services provided to the residents of these facilities using the existing codes for domiciliary care. The growth and change in the assisted living industry has been documented in a report sponsored by the Department of Health and Human Services entitled “A National Study of Assisted Living for the Frail Elderly”.<sup>1</sup> This report was prepared under contracts #HHS-100-94-0024 and #HHS-100-98-0013 between the U.S. Department of Health and Human Services (HHS) and the Research Triangle Institute. Information from this report is provided below.

The expansion of congregate living is a new industry: 58% have been in business for less than 10 years, 32% for less than 5 years. As of early 1998, “there were 11,459 assisted living facilities (ALF) nationwide, with approximately 611,300 beds and 521,500 residents.” By including all foster homes and about 7000 GH, a current estimate of licensed beds is approximately 1,000,000, rivaling (NF) beds nationally (17,000 nursing homes with 1,680,000 beds and 1,500,000 residents). However, unlike NFs, the requirements for ALF licensure differ widely from state to state, and many facilities remain unlicensed and uncounted.

Prospective residents consider entry to an ALF only when disabilities related to chronic illness threaten their independence. Not surprisingly, 24% of residents in ALF require assistance with 3 or more activities of daily living and 34% have moderate to severe cognitive impairment. The majority of states licensing agencies allow ALF to retain residents who are wheelchair bound, and approximately 75% of ALF administrators allow this level of disability. Nearly a third of state agencies also allow ALF to retain residents who are bedfast. The challenge of frailty and age-related illness has been met with increasing complexity in therapeutic options, and many providers have increased their point-of-care diagnostic capabilities. There is also greater demand on health care providers to address issues of function, mental health, social supports and caregiver concerns.

Although the lines have blurred between ALF and custodial care in a NF, there are stark distinctions between these settings. Nursing services are offered as a matter of course in NF, but there is a broad range of variability in the support available in ALF. Over 90% of ALFs offer medication reminders and monitor compliance. Forty percent have a full-time registered nurse (RN), 15% a part-time RN and an additional 16% had a full or part-time licensed practical nurse (LPN); however, 21% provided no care or monitoring by a licensed nurse. Skilled nursing care was available in 31% of ALFs, but rarely for more than 14 days. Although not providing such services themselves, 65% of ALFs were willing to allow home health services on site.

Four distinct forces have led to profound changes in the practice of medicine in community-based settings. The Prospective Payment System used by Medicare, and most other health insurance carriers, has pushed patients with increasing medical complexity and frailty “downstream” into nursing facilities, assisted living facilities and home care. Advances in the miniaturization and simplification of point-of-service diagnostic and therapeutic technologies allow practitioners to provide a comprehensive level of care in virtually any setting, including the management of unstable patients comparable to an urgent care center. Research in health

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<sup>1</sup> U.S. Department of Health and Human Services. A National Study of Assisted Living for the Frail Elderly: Results of a National Survey of Facilities. By Catherine Hawes, Miriam Rose and Charles D. Phillips. Myers Research Institute. December 14, 1999. <http://aspe.os.dhhs.gov/daltcp/reports/facres.htm>.

care delivery has consistently found that extension of the medical care plan into the home improves our understanding of the interplay between disease and the social, psychological and environmental factors that determine compliance, and improves patient education and self-management. Finally, people have a strong desire to remain in the community and avoid institutional placement.

Many ALF and group home residents have psychiatric conditions or Alzheimer's disease and related disorders complicated by psychiatric and behavioral disturbances. These problems often complicate and compromise the management of their medical illnesses and increase the risk of institutional placement. Effective management of psychiatric and behavioral problems usually requires a complex and work-intensive coordination of medical treatment, environmental manipulation including liaison with facility staff, and education and counseling of family members.

The assisted living industry has responded to this demand and transformed the landscape of long term care, greatly expanding the number of residents in congregate housing and allowing them to age-in-place. State agency regulations and Medicaid policies have allowed residents of increasing frailty to remain in these non-medical facilities.

Recently published studies provide additional support for the changing physician work in assisted living facility settings and these are cited below.

**Spillman BC, Liu K, and McGilliard C. *Trends in Residential Long-Term Care: Use of Nursing Homes and Assisted Living and Characteristics of Facilities and Residents.* November 25, 2002. Prepared for the Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services.**

This study used data from the Medicare Current Beneficiary Survey and focused only on individuals 65 years of age or older. Findings and conclusions included the following:

From 1992 to 1998, the proportion of assisted living facility residents age 85 and older went from 44.8 percent to 50.4 percent. Over the same time period, the proportion of assisted living facility residents showing impairment in 3 or more activities of daily living rose from 34.6 percent to 52.1 percent. The proportion of residents self-reporting their health as fair or poor went from 45.8 percent to 49.6 percent, and the proportion reporting their health as excellent or very good went from 26.0 percent to 11.5 percent.

“...we also see some evidence that assisted living facilities either are accepting less healthy residents than in the past or that their residents are ‘aging in place’ and becoming less healthy and more disabled over time.”

“...there is an unequivocal upward shift in functional disability among assisted living residents.”

**Hawes C, Phillips CD and Rose M. *High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey.* November 2000.**

This study was based on site visits of 300 ALFs meeting specified criteria (e.g., having 11 or more beds, with 80-100% of its units private and/or providing at least the following services: 24-hour staff oversight; housekeeping; at least 2 meals a day; personal assistance, defined as help with at least two of the following: medications, bathing, or dressing; at least one full-time registered nurse on staff; and nursing care—monitoring or services—with its own staff) and interviews of a probability sample of staff and residents from these facilities. Findings and conclusions included the following:

“In addition to creating new licensure categories and expanding Medicaid waiver programs, many states began allowing higher levels of care to be provided outside nursing homes. For example, by the mid-1990s, the majority of state licensing agencies allowed ALFs to house residents who were chair-fast because of health problems or who used wheelchairs to get around inside the facility. One-third of the licensing agencies allowed such facilities to retain residents who were bedfast (Hawes, Wildfire & Lux, 1993). Some states also embarked on more aggressive strategies for expanding the potential role of ALFs. These strategies included:

1. permitting the provision of daily or intermittent nursing care (including skilled care) and hospice care in these facilities,
2. allowing retention of residents with greater levels of impairment, and
3. modifying their nurse practice acts (Hawes, et., 1993; Kane & Wilson, 1993; Manard, Altman, Kane, & Zeuschner, 1992; Mollica, 1998; Mollica & Snow, 1996; Newcomer, Lee & Wilson, 1996).”

Over 54 percent of residents of high service or high privacy ALFs were 85 years old or older (data collection late 1997 and early 1998). Thirteen percent of the residents exhibited moderate cognitive impairment, while 14 percent had severe cognitive impairment. Thirteen percent received help with one or two ADLs, while just over 8 percent received help with three to five ADLs. In terms of physical health, 29.3 percent self-reported their health as fair and another 9.9 percent as poor; 18.5 percent reported that pain interferes with activities some of the time, and 6.1 percent said it did so all of the time.

***The domiciliary codes were never properly evaluated or valued.***

When the E/M codes were developed during the early 1990s, typical times were assigned based on the survey results obtained by the Harvard RBRVS study team and the clinical judgment of the CPT Editorial Panel and its Advisory Committee. Since domiciliary care services were not surveyed, “typical times” were not included in their code descriptions. As a result, physicians providing domiciliary care are not able to report their services based on time when counseling and/or coordination of care dominates (more than 50%) the encounter. In addition, they are precluded from using the prolonged services codes.

Initial work values for CPT codes 99321-99333 were not included in the Harvard RBRVS study and work values were simply assigned by staff at the Health Care Financing Administration (HCFA) based on the assumption, that may have been accurate at that time, that only limited services could be provided in this setting. The work values for these codes have not been

subsequently subjected to formal review by the RUC. Moreover, the work values assigned by HCFA were based on the faulty assumption that the domiciliary E/M codes included availability of personal assistant services. As long ago as 1996, the end of the first five-year review of relative values, HCFA observed, in the final physician fee schedule rule published November 22, 1996 (at page 59528), that the agency would wait to revalue the domiciliary E/M codes after the CPT Editorial Panel had reworked the codes. This has now been accomplished.

***Physician work for domiciliary and home E/M services is comparable.***

AAHCP members commonly provide E/M services in both home and domiciliary settings (including ALFs). In terms of physician work, we believe that the domiciliary care codes are the most closely related to the home visit codes (CPT 99341-99350). Physician intra-service work in the domiciliary setting is essentially the same as on a home visit, differing only in that taking the history and caregiver education involves unrelated staff, in addition to family members. However, our experience in this setting is that the counseling needs are required with every visit and may include any or all of the following: the patient, the family and/or the facility staff. Health education includes not only self-help instructions for the patient, but also caregiver instruction for disease monitoring and skills training for the non-professional facility staff, as well as the family. In some facilities, the presence of medical personnel who are unlicensed as nurses can actually increase the need for communication of care plans and clinical changes. Many facilities utilize the forms and procedures of nursing facilities yet lack the licensed personnel that can accept delegated tasks from the physician.

In fact, since ALFs are non-medical facilities, by definition, the practitioner must provide all necessary equipment and supplies, must rely on their own medical records and have very little support from nursing staff. The greater complexity of care and the extended capabilities of providing care on site prompted an expansion in the breadth of services described by the CPT Editorial Panel. It is for this reason that changes in the codes for the domiciliary E/M services parallel those for the Home Visit Codes (99341-99350)--with the delineation of 5 new patient codes and 4 established patient codes.

**2. Summary of Recommendations.**

There currently are only 3 levels of service for new patients in the Domiciliary Care section of CPT and the highest level of service is restricted to a detailed history and a detailed examination. This is inconsistent with current clinical practice. To correct this problem, the CPT Editorial Panel in February, 2005 approved two new codes to permit the reporting of comprehensive levels of service. The descriptions of these new codes correspond to level 4 and level 5 codes for new patients in the home services section of CPT (99344 and 99345).

Second, there currently are only 3 levels of service for established patients in the Domiciliary Care section of CPT and the highest level of service is restricted to a detailed interval history and a detailed examination. This is inconsistent with current clinical practice. To correct this problem, the CPT Editorial Panel also approved one new code to permit the reporting of a comprehensive level of service. The description of this new code corresponds to the level 4 code for established patients in the home services section of CPT (99350).

Finally, unlike most other families of E/M services, these codes do not have “typical times” included in their code descriptions. As a result, physicians providing domiciliary care are not able to report their services based on time when counseling and/or coordination of care dominates (more than 50%) the encounter and they are precluded from using the prolonged services codes because the “typical times” of domiciliary care have not been established. To correct this problem, a sentence regarding “typical time” has been added to the code descriptions. The amount of time physicians typically spend face-to-face with the patient and/or family has been listed as “XX”. This is being done on a temporary basis. It is anticipated that the “typical times” will be determined through the RUC survey process and that those times will then be included in the 2006 CPT Manual.

The proposal to be evaluated through the survey process is the creation of a family of 9 codes including three new codes comparable in their progression to the house call codes. These codes (99324-9) were surveyed with the key questions being whether the survey data would support the comparability of the codes, and their valuation. In sum, the data did.

***Recommendation 1: Adopt work values for domiciliary care codes comparable to those currently in place for house call codes.***

As the tables below compiled from survey results show, respondents assigned work values to the domiciliary care codes similar to those currently in place for house call codes:

### Survey Results: Work RVUs

<i>Code</i>	<i>Description</i>	<i>Low</i>	<i>25<sup>th</sup> Percentile</i>	<i>Median</i>	<i>75<sup>th</sup> Percentile</i>	<i>High</i>
99324	Rest home visit, new pt	0.80	1.01	<b>1.01</b>	1.10	2.00
99325	Rest home visit, new pt	1.00	1.50	<b>1.52</b>	1.56	2.50
99326	Rest home visit, new pt	1.00	2.27	<b>2.27</b>	2.29	3.40
99327	Rest home visit, new pt	1.00	3.03	<b>3.03</b>	3.13	4.53
99328	Rest home visit, new pt	1.00	3.78	<b>3.78</b>	4.00	5.17
99334	Rest home visit, est pt	0.50	0.76	<b>0.76</b>	0.80	1.25
99335	Rest home visit, est pt	0.75	1.26	<b>1.26</b>	1.26	2.40
99336	Rest home visit, est pt	1.00	2.02	<b>2.02</b>	2.20	3.02
99337	Rest home visit, est pt	1.00	3.03	<b>3.03</b>	3.20	4.53

### Recommended Work RVUs

<i>Code</i>	<i>Description</i>	<i>Rec. Work RVU</i>	<i>Survey Result</i>	<i>Reference Code</i>	<i>Description</i>	<i>Ref. Work RVU</i>
99324	Rest home visit, new pt	<b>1.01</b>	Median	99341	Home visit, new pt	<b>1.01</b>
99325	Rest home visit, new pt	<b>1.52</b>	Median	99342	Home visit, new pt	<b>1.52</b>
99326	Rest home visit, new pt	<b>2.27</b>	Median	99343	Home visit, new pt	<b>2.27</b>
99327	Rest home visit, new pt	<b>3.03</b>	Median	99344	Home visit, new pt	<b>3.03</b>
99328	Rest home visit, new pt	<b>3.78</b>	Median	99345	Home visit, new pt	<b>3.78</b>
99334	Rest home visit, est pt	<b>0.76</b>	Median	99347	Home visit, est pt	<b>0.76</b>
99335	Rest home visit, est pt	<b>1.26</b>	Median	99348	Home visit, est pt	<b>1.26</b>
99336	Rest home visit, est pt	<b>2.02</b>	Median	99349	Home visit, est pt	<b>2.02</b>
99337	Rest home visit, est pt	<b>3.03</b>	Median	99350	Home visit, est pt	<b>3.03</b>

***Recommendation 2: Make time values for the domiciliary care codes comparable to those for house call codes so that the time/intensity relationship can be maintained at its current graduated level among codes by adopting the intra-service times at the 75 percentile of the data for the codes where the times do not match exactly.***

As seen in the summary tables below, the median for intra-service times from the survey are the same in some cases (99X1 and 99X2) as the house call codes, but are somewhat lower for 99326, 99327, 99328, 99336 and 99337. However, ratings for intensities are in many cases higher than the ratings for reference codes. Therefore, to promote uniformity in relationships within this family of codes, we propose using the 75th percentile for times rather than the median for the affected codes, as shown below.

### Survey Results: Intra-service Time

<i>Code</i>	<i>Description</i>	<i>Low</i>	<i>25<sup>th</sup> Percentile</i>	<i>Median</i>	<i>75<sup>th</sup> Percentile</i>	<i>High</i>
99324	Rest home visit, new pt	3	19	20	20	45
99325	Rest home visit, new pt	5	20	30	30	50
99326	Rest home visit, new pt	8	30	40	45	60
99327	Rest home visit, new pt	10	45	50	60	75
99328	Rest home visit, new pt	15	60	60	75	90
99334	Rest home visit, est pt	5	15	15	15	30
99335	Rest home visit, est pt	8	20	25	25	40
99336	Rest home visit, est pt	10	30	35	40	60
99337	Rest home visit, est pt	15	40	40	60	70

### Recommended CPT (Intra-service) Times

<b>New Code</b>	<b>Description</b>	<b>Rec. CPT Time</b>	<b>Survey Result</b>	<b>Ref. Code</b>	<b>Description</b>	<b>Ref. CPT time</b>
99324	Rest home visit, new pt	20	Median	99341	Home visit, new pt	20
99325	Rest home visit, new pt	30	Median	99342	Home visit, new pt	30
99326	Rest home visit, new pt	45	75 <sup>th</sup> Percentile	99343	Home visit, new pt	45
99327	Rest home visit, new pt	60	75 <sup>th</sup> Percentile	99344	Home visit, new pt	60
99328	Rest home visit, new pt	75	75 <sup>th</sup> Percentile	99345	Home visit, new pt	75
99334	Rest home visit, est pt	15	Median	99347	Home visit, est pt	15
99335	Rest home visit, est pt	25	Median	99348	Home visit, est pt	25
99336	Rest home visit, est pt	40	75 <sup>th</sup> Percentile	99349	Home visit, est pt	40
99337	Rest home visit, est pt	60	75 <sup>th</sup> Percentile	99350	Home visit, est pt	60

***Recommendation 3: Recommend projected utilization statistics that mimic past experience with the house call codes, and that follow a methodology based on past experience with these codes.***

We project a 2-3 year period of flat utilization, followed by modest growth. Our experience is based on data derived from utilization statistics following revaluation of the home visit codes. As seen in the table below, despite the 1998 home visit code additions and revaluation (comparable to what is being proposed for domiciliary care), there was no sudden rise in utilization. We believe this reflects the small numbers of physicians and other providers willing to take the time to make house calls in patient homes, and we believe the same thing will be true in Domiciliary Care facilities. Thus, rather than significant adding to national Medicare expenditures, our projections are for flat utilization, at the percentage distribution by specialty reported by CMS in 2003. Obviously, over time, we hope existing practices will gradually be able to expand to meet more of the need.

<b>MEDICARE DATA BASE NATIONAL PROCEDURE SUMMARY DATA FILE</b>	
<b>Allowed Frequency Totals for House Call Codes 99341-99350</b>	
2003	1,833,598
2002	1,704,460
2001	1,602,020
2000	1,531,304
1999	1,448,030
1998	1,476,602
1997	1,547,713
1996	1,615,155
1995	1,513,016

With regard to the question of the distribution of utilization across codes, we propose what CMS (then HCFA) projected for the house call codes in 1998 and what in fact has proven to be the fact with regard to new patient domiciliary care codes. With regard to the established patient codes and new code, we estimate the distribution of utilization as it has actually occurred. The table below explains these projections:

### Projected Utilization

<i>New Code</i>	<i>Description</i>	<i>Predecessor (Deleted) Code</i>	<i>Description</i>	<i>Medicare Freq of Predecessor (Deleted) Code</i>	<i>% of Predecessor (Deleted) Code Freq That Will Be Reported Using The New Code</i>	<i>Projected Freq of New Code</i>
99324	Rest home visit, new pt	99321	Rest home visit, new pt	39,908	100%	39,908
99325	Rest home visit, new pt	99322	Rest home visit, new pt	46,833	100%	46,833
99326	Rest home visit, new pt	99323	Rest home visit, new pt	40,291	33%	13,430
99327	Rest home visit, new pt	99323	Rest home visit, new pt	40,291	33%	13,430
99328	Rest home visit, new pt	99323	Rest home visit, new pt	40,291	33%	13,430
99334	Rest home visit, est pt	99331	Rest home visit, est pt	346,161	100%	346,161
99335	Rest home visit, est pt	99332	Rest home visit, est pt	571,452	100%	571,452
99336	Rest home visit, est pt	99333	Rest home visit, est pt	237,934	67%	159,416
99337	Rest home visit, est pt	99333	Rest home visit, est pt	237,934	33%	78,518

***Recommendation 5: Adopt Practice Expense recommendations that crosswalk those for the house call codes with some post-service increases.***

You will see from our Practice Expense Summary of Recommendations sheet that we recommend adopting the same basic set of clinical staff composition, and supplies recommendation. We also accept current CMS decisions for clinical staff time for pre and intra service work. It is only in the post service period that we suggest increases beyond the current level. We also recommend one piece of equipment (pulse oxymeter) not currently included in the calculations.

The list of clinical staff duties is outlined in the practice expense worksheet and the list is quite voluminous. However, while not every patient will need all clinical staff services, these are considered “typical.” With regard to post service time, where most of the work occurs, it needs to be remembered that house calls to homes including domiciliary care facilities are not like surgical encounters or office visits. It may be up to three months between visits, especially in domiciliary care facilities. Therefore the sheer volume of clinical staff activity between face-to-

face encounters cannot be under-estimated. These very sick patients typically have two or more concurrent chronic conditions and disabilities leading to multiple medication calls, multiple calls to arrange consult appointments, and multiple interactions with family members and domiciliary care staff.

### **3. The Survey Process**

#### **a. Sample Size and Diversity**

We are pleased to be able to present work survey data from 33 primary care physicians (mostly internal medicine and family practice), eight gero-psychiatrists, and 18 podiatrists for a total of 59 surveys. The surveys not only represent specialty diversity reflective of the current usage of the domiciliary care codes, but also geographic and practice style diversity. Surveys were returned from 21 states and the District of Columbia representing the East, West, North, South and Midwest. All practice settings were represented including seven rural, 27 suburban, and 25 urban. All practice styles were represented including ten solo, 31 single specialty practices, 11 multispecialty, and eight in faculty practice plans. Survey data for the primary care physicians was collected by the American Academy of Home Care Physicians; gero-psychiatrist surveys were collected by the American Association for Geriatric Psychiatry, podiatrist surveys were collected by the American Podiatric Medical Association.

#### **b. Survey and Recommendation Development Process**

We used a Panel approach to collect the work data. Each organization attempted to assure diversity in all relevant categories by recruiting participants from among those with interest, experience in the setting, and an expressed willingness to take the time to complete surveys during the compressed time allowed by the process.

The practice expense recommendations were developed by a Panel consisting of a subset of the survey participants, selected to represent diversity in geography, and primary type of practice. Again, participants were recruited in advance of the required conference calls.

Final recommendations were again developed by a Panel consisting of a subset of the work/practice expense survey participants who represented diversity in geography and primary type of practice some of whom had been participants in the previous 1997 house call code RUC process. Recommendations were then discussed with representatives of APMA, and AAGP, with final discussion with AGS and AMDA. All documents have been forwarded to ACP and AAFP. In this way, we have involved the major specialties currently involved in domiciliary care.

#### **c. Percentage of respondents who found vignette to be typical**

We had a variety of specialties filling out the surveys. It is therefore not surprising that not all who took the survey found the vignettes to be typical. However, the overall percentages (about 50%) mask important differences among groups. For example, a group of primary home care medicine providers in Michigan (13 surveys) with extensive experience in the domiciliary care setting all found the vignettes to be typical. The CPT committee asked that separate vignettes be



developed for podiatric medicine. The podiatrists also have relatively greater experience in domiciliary care. They found their vignettes to be typical of their patients.

We hope you find the submission of data complete, and in compliance with all applicable instructions. Please call Constance Row, Executive Director, American Academy of Home Care Physicians at 410-676-7966 (phone) if there are questions or concerns. I will look forward to presenting the data at the pre-facilitation meeting and the April RUC meeting with my colleagues from AGS and APMA.

Sincerely,

George Taler, MD  
Chair, Public Policy Committee  
Past President, American Academy of Home Care Physicians

Attachments:

Summary of Work Recommendation Forms (99324-99337)  
Summary of Practice Expense Recommendation Forms (99324-99337)  
Podiatric Medicine Survey

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:99324 Tracking Number: CCC1 Global Period: XXX

Specialty Society RVU: 1.01

RUC RVU: 1.01

CPT Descriptor: Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: A) a problem focused history; B) a problem focused examination; and C) straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: AAHCP: An 84-year-old male with advanced osteoarthritis, which has rendered him wheelchair bound and left him with persistent pain, controlled on his current regimen. PODIATRY: An 84-year-old male with advanced osteoarthritis, which has rendered him wheelchair bound, complains of a rash and itching involving the plantar surface of the foot.

Percentage of Survey Respondents who found Vignette to be Typical: 51%

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 pre-service period includes services provided before the service and may include preparing to see the patient, reviewing records, and communicating with other professionals.

Description of Intra-Service Work: The intra-service period includes the services provided while you are with the patient and/or family. This includes the time in which the physician obtains the history, performs an evaluation, and counsels the patient.

Description of Post-Service Work: The post-service period includes services provided after the service and may include arranging for further services, reviewing results of studies, and communicating further with the patient, family, and other professionals which includes written and telephone reports.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005			
Presenter(s):	George Taler, M.D.				
Specialty(s):	Home Care Medicine, Geriatric Psychiatry, Podiatric Medicine				
CPT Code:	99324				
Sample Size:	87	Resp n:	59	Response:	%
Sample Type:	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
Survey RVW:	0.80	1.01	1.01	1.10	2.00
Pre-Service Evaluation Time:			<del>10.0</del>	6.5	
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		

<b>Intra-Service Time:</b>		3.00	19.00	20.00	20.00	45.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>10.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99341	XXX	1.01

CPT Descriptor Home visit for the evaluation and management of a new patient, which requires these three key components: A) a problem focused history; B) a problem focused examination; and C) straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 56      % of respondents: 94.9 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 99324	Key Reference CPT Code: 99341
Median Pre-Service Time	10.00	6.00
Median Intra-Service Time	20.00	20.00
Median Immediate Post-service Time	10.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	40.00	36.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.18	2.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.32	2.27
Urgency of medical decision making	1.91	1.91

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.38	2.32
Physical effort required	2.00	2.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.19	2.21
Outcome depends on the skill and judgment of physician	2.32	2.29
Estimated risk of malpractice suit with poor outcome	2.12	2.11

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.56	1.57
Intra-Service intensity/complexity	2.19	2.11
Post-Service intensity/complexity	1.94	1.84

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The decisions were made after review of survey data by the AAHCP, AAGP, and APMA, and review and comment by AGS and AMDA. They have been sent to ACP and AAFP. See compelling evidence and work neutrality discussion in transmittal memo.



Specialty Psychiatry	Frequency 0	Percentage	%
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Do many physicians perform this service across the United States? No

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:99325 Tracking Number: CCC2 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 1.52

RUC RVU: 1.52

CPT Descriptor: Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A) an expanded problem focused history; B) an expanded problem focused examination; and C) 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.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: AAHCP: An 85-year-old woman with non-insulin dependent diabetes, peripheral neuropathy with loss of sensory perception, hypertension and heart failure; she was hospitalized 2 months ago with hypoglycemia. The patient has not kept appointments at the out-patient clinic due to dyspnea and fear of falling. Other related problems include very poor vision. PODIATRY: An 84-year-old male with advanced osteoarthritis and peripheral vascular disease, which has rendered him wheelchair bound, is followed for vascular insufficiency ulcers that have healed after treatment with custom shoes and topical wound care.

Percentage of Survey Respondents who found Vignette to be Typical: 51%

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 pre-service period includes services provided before the service and may include preparing to see the patient, reviewing records, and communicating with other professionals.

Description of Intra-Service Work: The intra-service period includes the services provided while you are with the patient and/or family. This includes the time in which the physician obtains the history, performs an evaluation, and counsels the patient.

Description of Post-Service Work: The post-service period includes services provided after the service and may include arranging for further services, reviewing results of studies, and communicating further with the patient, family, and other professionals which includes written and telephone reports.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	George Taler, M.D.				
<b>Specialty(s):</b>	Home Care Medicine, Geriatric Psychiatry and Podiatric Medicine				
<b>CPT Code:</b>	99325				
<b>Sample Size:</b>	87	<b>Resp n:</b>	59	<b>Response:</b> 67.81 %	
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	1.50	1.52	1.56	2.50
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		5.00	20.00	<b>30.00</b>	30.00	50.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u><b>12.00</b></u>					
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99342	XXX	1.52

CPT Descriptor Home visit for the evaluation and management of a new patient, which requires these three key components: A) an expanded problem focused history; B) an expanded problem focused examination; and C) medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 55      % of respondents: 93.2 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 99325</u>	<u>Key Reference CPT Code: 99342</u>
Median Pre-Service Time	10.00	10.00
Median Intra-Service Time	30.00	30.00
Median Immediate Post-service Time	12.00	12.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	52.00	52.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.02	2.96
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	2.71
Urgency of medical decision making	2.70	2.69

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.05	3.05
Physical effort required	2.45	2.44

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.89	2.85
Outcome depends on the skill and judgment of physician	2.93	2.93
Estimated risk of malpractice suit with poor outcome	2.93	2.87

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.19	2.18
Intra-Service intensity/complexity	2.81	2.77
Post-Service intensity/complexity	2.51	2.35

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The decisions were made after review of survey data by the AAHCP, AAGP, and APMA, and review and comment by AGS and AMDA. They have been sent to ACP and AAFP. See compelling evidence and work neutrality discussion in transmittal memo.

**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) 99322

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Primary Care (IM, FP, GEN)	How often? Rarely
Specialty Podiatry	How often? Sometimes
Specialty Psychiatry	How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 49175  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Primary Care (IM, FP, GEN)	Frequency 15047	Percentage 30.59 %
Specialty Podiatry	Frequency 27783	Percentage 56.49 %
Specialty Psychiatry	Frequency 688	Percentage 1.39 %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 46,833  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Primary Care (IM, FP, GEN)	Frequency 14331	Percentage 30.60 %
Specialty Podiatry	Frequency 26461	Percentage 56.50 %

Specialty Psychiatry

Frequency 655

Percentage 1.39 %

Do many physicians perform this service across the United States? No

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:99326 Tracking Number: CCC3 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: 2.27

RUC RVU: 2.27

CPT Descriptor: Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A) a detailed history; B) a detailed examination; and C) 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.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 77-year-old woman with aortic valve replacement, is maintained on Coumadin. Her past medical history includes atrial fibrillation and insulin dependent diabetes. She has had several falls recently. Anti-coagulation and diabetic management have been in good control through close monitoring by the nurse in the assisted living facility.

Pre-service work includes record review of her previous primary care and assisted living facility records, and communication with other professionals as appropriate. Detailed history includes an evaluation of antecedent symptoms to the falls, as well as adherence to diet, compliance with medications, glucose and anti-coagulation monitoring schedule, and level of family support. Detailed examination includes vital signs in various positions, assessment of cognitive status and stability of gait, and a detailed examination of the cardiac, musculoskeletal and neurologic systems. A plan of care is developed, which includes initiation of in-home physical therapy and adjustments, as appropriate, in diet, glucose monitoring, and medications. Post-service work includes telephone calls with the patient or family, plus all coordination of care, documentation, and interaction with other health professionals associated with delivery of care to this patient until the next face-to-face encounter.

Percentage of Survey Respondents who found Vignette to be Typical: 46%

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 pre-service period includes services provided before the service and may include preparing to see the patient, reviewing records, and communicating with other professionals.

Description of Intra-Service Work: The intra-service period includes the services provided while you are with the patient and/or family. This includes the time in which the physician obtains the history, performs an evaluation, and counsels the patient.

Description of Post-Service Work: The post-service period includes services provided after the service and may include arranging for further services, reviewing results of studies, and communicating further with the patient, family, and other professionals which includes written and telephone reports.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	George Taler, MD
<b>Specialty(s):</b>	Home Care Medicine and Collaborators
<b>CPT Code:</b>	99326

<b>Sample Size:</b> 69	<b>Resp n:</b> 41	<b>Response:</b> 59.42 %			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	2.27	2.27	2.29	3.40
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	8.00	30.00	45.00	45.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>17.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99343	XXX	2.27

CPT Descriptor Home visit for the evaluation and management of a new patient, which requires these three key components: A) a detailed history; B) a detailed examination; and C) 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.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 40      % of respondents: 97.5 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 99326	Key Reference CPT Code: 99343
Median Pre-Service Time	15.00	15.00
Median Intra-Service Time	45.00	50.00
Median Immediate Post-service Time	17.00	17.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	77.00	82.00
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	3.90	3.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.73
Urgency of medical decision making	3.49	3.45

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.54	3.53
Physical effort required	3.15	3.13

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.76	3.73
Outcome depends on the skill and judgment of physician	3.68	3.70
Estimated risk of malpractice suit with poor outcome	3.44	3.35

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.53	2.46
Intra-Service intensity/complexity	3.55	3.49
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 IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The decisions were made after review of survey data by the AAHCP with consultation by AAGP and APMA, then review and comment by AGS and AMDA. They have been sent to ACP and AAFP. See cover letter for compelling evidence/work neutrality information.

**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) 99323

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Primary Care (IM, FP, GEN)	How often? Sometimes
Specialty Psychiatry	How often? Rarely
Specialty Podiatry	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 14101  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Primary Care (IM, FP, GEN)	Frequency 9025	Percentage 64.00 %
Specialty Psychiatry	Frequency 479	Percentage 3.39 %
Specialty Podiatry	Frequency 1241	Percentage 8.80 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 13,430  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Primary Care (IM, FP, GEN)	Frequency 8581	Percentage 63.89 %
Specialty Psychiatry	Frequency 457	Percentage 3.40 %

Specialty Podiatry

Frequency 1181

Percentage 8.79 %

Do many physicians perform this service across the United States? No

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:99327 Tracking Number: CCC4 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: 3.03

RUC RVU: 3.03

CPT Descriptor: Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A) a comprehensive history; B) a comprehensive examination; and C) medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A family refers a 73-year-old female patient to you for evaluation and management. Despite having been moved to an assisted living facility, she has had progressive weight loss, social withdrawal and intermittent agitation over the past two months. She refuses to leave her room for visits to her physicians. Her meals are brought to her, but she eats sparingly. The patient has been followed through telephonic conversations between the nurse and the primary care physician, who has been ordering psychotropic medications to control behavior, and a cardiologist for management of her ischemic heart disease, for which she takes four medications. She has seen neither physician for over a year.

Pre-service work includes record review and communication with other professionals as appropriate. Comprehensive history includes signs and symptoms of depression and delirium, past medical history, review of systems, functional status, diet, medications, social interactions and level of family support. Examination includes a comprehensive physical, functional assessment and mental status testing. The patient is interviewed for depression and suicidal ideation. A new plan of care is developed, which includes adjustments in medications and diet, and referral to a visiting mental health counselor. Laboratory tests are drawn. Post-service work includes telephone calls with the patient or family and facility, plus all coordination of care, documentation, and interaction with other health professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

Percentage of Survey Respondents who found Vignette to be Typical: 43%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The pre-service period includes services provided before the service and may include preparing to see the patient, reviewing records, and communicating with other professionals.

Description of Intra-Service Work: The intra-service period includes the services provided while you are with the patient and/or family. This includes the time in which the physician obtains the history, performs an evaluation, and counsels the patient.

Description of Post-Service Work: The post-service period includes services provided after the service and may include arranging for further services, reviewing results of studies, and communicating further with the patient, family, and other professionals which includes written and telephone reports.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	George Taler, M.D.
<b>Specialty(s):</b>	Home Care Medicine and Collaborators

<b>CPT Code:</b> 99327					
<b>Sample Size:</b> 69	<b>Resp n:</b> 41	<b>Response:</b> 59.42 %			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	3.03	3.03	3.13	4.53
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	10.00	45.00	60.00	60.00	75.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>25.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99344	XXX	3.03

CPT Descriptor Home visit for the evaluation and management of a new patient, which requires these three key components: A) a comprehensive history; B) a comprehensive examination; and C) medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 39      % of respondents: 95.1 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 99327	Key Reference CPT Code: 99344
Median Pre-Service Time	15.00	15.00
Median Intra-Service Time	60.00	60.00
Median Immediate Post-service Time	25.00	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	100.00	100.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.51	4.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.51	4.45
Urgency of medical decision making	4.03	4.08

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.44	4.43
Physical effort required	3.69	3.63

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.28	4.30
Outcome depends on the skill and judgment of physician	4.56	4.58
Estimated risk of malpractice suit with poor outcome	4.18	4.10

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.08	3.03
Intra-Service intensity/complexity	4.26	4.28
Post-Service intensity/complexity	3.97	3.95

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The decisions were made after review of survey data by the AAHCP with consultation by AAGP and APMA, then review and comment by AGS and AMDA. They have been sent to ACP and AAFP. See cover letter for compelling evidence/work neutrality information.

**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) 99323

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Primary Care (IM, FP, GEN) How often? Sometimes

Specialty Psychiatry How often? Rarely

Specialty Podiatry How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 14101

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Primary Care (IM, FP, GEN) Frequency 9025 Percentage 64.00 %

Specialty Psychiatry Frequency 479 Percentage 3.39 %

Specialty Podiatry Frequency 1241 Percentage 8.80 %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 13,430 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Primary Care (IM,FP,GEN) Frequency 8581 Percentage 63.89 %

Specialty Psychiatry Frequency 457 Percentage 3.40 %

Specialty Podiatry

Frequency 1182

Percentage 8.80 %

Do many physicians perform this service across the United States? No

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:99328 Tracking Number: CCC5 Global Period: XXX

Specialty Society RVU: 3.78

RUC RVU: 3.78

CPT Descriptor: Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: A) a comprehensive history; B) a comprehensive examination; and C) medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An 83-year-old male with a history of schizophrenia, and progressive neurologic degeneration with dementia, emphysema from smoking, osteoporosis with vertebral fractures and kyphosis, non-insulin dependent diabetes mellitus, and osteoarthritis of the back, hips and knees. He now has a fever of 101.5, productive cough, tachypnea, and delirium. Oral intake has dropped sharply for the past two days. His family does not want him to be hospitalized, accepts that this may be a terminal event, but wants to take all available measures to help him recover at the group home. The resident counselor is willing to participate in providing intravenous therapies.

Pre-service work includes record review, and communication with other professionals as appropriate. Comprehensive history includes the present illness, review of medications, glucose monitoring records, level of functional and mental status, and an assessment of the family's intentions. Examination includes vital signs, a comprehensive examination of the pulmonary, cardiac, musculoskeletal and neurolo-psychiatric systems, and an assessment of the level of decisional capacity. Orders are initiated for IV fluids, antibiotics and oxygen with an infusion service, and daily nursing visits through a home care agency. Blood is drawn for laboratory testing and portable radiography is ordered to verify the pneumonia. Post-service work includes review of the test results, telephone calls with the patient or family, instructing the counselor, plus all coordination of care, documentation, and interaction with other health professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

Percentage of Survey Respondents who found Vignette to be Typical: 43%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The pre-service period includes services provided before the service and may include preparing to see the patient, reviewing records, and communicating with other professionals.

Description of Intra-Service Work: The intra-service period includes the services provided while you are with the patient and/or family. This includes the time in which the physician obtains the history, performs an evaluation, and counsels the patient.

Description of Post-Service Work: The post-service period includes services provided after the service and may include arranging for further services, reviewing results of studies, and communicating further with the patient, family, and other professionals which includes written and telephone reports.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	04/2005
Presenter(s):	George Taler, M.D.

<b>Specialty(s):</b>	Home Care Medicine and Collaborators				
<b>CPT Code:</b>	99328				
<b>Sample Size:</b>	69	<b>Resp n:</b>	41	<b>Response:</b> 59.42 %	
<b>Sample Type:</b>	Panel				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
<b>Survey RVW:</b>	1.00	3.78	3.78	4.00	5.17
<b>Pre-Service Evaluation Time:</b>			15.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	15.00	60.00	75.00	75.00	90.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>30.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99345	XXX	3.78

CPT Descriptor Home visit for the evaluation and management of a new patient, which requires these three key components: A) a comprehensive history; B) a comprehensive examination; and C) medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 39      % of respondents: 95.1 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 99328</b>	<b>Key Reference CPT Code: 99345</b>
Median Pre-Service Time	15.00	15.00
Median Intra-Service Time	75.00	90.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	120.00	135.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.95	4.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.95	4.90
Urgency of medical decision making	4.92	4.95

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.84	4.80
Physical effort required	4.34	4.23

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.89	4.90
Outcome depends on the skill and judgment of physician	4.89	4.88
Estimated risk of malpractice suit with poor outcome	4.49	4.46

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.64	3.60
Intra-Service intensity/complexity	4.90	4.93
Post-Service intensity/complexity	4.72	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.*

The decisions were made after review of survey data by the AAHCP with consultation by AAGP and APMA, then review and comment by AGS and AMDA. They have been sent to ACP and AAFP. See cover letter for compelling evidence/work neutrality information.

**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) 99323

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Primary Care (IM, FP, GEN) How often? Sometimes

Specialty Psychiatry How often? Rarely

Specialty Podiatry How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 14101

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Primary Care (IM,FP, GEN) Frequency 9025 Percentage 64.00 %

Specialty Psychiatry Frequency 479 Percentage 3.39 %

Specialty Podiatry Frequency 1242 Percentage 8.80 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 13,430 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Primary Care (IM, FP, GEN) Frequency 8581 Percentage 63.89 %

Specialty Psychiatry Frequency 457 Percentage 3.40 %

Specialty Podiatry

Frequency 1182

Percentage 8.80 %

CPT Code:99328

Do many physicians perform this service across the United States? No

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:99334 Tracking Number: CCC6 Global Period: XXX

**Recommended Work Relative Value**Specialty Society RVU: **0.76****RUC RVU: 0.76**

CPT Descriptor: Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A) a problem focused interval history; B) a problem focused examination; C) 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.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 74-year-old man with hypertension and peripheral vascular disease, has lived in a board and care home for two years following a stroke, resulting in right-sided hemiparesis. Patient is seen routinely for hypertension monitoring, medication refills and preventive care.

Pre-service work includes record review, and communicating with other professionals, as appropriate. Interval history includes stability of neurologic deficits, medication compliance with assessment for side-effects or toxicity and adherence to diet; a review of systems includes a history of falls, incontinence, constipation and cognitive status. Examination includes vital signs and a focused evaluation of the cardiovascular or neurologic systems. Medications are refilled, as appropriate. Post-service work includes telephone calls with patient or family, plus all coordination of care, documentation, and interaction with other health professionals associated with delivery of care to this patient until the next face-to-face encounter.

Percentage of Survey Respondents who found Vignette to be Typical: 48%

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 pre-service period includes services provided before the service and may include preparing to see the patient, reviewing records, and communicating with other professionals.

Description of Intra-Service Work: The intra-service period includes the services provided while you are with the patient and/or family. This includes the time in which the physician obtains the history, performs an evaluation, and counsels the patient.

Description of Post-Service Work: The post-service period includes services provided after the service and may include arranging for further services, reviewing results of studies, and communicating further with the patient, family, and other professionals which includes written and telephone reports.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	George Taler, M.D.		
<b>Specialty(s):</b>	Home Care Medicine and Collaborators		
<b>CPT Code:</b>	99334		
<b>Sample Size:</b>	69	<b>Resp n:</b>	41
		<b>Response:</b>	59.42 %
<b>Sample Type:</b>	Panel		

	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
<b>Survey RVW:</b>	0.50	0.76	0.76	0.80	1.25
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	5.00	15.00	15.00	15.00	30.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>10.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99347	XXX	0.76

CPT Descriptor Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A) a problem focused interval history; B) a problem focused examination; C) 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 15 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 39      % of respondents: 95.1 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 99334	Key Reference CPT Code: 99347
Median Pre-Service Time	5.00	5.00
Median Intra-Service Time	15.00	15.00
Median Immediate Post-service Time	10.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	30.00	30.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.15	2.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.21	2.15
Urgency of medical decision making	1.72	1.74

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.46	2.43
Physical effort required	1.85	1.88

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.38	2.31
Outcome depends on the skill and judgment of physician	2.41	2.38
Estimated risk of malpractice suit with poor outcome	2.26	2.15

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.71	1.68
Intra-Service intensity/complexity	2.45	2.35
Post-Service intensity/complexity	2.05	2.03

**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 decisions were made after review of survey data by the AAHCP with consultation by AAGP and APMA, then review and comment by AGS and AMDA. They have been sent to ACP and AAFP. See cover letter for compelling evidence/work neutrality information.



Specialty Podiatry

Frequency 103848

Percentage 29.99 %

Do many physicians perform this service across the United States? No

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:99335 Tracking Number: CCC7 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 1.26

RUC RVU: 1.26

CPT Descriptor: Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A) an expanded problem focused interval history; B) an expanded problem focused examination; C) medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 78-year-old man with Alzheimer's Disease had been agitated due to hallucinations and difficult to control for two weeks. Psychotropic medications were initiated with partial resolution of the agitation. The aides at the assisted living facility assure his safety, but are worried that he might fall.

Pre-service work includes record review, and communication with other professionals, as appropriate. History includes a review of changes in behavior during the interval since the medications were begun and of any new neurologic symptoms. Expanded interval exam includes an assessment for change in behavior and neurologic assessment for medication side-effects. Behavioral modifications are suggested for the staff; medications are adjusted, as indicated. Post-service work includes follow-up of the laboratory tests, telephone calls with the family, facility staff plus all coordination of care, documentation, and interaction with other health professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

Percentage of Survey Respondents who found Vignette to be Typical: 53%

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 pre-service period includes services provided before the service and may include preparing to see the patient, reviewing records, and communicating with other professionals.

Description of Intra-Service Work: The intra-service period includes the services provided while you are with the patient and/or family. This includes the time in which the physician obtains the history, performs an evaluation, and counsels the patient.

Description of Post-Service Work: The post-service period includes services provided after the service and may include arranging for further services, reviewing results of studies, and communicating further with the patient, family, and other professionals which includes written and telephone reports.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	George Taler, M.D.		
<b>Specialty(s):</b>	Home Care Medicine and Collaborators		
<b>CPT Code:</b>	99335		
<b>Sample Size:</b>	69	<b>Resp n:</b>	41
		<b>Response:</b>	59.42 %
<b>Sample Type:</b>	Panel		

	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.75	1.26	1.26	1.26	2.40
<b>Pre-Service Evaluation Time:</b>			<del>10.0</del> <b>0</b>		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	8.00	20.00	25.00	25.00	40.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b><u>10.00</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99348	XXX	1.26

CPT Descriptor Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A) an expanded problem focused interval history; B) an expanded problem focused examination; C) medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 39      % of respondents: 95.1 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 99335	Key Reference CPT Code: 99348
Median Pre-Service Time	10.00	9.00
Median Intra-Service Time	25.00	30.00
Median Immediate Post-service Time	10.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	45.00	49.00
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	3.13	3.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.05	3.00
Urgency of medical decision making	2.72	2.65

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.15	3.13
Physical effort required	2.64	2.63

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.97	3.00
Outcome depends on the skill and judgment of physician	3.18	3.23
Estimated risk of malpractice suit with poor outcome	2.85	2.73

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.53	2.48
Intra-Service intensity/complexity	3.18	3.18
Post-Service intensity/complexity	2.95	2.95

**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 decisions were made after review of survey data by the AAHCP with consultation by AAGP and APMA, then review and comment by AGS and AMDA. They have been sent to ACP and AAFP. See cover letter for compelling evidence/work neutrality information.



Specialty Podiatry

Frequency 75432

Percentage 13.20 %

Do many physicians perform this service across the United States? No

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:99336 Tracking Number: CCC8 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 2.02

RUC RVU: 2.02

CPT Descriptor: Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A) a detailed interval history; B) a detailed examination; C) 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.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 78-year-old male patient with insulin dependent diabetes mellitus and chronic obstructive pulmonary disease, requiring continuous home oxygen complains of worsening symptoms of peripheral vascular disease. He is becoming progressively more dependent for assistance with transfers and bathing. He complains of increasing left leg pain at night due to nocturnal ischemic claudication.

Pre-service work includes record review, and communicating with other professionals, as appropriate. History at the assisted living facility includes a detailed assessment of changes in pain, functional status and skin integrity; recent changes in caregiver support needs, and review of glucose monitoring and nutritional intake. Detailed examination includes the cardiovascular system and inspection of the skin with Doppler assisted ankle-brachial index assessment; focused examination includes the patient's pulmonary status and bedside pulse oximetry. Blood is drawn to evaluate diabetic control. Post-service work includes follow-up of test results, telephone calls with the patient or family, plus all coordination of care, documentation, and interaction with other health professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

Percentage of Survey Respondents who found Vignette to be Typical: 48%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The pre-service period includes services provided before the service and may include preparing to see the patient, reviewing records, and communicating with other professionals.

Description of Intra-Service Work: The intra-service period includes the services provided while you are with the patient and/or family. This includes the time in which the physician obtains the history, performs an evaluation, and counsels the patient.

Description of Post-Service Work: The post-service period includes services provided after the service and may include arranging for further services, reviewing results of studies, and communicating further with the patient, family, and other professionals which includes written and telephone reports.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005
<b>Presenter(s):</b>	George Taler, M.D.
<b>Specialty(s):</b>	Home Care Medicine and Collaborators
<b>CPT Code:</b>	99336

<b>Sample Size:</b> 69	<b>Resp n:</b> 41	<b>Response:</b> 59.42 %			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	2.02	2.02	2.20	3.02
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	10.00	30.00	40.00	40.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>15.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99349	XXX	2.02

CPT Descriptor Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A) a detailed interval history; B) a detailed examination; C) 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 moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 39      % of respondents: 95.1 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 99336	Key Reference CPT Code: 99349
Median Pre-Service Time	10.00	10.00
Median Intra-Service Time	40.00	40.00
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	65.00	65.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.15	4.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.74	3.80
Urgency of medical decision making	3.67	3.65

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.97	3.98
Physical effort required	3.31	3.31

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.95	3.93
Outcome depends on the skill and judgment of physician	4.00	4.03
Estimated risk of malpractice suit with poor outcome	3.69	3.58

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.05	3.07
Intra-Service intensity/complexity	4.11	4.05
Post-Service intensity/complexity	3.71	3.66

**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 decisions were made after review of survey data by the AAHCP with consultation by AAGP and APMA, then review and comment by AGS and AMDA. They have been sent to ACP and AAFP. See cover letter for compelling evidence/work neutrality information.

**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) 99333

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Primary Care (IM, FP, GEN) How often? Sometimes

Specialty Psychiatry How often? Rarely

Specialty Podiatry How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 167387

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Primary Care (IM, FP, GEN) Frequency 115664 Percentage 69.09 %

Specialty Psychiatry Frequency 8704 Percentage 5.19 %

Specialty Podiatry Frequency 5021 Percentage 2.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
159,416 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Primary Care (IM, FP, GEN) Frequency 110156 Percentage 69.09 %

Specialty Psychiatry Frequency 8290 Percentage 5.20 %

Specialty Podiatry

Frequency 4782

Percentage 2.99 %

Do many physicians perform this service across the United States? No

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:99337 Tracking Number: CCC9 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 3.03

RUC RVU: 3.03

CPT Descriptor: Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A) a comprehensive interval history; B) a comprehensive examination; and C) medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An 89-year-old female with a history of multi-infarct dementia due to hypertension and insulin dependent diabetes mellitus; chronic renal insufficiency has worsened with difficult to control hypertension and progressively more fatigue, but the nephrologist is reluctant to offer dialysis. Approximately 1 year ago, she became wheelchair bound and non-verbal; for 4 months, she has been unable to feed herself. Last month, she began to "pocket" her medications and solid foods in her cheek, and was found to spit them out later. She has lost weight over the past 3 months, associated with several episodes of hypoglycemia and she recently developed a stage 3 pressure ulcer at her coccyx. Her family has been undecided as to resuscitation status.

Pre-service work includes record review, and communication with other professionals as appropriate. Comprehensive history includes a review of the interval changes in functional status, medications, glucose, BP and weight monitoring, cognitive and affective status, and an assessment of patient behavior. Comprehensive examination includes the cardiac, pulmonary, gastrointestinal, genitourinary, and neuro-psychiatric systems; she is also evaluated for anasarca and nutritional status. Decision making includes a review of the medication regimen in light of the progressive renal failure, instructing staff regarding monitoring parameters and updating the family, emphasizing end-of-life care counseling. Post-service work includes telephone calls with the family and facility staff, coordination of all care, documentation, and interaction with other health professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

Percentage of Survey Respondents who found Vignette to be Typical: 48%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 5%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The pre-service period includes services provided before the service and may include preparing to see the patient, reviewing records, and communicating with other professionals.

Description of Intra-Service Work: The intra-service period includes the services provided while you are with the patient and/or family. This includes the time in which the physician obtains the history, performs an evaluation, and counsels the patient.

Description of Post-Service Work: The post-service period includes services provided after the service and may include arranging for further services, reviewing results of studies, and communicating further with the patient, family, and other professionals which includes written and telephone reports.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>	George Taler, M.D.					
<b>Specialty(s):</b>	Home Care Medicine and Collaborators					
<b>CPT Code:</b>	99337					
<b>Sample Size:</b>	69	<b>Resp n:</b>	41	<b>Response:</b> 59.42 %		
<b>Sample Type:</b>	Panel					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		1.00	3.03	3.03	3.20	4.53
<b>Pre-Service Evaluation Time:</b>				15.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		15.00	40.00	60.00	60.00	70.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>20.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99350	XXX	3.03

CPT Descriptor Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A) a comprehensive interval history; B) a comprehensive examination; C) medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 39      % of respondents: 95.1 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 99337</u>	<u>Key Reference CPT Code: 99350</u>
Median Pre-Service Time	15.00	15.00
Median Intra-Service Time	60.00	72.00
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
<b>Median Total Time</b>	<b>95.00</b>	<b>107.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.82	4.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.64	4.64
Urgency of medical decision making	4.64	4.63

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.77	4.70
Physical effort required	3.92	3.83

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.77	4.78
Outcome depends on the skill and judgment of physician	4.79	4.75
Estimated risk of malpractice suit with poor outcome	4.28	4.30

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.95	3.88
Intra-Service intensity/complexity	4.79	4.78
Post-Service intensity/complexity	4.74	4.66

**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 decisions were made after review of survey data by the AAHCP with consultation by AAGP and APMA, then review and comment by AGS and AMDA. They have been sent to ACP and AAFP. See cover letter for compelling evidence/work neutrality information.

**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) 99333

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Primary Care (IM, FP, GEN) How often? Sometimes

Specialty Psychiatry How often? Rarely

Specialty Podiatry How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 167387

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Primary Care (IM, FP, GEN) Frequency 115664 Percentage 69.09 %

Specialty Psychiatry Frequency 8704 Percentage 5.19 %

Specialty Podiatry Frequency 5021 Percentage 2.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 78,518 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Primary Care (IM, FP, GEN) Frequency 54256 Percentage 69.10 %

Specialty Psychiatry Frequency 4083 Percentage 5.20 %

Specialty Podiatry

Frequency 2355

Percentage 2.99 %

Do many physicians perform this service across the United States? No

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: see descriptions on forms for each of 99324-99337

Sample Size: 87 \_\_\_\_\_ Response Rate: (%) : 67.8 \_\_\_\_\_ Global Period: \_\_\_\_\_

Geographic Practice Setting %: Rural \_12\_\_ Suburban \_45\_\_ Urban \_42\_\_

Type of Practice %:    \_17\_\_ Solo Practice  
                          \_52\_\_ Single Specialty Group  
                          \_18\_\_ Multispecialty Group  
                          \_13\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Practice Expense recommendations were developed by a Panel consisting of a subset of the survey participants, selected to represent diversity in geography, and primary type of practice. Participants were recruited in advance of the required conference calls.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review medical history (new patient) or previous note, lab and other reports (established patient)

For requested visits, field calls from family or facility

For scheduled monitoring visits, call family or facility to prescreen issues needing to be addressed

Assure necessary equipment and supplies are available during visit

Assure adequate time is available to meet the anticipated needs in time allocated

Intra-Service Clinical Labor Activities: None

Post-Service Clinical Labor Activities:

Conduct phone calls and call in prescriptions or refills

Review encounter sheet and notes for ordering facility-delivered medications, monitoring equipment, tests and imaging studies

Complete referrals to specialty for consultation or monitoring

Order equipment, supplies, infusions, oxygen, screens, etc.

Prepare Certificates of Medical Necessity for durable medical equipment and oxygen, Medicaid forms for non-durable supplies

Prescreens calls from family and facility until next face to face physician visit.

Calls Home Care Agency and prepares Form 485

New Domiciliary Care Codes		99324		99325		99326		99327		99328		99334		99335		99336		99337	
		99341		99342		99343		99344		99345		99347		99348		99349		99350	
		Home visit, new patient, level 1		Home visit, new patient, level 2		Home visit, new patient, level 3		Home visit, new patient, level 4		Home visit, new patient, level 5		Home visit, established patient, level 1		Home visit, established patient, level 2		Home visit, established patient, level 3		Home visit, established patient, level 4	
Crosswalked to these home visit codes		CMS CODE																	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office								
GLOBAL PERIOD		XXX		XXX		XXX		XXX											
TOTAL CLINICAL LABOR TIME	RN/LPN/MTA	12.0		12.0		12.0		12.0		12.0		12.0		12.0		12.0		12.0	
TOTAL PRE-SERV CLINICAL LABOR TIME		6.0		6.0		6.0		6.0		6.0		6.0		6.0		6.0		6.0	
TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0	
TOTAL POST-SERV CLINICAL LABOR TIME		6.0		6.0		6.0		6.0		6.0		6.0		6.0		6.0		6.0	
<b>PRE-SERVICE</b>																			
Start: Following visit when decision for surgery or procedure made																			
Complete pre-service diagnostic & referral forms																			
Coordinate pre-surgery services																			
Schedule space and equipment in facility																			
Office visit before surgery/procedure. Review test and exam results																			
Provide pre-service education/obtain consent																			
Follow-up phone calls & prescriptions		6		6		6		6		6		6		6		6		6	
Other Clinical Activity (please specify)																			
End:When patient enters office/facility for surgery/procedure																			
<b>SERVICE PERIOD</b>																			
No staff time in the service period																			
<b>POST-SERVICE PERIOD</b>																			
Start: Patient leaves office/facility																			
End: with last office visit before end of global period																			
Phone calls		6		6		6		6		6		6		6		6		6	
<b>MEDICAL SUPPLIES</b>																			
non-sterile gloves		1 pair		1 pair		1 pair		1 pair											
disposable otoscope speculum		1		1		1		1		1		1		1		1		1	
patient education booklet		1		1		1		1		1		1		1		1		1	
alcohol swab		2		2		2		2		2		2		2		2		2	
disposable thermometer probe cover		1		1		1		1		1		1		1		1		1	
tongue depressor		1		1		1		1		1		1		1		1		1	
<b>Equipment</b>																			
none																			

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Care Plan Oversight**

The limitation of the existing care plan oversight codes for children and adults with special health care needs is not in the definition of the service, but in the restriction on setting – patients must be under the care of a home health agency, in hospice or in a nursing facility. While a significant number of children and adults with special health care needs and chronic medical conditions for the care model and the care plan oversight service code requirements that the patient be under the care of a multidisciplinary care modality, many patients are not under the care of a home health agency, in a hospice or in a nursing facility. Thus the limitation of the care plan oversight codes is not in the definition of the typical activities and services provided, but in the restriction on setting and circumstance. Therefore, the CPT Editorial Panel created two new codes to address this limitation of the existing care plan oversight codes.

**99339**

The RUC reviewed the survey results of 64 pediatricians, geriatricians and home care physicians in regard to the valuation of 99339 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes* and determined that the reference code 99374 *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes* (Work RVU=1.10) was reasonable. When comparing the surveyed code to the reference code, it was determined that the surveyed code has more total time than the reference code, 40 and 34 minutes respectively. Furthermore, the RUC recognized that the surveyed code required more mental effort, and judgement and higher technical skill than the reference code. Therefore, due to increased times and greater intensity and complexity measures, the RUC recommends the median survey value of 1.25 work RVUs for 99339. The

RUC agreed with the specialty societies' recommendation and felt that this value appropriately places this service relative to other procedures. In addition, the specialty societies recommended and the RUC agreed that it is reasonable to expect that the proposed work values should be more than the existing care plan oversight codes because of an absence of a home health agency to provide organizational support for the physician. **The RUC recommends 1.25 work RVUs for 99339.**

### **99340**

The RUC reviewed the survey results of 61 pediatricians, geriatricians and home care physicians in regard to the valuation of 99340 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more* and determined that the reference code 99375 *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more* (Work RVU=1.73) was reasonable. When comparing the surveyed code to the reference code, it was determined that the surveyed code has more total time than the reference code, 60 and 57 minutes respectively. Furthermore, the RUC recognized that the surveyed code required more mental effort, and judgement and higher technical skill than the reference code. Therefore, due to increased times and greater intensity and complexity measures, the specialty societies recommends the median survey value of 1.80 work RVUs for 99340. The RUC agreed with the specialty societies' recommendation and felt that this value appropriately places this service relative to other procedures. In addition, the specialty societies recommended and the RUC agreed that it is reasonable to expect that the proposed work values should be more than the existing care plan oversight codes because of an absence of a home health agency to provide organizational support for the physician. **The RUC recommends 1.80 work RVUs for 99340.**

### **Practice Expense**

The specialty society recommended that the practice expense inputs for the new codes, 99339 and 99340, be crosswalked to the existing care plan oversight codes 99374 and 99375. The RUC agreed with this crosswalk. The practice expense recommendations are attached to this report.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommen- dation
For instructions on the use of codes 99339, 99340, see introductory notes for codes 99374-99380				
For care plan oversight services for patients under the care of a home health agency, hospice or nursing facility, see codes 99374-99380				
•99339	DDD1	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	XXX	1.25
•99340	DDD2	30 minutes or more  (Do not report 99339, 99340 for patients under the care of a home health agency, enrolled in a hospice program, or for nursing facility residents)	XXX	1.80

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

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**Recommended Work Relative Value**

CPT Code:99339 Tracking Number: DDD1 Global Period: XXX

Specialty Society RVU: 1.25

**RUC RVU: 1.25**

CPT Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: PEDIATRIC VIGNETTE: A 21-year old with Down Syndrome who is transitioning from home care and public special education to a sheltered work program operated by the community service agency. He is moderately mentally retarded and ongoing medical problems include hypothyroidism and sensorineural hearing loss. Over the past two months his behavior has become progressively disruptive. His previously developed care plan includes the active medical and educational/vocational problems with ongoing adjustments being made based on feedback from the family and other health care professionals and service providers. The primary care physician (internal medicine, family physician, pediatrician) delivers primary care services and manages and coordinates care plan activities. Typical ongoing care plan oversight activities include:

- Review of reports including a new audiology assessment and endocrine consultation report
- Telephone call to the audiologist about results of the most recent hearing assessment and recommendations to provide hearing amplification to the patient
- Completion of medical forms for the vocational program listing medical problems, general cognitive and physical abilities, and recommendations for behavior management
- Discussion by phone with the family of recent appetite and weight gain noted by the family after beginning a new behavior medication, and subsequent call to the psychiatric nurse practitioner at the mental health center who recommends a dose change and a dietary consultation
- Review of endocrine recommendations to increase the thyroid dosage, with ensuing phone call to family and the pharmacy to prescribe a different dose form of Synthroid

The physician documents the relevant information in the record that summarizes the above activities. GERIATRIC VIGNETTE: The patient is an 84-year old female who lives with her daughter. She has advanced Alzheimer's Disease and is dependent in all IADL and most ADL. She has begun to become increasingly agitated. She could not cooperate sufficiently to be brought to the office for evaluation so a home visit was made (reported separately).

Over the next month the doctor will need to review the care of the patient assessing progress and the effects of the interventions. This requires contact with the caregiver to review impacts and to support the caregiver to avoid hospitalization and the likely cycle of delirium and nursing home placement that would result. Between 15 and 29 minutes are spent and documented in these activities.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review of subsequent reports of patient status; review of related laboratory and other studies

Description of Intra-Service Work: Communication for purposes of assessment or care decisions with health care professional(s), family member(s), and or key caregivers(s); development/revision of care plan

Description of Post-Service Work: Integration of new information into the patient chart

### SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2005				
Presenter(s):	Steve Krug, MD, and Meghan Gerety, MD					
Specialty(s):	American Academy of Pediatrics; American Geriatric Society; American Academy of Home Care Physicians					
CPT Code:	99339					
Sample Size:	106	Resp n:	64	Response: 60.37 %		
Sample Type:	Convenience					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:		0.90	1.10	1.25	1.60	2.50
Pre-Service Evaluation Time:				10.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		0.00	12.25	20.00	25.00	60.00
Post-Service	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>10.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u> 99374	<u>Global</u> XXX	<u>Work RVU</u> 1.10
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CPT Descriptor Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u> 99377	<u>Global</u> XXX	<u>Work RVU</u> 1.10
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CPT Descriptor Physician supervision of hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 58      % of respondents: 90.6 %**

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 99339</u>	<u>Key Reference CPT Code: 99374</u>
Median Pre-Service Time	10.00	5.00
Median Intra-Service Time	20.00	20.00
Median Immediate Post-service Time	10.00	9.00
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	34.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.74	3.63
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.74
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Urgency of medical decision making	3.33	3.21
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.56	3.44
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Physical effort required	2.47	2.40
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.53	3.49
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Outcome depends on the skill and judgment of physician	4.09	3.88
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Estimated risk of malpractice suit with poor outcome	3.14	3.09
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.74	2.65
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Intra-Service intensity/complexity	3.60	3.42
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Post-Service intensity/complexity	3.19	2.95
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**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 to Medicare patients** nationally in a one-year period?  
80,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Pediatrics	Frequency 50	Percentage 0.06 %
Specialty Geriatrics	Frequency 79000	Percentage 98.75 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:99340 Tracking Number: DDD2 Global Period: XXX

Specialty Society RVU: **1.80****RUC RVU: 1.80**

CPT Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: **PEDIATRIC VIGNETTE:** A 21-year old with Down Syndrome who is transitioning from home care and public special education to a sheltered work program operated by the community service agency. He is moderately mentally retarded and ongoing medical problems include hypothyroidism and sensorineural hearing loss. Over the past two months his behavior has become progressively disruptive. His previously developed care plan includes the active medical and educational/vocational problems with ongoing adjustments being made based on feedback from the family and other health care professionals and service providers. The primary care physician (internal medicine, family physician, pediatrician) delivers primary care services and manages and coordinates care plan activities. Typical ongoing care plan oversight activities include:

- Review of reports including a new audiology assessment and endocrine consultation report
- Telephone call to the audiologist about results of the most recent hearing assessment and recommendations to provide hearing amplification to the patient
- Completion of medical forms for the vocational program listing medical problems, general cognitive and physical abilities, and recommendations for behavior management
- Discussion by phone with the family of recent appetite and weight gain noted by the family after beginning a new behavior medication, and subsequent call to the psychiatric nurse practitioner at the mental health center who recommends a dose change and a dietary consultation
- Review of endocrine recommendations to increase the thyroid dosage, with ensuing phone call to family and the pharmacy to prescribe a different dose form of Synthroid

The physician documents the relevant information in the record that summarizes the above activities. **GERIATRIC VIGNETTE:** The patient is an 84-year old female who lives with her daughter. She has advanced Alzheimer's Disease and is dependent in all IADL and most ADL. She has begun to become increasingly agitated. She could not cooperate sufficiently to be brought to the office for evaluation so a home visit was made (reported separately).

Over the next month the doctor will need to review the care of the patient assessing progress and the effects of the interventions. This requires contact with the caregiver to review impacts and to support the caregiver to avoid hospitalization and the likely cycle of delirium and nursing home placement that would result. Thirty minutes or more are spent and documented in these activities.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review of subsequent reports of patient status; review of related laboratory and other studies

Description of Intra-Service Work: Communication for purposes of assessment or care decisions with health care professional(s), family member(s), and or key caregivers(s); development/revision of care plan

Description of Post-Service Work: Integration of new information into the patient chart

### SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2005				
Presenter(s):	Steve Krug, MD, and Meghan Gerety, MD					
Specialty(s):	American Academy of Pediatrics; American Geriatric Society; American Academy of Home Care Physicians					
CPT Code:	99340					
Sample Size:	106	Resp n:	61	Response: 57.54 %		
Sample Type:	Convenience					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:		1.30	1.73	1.80	2.00	3.00
Pre-Service Evaluation Time:				15.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		0.00	17.50	30.00	40.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
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>
99375	XXX	1.73

CPT Descriptor Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer’s facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in the patient’s care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC’s MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99378	XXX	1.73

CPT Descriptor Physician supervision of hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in the patient’s care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 57      % of respondents: 93.4 %

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 99340	Key Reference CPT Code: 99375
Median Pre-Service Time	15.00	10.00
Median Intra-Service Time	30.00	32.00
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
<b>Median Total Time</b>	<b>60.00</b>	<b>57.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.08	3.90
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.36	4.08
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Urgency of medical decision making	3.46	3.38
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.59	3.59
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Physical effort required	2.64	2.56
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.77	3.74
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Outcome depends on the skill and judgment of physician	4.26	4.08
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Estimated risk of malpractice suit with poor outcome	3.23	3.15
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.95	2.82
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Intra-Service intensity/complexity	3.95	3.77
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Post-Service intensity/complexity	3.41	3.10
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**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 to Medicare patients** nationally in a one-year period?  
80,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Pediatrics                      Frequency 50                      Percentage 0.06 %

Specialty Geriatrics                      Frequency 79000                      Percentage 98.75 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

**CPT Long Descriptor:** Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

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:

**After discussion and analysis by an expert panel consisting of representatives from AAP, AGS, and AAHCP, the PEAC-approved direct practice expense inputs for codes 99374 and 99375 were crosswalked to the new codes, 99339 and 99340, respectively.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **Selecting appropriate patient chart; telephone calls to patient/family, other health care professionals, pharmacy, and/or preauthorization calls to payors; completing forms not otherwise completed by the physician**

Intra-Service Clinical Labor Activities: **N/A**

Post-Service Clinical Labor Activities: **Selecting appropriate patient chart; telephone calls to patient/family, other health care professionals, pharmacy, and/or payors; completing forms not otherwise completed by the physician**

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

**CPT Long Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**

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:

**After discussion and analysis by an expert panel consisting of representatives from AAP, AGS, and AAHCP, the PEAC-approved direct practice expense inputs for codes 99374 and 99375 were crosswalked to the new codes, 99339 and 99340, respectively.**

Please describe the clinical activities of your staff:

**Pre-Service Clinical Labor Activities: Selecting appropriate patient chart; telephone calls to patient/family, other health care professionals, pharmacy, and/or preauthorization calls to payors; completing forms not otherwise completed by the physician**

**Intra-Service Clinical Labor Activities: N/A**

**Post-Service Clinical Labor Activities: Selecting appropriate patient chart; telephone calls to patient/family, other health care professionals, pharmacy, and/or payors; completing forms not otherwise completed by the physician**

	A	B	C	D	E	F	G	H	I
1									
2	Meeting Date: April 2005 RUC			<b>Crosswalk Reference Code: 99374</b> <b>Code Descriptor: Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes</b>		<b>CPT Code: 99339</b> <b>Code Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes</b>		<b>Crosswalk Reference Code: 99375</b> <b>Code Descriptor: Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more</b>	
3									
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>								
6	<b>TOTAL CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	30.0	0.0	30.0	0.0	36.0	0.0
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			15.0	0.0	15.0	0.0	18.0	0.0
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			15.0	0.0	15.0	0.0	18.0	0.0
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			0.0	0.0	0.0	0.0	0.0	0.0
10	<b>PRE-SERVICE</b>								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions	L037D				9	0		
17	Other Clinical Activity (please specify): <b>Completing forms not otherwise completed by the physician</b>	L037D				6	0		
18	End: When patient enters office/facility for surgery/procedure								
19	<b>SERVICE PERIOD</b>								
20	Start: When patient enters office/facility for surgery/procedure								
21	<b>Pre-service services</b>								
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	Set up/apply anesthesia								
30	Intra-service								
31	Assist physician in performing procedure								

	A	B	C	D	E	F	G	H	I
2				<b>Crosswalk Reference Code: 99374</b>		<b>CPT Code: 99339</b>		<b>Crosswalk Reference Code: 99375</b>	
	Meeting Date: April 2005 RUC			Code Descriptor: Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes		Code Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes		Code Descriptor: Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	
3									
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
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): <b>Completing forms not otherwise completed by the physician; follow-up phone calls and prescriptions</b>	L037D				15	0		
42	End: Patient leaves office								
43	<del>POST-SERVICE Period</del>								
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	AMA Specialty Society								
55	Return of visit time			0	0	0	0	0	0
56	Other Activity (please specify)								

	A	B	C	D	E	F	G	H	I
2				<b>Crosswalk Reference Code: 99374</b>		<b>CPT Code: 99339</b>		<b>Crosswalk Reference Code: 99375</b>	
	Meeting Date: April 2005 RUC			<b>Code Descriptor: Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes</b>		<b>Code Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes</b>		<b>Code Descriptor: Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more</b>	
3									
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
57	End: with last office visit before end of global period								
58	<b>MEDICAL SUPPLIES</b>	<b>CMS Code</b>	<b>Unit</b>						
59	N/A								
60	<b>Equipment</b>	<b>CMS Code</b>	<b>Unit</b>						
61	N/A								
62									
63									
64									
65									
66									
67									
68									
69									

	A	B	C	J	K
1					
2				<b>CPT Code: 99340</b>	
3	Meeting Date: April 2005 RUC			<b>Code Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more</b>	
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>				
6	<b>TOTAL CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	36.0	0.0
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			18.0	0.0
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			18.0	0.0
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			0.0	0.0
10	<b>PRE-SERVICE</b>				
11	Start: Following visit when decision for surgery or procedure made				
12	Complete pre-service diagnostic & referral forms				
13	Coordinate pre-surgery services				
14	Schedule space and equipment in facility				
15	Provide pre-service education/obtain consent				
16	Follow-up phone calls & prescriptions	L037D		12	0
17	Other Clinical Activity (please specify) <b>Completing forms not otherwise completed by the physician</b>	L037D		6	0
18	End: When patient enters office/facility for surgery/procedure				
19	<b>SERVICE PERIOD</b>				
20	Start: When patient enters office/facility for surgery/procedure				
21	<b>Pre-service services</b>				
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				

	A	B	C	J	K
2				<b>CPT Code: 99340</b>	
	Meeting Date: April 2005 RUC			<b>Code Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more</b>	
3					
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>
32	<b>Post-Service</b>				
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) <b>Completing forms not otherwise completed by the physician; follow-up phone calls and prescriptions</b>	L037D		18	0
42	<b>End: Patient leaves office</b>				
43	<b>POST-SERVICE PERIOD</b>				
44	<b>Start: Patient leaves office/facility</b>				
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	AMA Specialty Society				
55	Retention of Records			0	0
56	Other Activity (please specify)				

	A	B	C	J	K
2				<b>CPT Code: 99340</b>	
	Meeting Date: April 2005 RUC			<p><b>Code Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more</b></p>	
3					
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>
57	End: with last office visit before end of global period				
58	<b>MEDICAL SUPPLIES</b>	<b>CMS Code</b>	<b>Unit</b>		
59	N/A				
60	<b>EQUIPMENT</b>	<b>CMS Code</b>	<b>Unit</b>		
61	N/A				
62					
63					
64					
65					
66					
67					
68					
69					

# HCPAC Recommendations

For CPT 2006

*RUC Meetings:  
September 2004, February 2005  
and April 2005*

# American Medical Association

Physicians dedicated to the health of America



AMA/Specialty Society RVS    515 North State Street    312 464-4736  
Update Process                    Chicago, Illinois 60610    312 464-5849 Fax

May 26, 2005

Stephen M. Phillips  
Director, Division of Practitioner Services  
Hospital and Ambulatory Policy Group  
Center for Medicare Management, C4-03-06  
7500 Security Blvd.  
Baltimore, MD 21244

Dear Mr. Phillips:

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 2006.

These work relative value and direct practice expense input recommendations address new codes for:

- Auditory Rehabilitation Assessment
- Psychological Testing Exam
- Neurobehavioral Status Exam

In addition, the Practice Expense Review Committee (PERC) 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.

If you have any questions please contact AMA staff, Susan Dombrowski, at (312) 464-4308.

Sincerely,

Handwritten signature of Richard W. Whitten in black ink.

Richard W. Whitten, MD

Handwritten signature of Mary Foto, OTR in black ink.

Mary Foto, OTR

cc: Ken Simon, MD  
Edith L. Hambrick, MD  
Carolyn Mullen  
Pam West, PT  
Rick Ensor  
Susan Dombrowski

# CPT 2006 RUC HCPAC Review Board Recommendations

CPT Code	Global	Coding Period	CPT Change	CPT Date	Issue Tab	Tracking Number	RUC Date	RUC S.S. Tab	Specialty	RUC Rec	Same Rec as last year?	RUV	MFS	Comments
92506	XXX	R	Feb05	85	Auditory Rehabilitation Assessment	WW1	HCPAC	J	ASHA	0.86	<b>0.86</b>	Yes	Yes	
92507	XXX	R	Feb05	87	Auditory Rehabilitation Assessment	WW2	HCPAC	J	ASHA	0.52	<b>0.52</b>	Yes	Yes	
92508	XXX	R	Feb05	87	Auditory Rehabilitation Assessment	WW3	HCPAC	J	ASHA	0.26	<b>0.26</b>	Yes	Yes	
92510	XXX	D	Feb05	87	Auditory Rehabilitation Assessment		HCPAC						Yes	
92626	XXX	N	Feb05	85	Auditory Rehabilitation Assessment	WW4	HCPAC	J	ASHA	0.00	<b>0.00</b>		Yes	PE Inputs Only
92627	ZZZ	N	Feb05	85	Auditory Rehabilitation Assessment	WW5	HCPAC	J	ASHA	0.00	<b>0.00</b>		Yes	PE Inputs Only
92630	XXX	N	Feb05	86	Auditory Rehabilitation Assessment	WW6	HCPAC	J	ASHA	0.00	<b>0.00</b>		Yes	PE Inputs Only
92633	XXX	N	Feb05	86	Auditory Rehabilitation Assessment	WW7	HCPAC	J	ASHA	0.00	<b>0.00</b>		Yes	PE Inputs Only
96100	XXX	D	Nov04	A25	Psychological Testing Exam		HCPAC						Yes	
96101	XXX	N	Nov04	A25	Psychological Testing Exam	DD1	HCPAC	J	APA	3.01	<b>1.86</b>		Yes	
96102	XXX	N	Nov04	A25	Psychological Testing Exam	DD2	HCPAC	J	APA	2.70	<b>0.50</b>		Yes	
96103	XXX	N	Nov04	A25	Psychological Testing Exam	DD3	HCPAC	J	APA	2.55	<b>0.51</b>		Yes	
96115	XXX	D	Nov04	A24	Neurobehavioral Status Exam		HCPAC						Yes	
96116	XXX	N	Nov04	A24	Neurobehavioral Status Exam	EE1	HCPAC	J	APA	3.00	<b>2.05</b>		Yes	
96117	XXX	D	Nov04	A24	Neurobehavioral Status Exam		HCPAC						Yes	

CPT Code	Global Coding	CPT Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
96118	XXX	N	Nov04	A24	Neurobehavioral Status Exam	EE2	HCPAC	J	APA		3.00	2.05		Yes	
96119	XXX	N	Nov04	A24	Neurobehavioral Status Exam	EE3	HCPAC	J	APA		2.21	0.55		Yes	
96120	XXX	N	Nov04	A24	Neurobehavioral Status Exam	EE4	HCPAC	J	APA		2.60	0.51		Yes	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Auditory Rehabilitation Assessment**

92506, 92507 and 92508

The HCPAC discussed codes 92506 *Evaluation of speech, language, voice, communication, and/or auditory processing* (Work RVU=0.86), 92507 *Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual* (Work RVU=0.52) and 92508 *group, two or more individuals* (Work RVU=0.26) and determined that the changes were editorial. **The HCPAC recommends that the current work values and practice expense inputs be maintained.**

92626, 92627, 92630 and 92633

The HCPAC reviewed the practice expense for codes 92626 *Evaluation of auditory rehabilitation status; first hour*, 92627 *each additional 15 minutes (List separately in addition to code for primary procedure)*, 92630 *Auditory rehabilitation, pre-lingual hearing loss*, and 92633 *Auditory rehabilitation, post-lingual hearing loss*. **For guidelines on defining time for 92626 and 92627 the HCPAC requested that CPT add the following parenthetical: (When reporting 92626,92627 use the face-to-face time with the patient or family). The CPT Editorial Panel Executive Committee accepted this modification. The HCPAC assessed and modified the practice expense to reflect PEAC standards.**

Code 92506 is used to report evaluation of speech production, receptive language, and expressive language abilities. Tests may examine speech sound production, articulatory movements of oral musculature, one's ability to understand the meaning and intent of written and verbal expressions, and the appropriate formulation and utterance of expressive thought. In contrast, 92626 and 92627 are reported for an evaluation of auditory rehabilitation status determining one's the patient's ability to use residual hearing in order to identify the acoustic characteristics of sounds associated with speech communication.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
92502		<i>(For laryngoscopy with stroboscopy, use 31579)</i> <i>Otolaryngologic examination under general anesthesia</i>	000	1.51 (No Change)
▲92506	WW1	Evaluation of speech, language, voice, communication, <u>and/or</u> auditory processing, <u>and/or aural rehabilitation status</u>	XXX	0.86
▲92507	WW2	Treatment of speech, language, voice, communication, and/or auditory processing disorder ( <del>includes aural rehabilitation</del> ); individual	XXX	0.52
▲92508	WW3	group, two or more individuals	XXX	0.26
D 92510		<del>Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming</del>  (92510 has been deleted (92510 has been deleted. For auditory rehabilitation, pre-lingual hearing loss, use 92630) (For cochlear implant programming, see 92601-92604))	XXX	N/A
●92626	WW4	Evaluation of auditory rehabilitation status; first hour	XXX	N/A
●+92627	WW5	each additional 15 minutes (List separately in addition to code for primary procedure)  (Use 92627 in conjunction with 92626)  (When reporting 92626, 92627 use the face-to-face time with the patient or family)	ZZZ	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•92630	WW6	Auditory rehabilitation, pre-lingual hearing loss	XXX	N/A
•92633	WW7	Auditory rehabilitation, post-lingual hearing loss	XXX	N/A

**AMTA/Specialty Society Update Process**  
**PEAC Summary of Recommendation**  
**XXX Global Period**  
**Non Facility Direct Inputs**  
92506

CPT Long Descriptor:

Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban 11% Urban 66%

Type of Practice %: 17% Solo Practice  
33% Single Specialty Group  
17% Multispecialty Group  
33% Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The practice expense inputs were developed through a consensus process. An expert consensus panel was formed with six speech-language pathologists who discussed the elements of the procedure and arrived at the reported times, equipment and supplies.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Speech-language pathologist speaks to parent on phone to gather referral information on specific nature of speech, language or other communication problem. Parent provides information about ages of acquisition of milestones and examples of situations in which it is difficult for the child to communicate. Speech-language pathologist reviews records from referring physician and other pertinent parties (e.g. preschool teacher, audiologist).

Intra-Service Clinical Labor Activities:

Speech-language pathologist prepares room and materials by selecting tests for articulation and language. Test forms selected and identifying information completed. Since the child is young, reinforcing toys and games are selected and brought to the room to keep the child's attention. Cup and juice are gathered for later use in session. Speech-language pathologist goes to waiting room to meet child and parent(s) and engages in play for a few minutes with child to increase child's comfort level. Child and parent accompany speech-language pathologist to evaluation room. Speech-language pathologist continues to work to gain child's trust and willingness to participate. Speech-language pathologist conducts evaluation which first consists of administration of a phonological/articulation assessment. Objects are presented to the child and he talks about each one. The speech-language pathologist transcribes the

child's responses to characterize the errors. An examination of the oral mechanism is completed to rule out structural or muscular deficits as cause of the articulation problem. The child is offered sips of liquid so that function of the oral mechanism during feeding task can be observed. A language test to assess receptive and expressive skills is administered. This involves manipulation of toys and looking at pictures. The reinforcement activities (e.g. putting a piece in the puzzle after every few responses) continue to maintain the child's cooperation. When specific deficits are noted in vocabulary, another test is retrieved and administered for more in-depth analysis of these skills. The speech-language pathologist completes a preliminary analysis of the results without actually scoring the tests and discusses preliminary results with parent including teaching. The parents are provided with written handouts concerning the nature of the child's deficits and activities they can begin to implement at home.

Post-Service Clinical Labor Activities:

Speech-language pathologist analyzes and scores tests and writes report including the development of a treatment plan with long term and short term goals and treatment objectives that will be used to achieve the goals. The speech-language pathologist shares report with referring physician, payer source, school and parents. The speech-language pathologist also provides additional written educational materials for the child's school to engage them in activities to help improve the child's communication skills.

**AMTA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs  
92507**

CPT Long Descriptor:

Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban 11% Urban 66%

Type of Practice %: 17% Solo Practice  
33% Single Specialty Group  
17% Multispecialty Group  
33% Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The practice expense inputs were developed through a consensus process. An expert consensus panel was formed with six speech-language pathologists who discussed the elements of the procedure and arrived at the reported times, equipment and supplies.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Speech-language pathologist reviews note from last session and analyzes which activities were most successful in engaging the child and in getting the maximum number of responses.

Intra-Service Clinical Labor Activities:

Speech-language pathologist prepares room by removing toys and games that are distracting to this child. Retrieves specific materials that will help to achieve the goals of the session, and selects homework materials that will likely be given to the parents. Speech-language pathologist plans specific activities for the session to address each of the short term goals. Speech-language pathologist goes to waiting room to greet child and to reestablish child's trust and willingness to accompany speech-language pathologist to treatment room. Speech-language pathologist presents auditory and visual stimulation for the targeted speech sound and engages the child in integral stimulation activities to help the child produce the sound in isolation. Speech-language pathologist uses lollipop to stimulate alveolar ridge and give tactile feedback to child about where tongue needs to be placed to make the sound. When the child is able to do this, the speech-language pathologist probes for other contexts in which the child can produce the sound and prepares picture cards with these words. The speech-language pathologist and child then play a variety of games with these cards to get a maximum number of correct responses from the child. The speech-

language pathologist presents a variety of activities to address the receptive and expressive language goals. The child and speech-language pathologist engage in play with a miniature firehouse to allow the speech-language pathologist to stimulate from the child appropriate sentence structure for asking questions (e.g., Where is the fireman? Who drives this truck?). A paper activity for more practice on question generation is introduced and placed in the child's notebook to go home for practice. The speech-language pathologist selects a book-reading activity to address the receptive vocabulary goal and engages in joint reading with the child, asking questions to elicit appropriate vocabulary responses. The child and speech-language pathologist then engage in play activity with dishes and pretend food designed for carryover of the correct production of the target sound as well as increased length of utterances for expressive language. Speech-language pathologist educates parent regarding home practice activities and reviews the specific sheets placed in the homework notebook for the parent to practice. Additional activities are written out and these suggestions are sent for the preschool teacher to use.

Post-Service Clinical Labor Activities:

Speech-language pathologist tallies scoring sheets used during therapy, analyzes child's performance and writes progress note.

**AMTA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor:

Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban 33% Urban 67%

Type of Practice %: 17% Solo Practice  
33% Single Specialty Group  
17% Multispecialty Group  
33% Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The practice expense inputs were developed through a consensus process. An expert consensus panel was formed with 6 speech-language pathologists who discussed the elements of the procedure and arrived at the reported times, equipment and supplies.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Speech-language pathologist reviews notes from last session and analyzes which activities were most successful in engaging the children and in getting the maximum number of responses from each child.

Intra-Service Clinical Labor Activities:

Speech-language pathologist prepares room by removing toys and games that are distracting to these children. Retrieves specific materials that will help to achieve the goals of the session, and selects homework materials that will likely be given to the parents. Speech-language pathologist plans specific activities for the session to address each of the short term goals. Speech-language pathologist goes to waiting room to greet children and to reestablish children's trust and willingness to accompany speech-language pathologist to treatment room. Speech-language pathologist presents auditory and visual stimulation for the targeted speech sound and engages the children in integral stimulation activities to help each child produce the sound in isolation. Each child takes turns making the sound, looking at the speech-language pathologist's face and looking in a mirror to monitor their production. When one of the children is unable to produce the sound, the speech-language pathologist uses a lollipop to stimulate the alveolar ridge to provide tactile input to the child. When each child can produce the sound in isolation, the speech-language pathologist probes for other contexts in which the children can produce the sound and prepares picture cards with these words. The speech-language pathologist and children then play a variety of games with these cards to get a maximum number of correct responses from each child. When

a child has difficulty, the speech-language pathologist analyzes the child's response and provides feedback as needed.

The speech-language pathologist presents a variety of activities to address the receptive and expressive language goals. The children and speech-language pathologist engage in play in a child-size kitchen with dishes and pretend food to allow the speech-language pathologist to stimulate from each child appropriate sentence structure for asking questions (e.g., Where is the spoon? Who wants soup?). The children are encouraged to take turns being the 'cook' so the others can ask questions. A paper activity for more practice on question generation is introduced and placed in each child's notebook to go home for practice. The speech-language pathologist selects a book-reading activity to address the receptive vocabulary goal and engages in joint reading with the children, asking questions to elicit appropriate vocabulary responses. The children and speech-language pathologist then engage in play activity with trucks and little people designed for carryover of the correct production of the target sound as well as increased length of utterances for expressive language. Speech-language pathologist educates each parent regarding home practice activities and reviews the specific sheets placed in the homework notebook for the parent to practice. Additional activities are written out and these suggestions are sent for the preschool teacher to use.

Post-Service Clinical Labor Activities:

Speech-language pathologist tallies scoring sheets used during therapy, analyzes each child's performance and writes progress note for each child.



**AMTA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: Evaluation of auditory rehabilitation status; first hour

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: \_\_\_\_\_

Geographic Practice Setting %: Rural 14% Suburban 29% Urban 57%

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:

The practice expense inputs were developed through a consensus process. Originally, ASHA distributed the Practice Expense Survey to a number of practicing audiologists. The data from the surveys were discarded because the item regarding "assist physician" confused the respondents. Audiologists do not assist physicians with this procedure but, rather, perform the procedure. An expert consensus panel was formed with seven audiologists who discussed the elements of the procedure and arrived at the reported times, equipment and supplies.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The audiologist performs a chart review looking for information related to the etiology of hearing loss, clinical notes regarding hearing aid or cochlear implant use, and other health issues that may influence communication and the ability to process auditory information.

Intra-Service Clinical Labor Activities:

The audiologist greets the child and family in the waiting room and escorts them to the auditory training area. The audiologist and child sit at a table while the other family members are seated across the room or in an observation room. After establishing rapport with the child, the audiologist begins the assessment of current listening and discrimination abilities using the following activities:

1. Determination of sound awareness (presence or absence of sound)
2. Determination of sound duration patterns (long, short, and rhythmic patterns)
3. Evaluation of supra-segmental features (loud vs. soft, high pitch vs. low pitch, vocal inflection)
4. Achievement of sound discrimination for a variety of environmental sounds

5. Achievement of sound discrimination for speech sounds (phonemes)
6. Achievement of word discrimination for naming words (nouns)
7. Achievement of listening abilities in noise
8. Determination of differential listening abilities between the child's cochlear implant and a personal FM system.

After the formal testing is completed, the audiologist scores each test and discusses with the patient and family the outcome and significance of the auditory rehabilitation status evaluation. Based on the outcome of the formal testing, intervention goals are established.

The audiologist cleans the room, putting away the test materials and disinfecting toys/manipulatives used in the testing process.

Post-Service Clinical Labor Activities:

The audiologist writes a formal report outlining the test outcomes and intervention goals.

**AMTA/Specialty Society Update Process  
PEAC Summary of Recommendation  
ZZZ Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: Evaluation of auditory rehabilitation status; each additional 15 minutes

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: \_\_\_\_\_

Geographic Practice Setting %: Rural 14% Suburban 29% Urban 57%

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:

The practice expense inputs were developed through a consensus process. Originally, ASHA distributed the Practice Expense Survey to a number of practicing audiologists. The data from the surveys were discarded because the item regarding "assist physician" confused the respondents. Audiologists do not assist physicians with this procedure but, rather, perform the procedure. An expert consensus panel was formed with seven audiologists who discussed the elements of the procedure and arrived at the reported times, equipment and supplies.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

None

Intra-Service Clinical Labor Activities:

The audiologist executes a continuation of the following activities from the first hour of service:

1. Determination of sound awareness (presence or absence of sound)
2. Determination of sound duration patterns (long, short, and rhythmic patterns)
3. Evaluation of supra-segmental features (loud vs. soft, high pitch vs. low pitch, vocal inflection)
4. Achievement of sound discrimination for a variety of environmental sounds
5. Achievement of sound discrimination for speech sounds (phonemes)
6. Achievement of word discrimination for naming words (nouns)
7. Achievement of listening abilities in noise
8. Determination of differential listening abilities between the child's cochlear implant and a personal FM system.

Post-Service Clinical Labor Activities: Clean room and disinfect toys and manipulatives; Write report

**AMTA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: Auditory rehabilitation, pre-lingual hearing loss

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: \_\_\_\_\_

Geographic Practice Setting %: Rural 14% Suburban 29% Urban 57%

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:

The practice expense inputs were developed through a consensus process. Originally, ASHA distributed the Practice Expense Survey to a number of practicing audiologists. The data from the surveys were discarded because the item regarding "assist physician" confused the respondents. Audiologists do not assist physicians with this procedure but, rather, perform the procedure. An expert consensus panel was formed with seven audiologists who discussed the elements of the procedure and arrived at the reported times, equipment and supplies.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

None

Intra-Service Clinical Labor Activities:

The audiologist greets the child and family in the waiting room and escorts them to the auditory training area. The audiologist and child sit at a table while the other family members are seated across the room or in an observation room. After establishing rapport with the child, the audiologist begins the instruction session beginning with sound awareness activities. The child was taught to place a peg in a board upon becoming aware when sound was present, employing basic reinforcement techniques. After ensuring a good stimulus-response format, the audiologist covers the face and vocalizes a neutral vowel (/ahhh/) varying the duration and loudness of vocalization to elicit a response from the child. After each correct response, the audiologist pauses to praise and reinforce the appropriate responses, then repeats the exercise until a level of mastery is achieved. Each successive therapeutic task becomes more difficult and complex and is exercised until criterion mastery is achieved. The long term goal is to achieve appropriate sound and speech discrimination sufficient to establish a language foundation and effective communication. The general order of activities may include:

1. Determination of sound awareness (presence or absence of sound)

2. Determination of sound duration patterns (long, short, and rhythmic patterns)
3. Evaluation of supra-segmental features (loud vs. soft, high pitch vs. low pitch, vocal inflection)
4. Achievement of sound discrimination for a variety of environmental sounds
5. Achievement of sound discrimination for speech sounds (phonemes)
6. Achievement of word discrimination for naming words (nouns)
7. Achievement of listening abilities in noise
8. Discrimination of speech sounds presented through a telephone
9. Determination of differential listening abilities between the child's cochlear implant and a personal FM system.

At the end of the session, the audiologist takes the child back to the family and reviews the activities of the day and the child's response levels and achievements. Home activities are given to the parent for practice before the next session.

The audiologist cleans the room, puts away intervention / therapy materials, and disinfects reinforcers and manipulatives used during the session.

The audiologist prepares a written summary of the day's activities, the child's achievements, and other notes in the form of a progress note.

Post-Service Clinical Labor Activities:

The audiologist makes a telephone call to the child's teacher or school based therapist to update that individual regarding the child's achievements.

**AMTA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: Auditory rehabilitation, post-lingual hearing loss

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: \_\_\_\_\_

Geographic Practice Setting %: Rural 14% Suburban 29% Urban 57%

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:

The practice expense inputs were developed through a consensus process. Originally, ASHA distributed the Practice Expense Survey to a number of practicing audiologists. The data from the surveys were discarded because the item regarding "assist physician" confused the respondents. Audiologists do not assist physicians with this procedure but, rather, perform the procedure. An expert consensus panel was formed with seven audiologists who discussed the elements of the procedure and arrived at the reported times, equipment and supplies.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The audiologist performs a chart review looking for notes / reports of hearing aid / cochlear implant fitting notes, any fitting problems associated with the devices, notes regarding frequency of use, and any notes focusing on concerns / problems reported previously by the patient.

Intra-Service Clinical Labor Activities:

The audiologist greets the patient in the waiting room and escorts him/her to the auditory skills training area. The audiologist and patient sit across from one another. After determining the situations that provide the greatest difficulty for listening, the audiologist initiates a set of exercises that simulate or recreate environmental conditions common to the individual's life style to allow instruction for appropriate listening techniques. The activities may include instruction on managing the environment when the background noise arises from a specific location, practicing listening strategies when immersed in background noise (i.e., multiple conversations), combining visual cues with audition to further enhance understanding of speech communication, and developing various compensatory strategies for unexpected, adverse listening conditions. In addition, specific listening situations will be simulated (i.e., listening to television) in order to demonstrate appropriate assistive listening devices that are intended eliminate or minimize the

effects of distance, room acoustics, and background noise as adverse factors that affect listening abilities. Telephone communication training may be another area of activity to minimize feedback from the hearing aid during telephone use, determining whether a special, amplified telephone would be more appropriate for improved understanding, and to render instruction using the telephone coil built into the hearing aid for enhance telephone use. Instruction may also focus on the adjustment and use of a special neck loop for communicating via cellular phones. A portion of the training may be devoted to communication strategies in order to facilitate ongoing verbal communication and improve overall conversational skills when misunderstandings occur. The importance of this element focuses on the frustration and avoidance experienced by many individuals when they realize that they misunderstood a portion of what was said resulting in a breakdown in communication. Other activities may include assessment of other types of assistive listening devices (i.e., infrared listening system, telephone adapter, portable telephone amplifier, closed-caption decoder for the television, alerting devices, and other options), identification of adverse listening situations, simulation, and development of compensation strategies unique to various situations at home and at work, and the development of compensatory strategies for various social situations where acoustics and lighting may cause further difficulty with speech understanding or enjoyment of the arts.

The audiologist then discusses the outcomes of the day's activities with the patient's spouse / significant other, answers questions, and provides home activities for reinforcement and carry-over of the skills acquired during the intervention session.

The audiologist then cleans the room putting away the items used for demonstration and intervention assistance.

The audiologist prepares a chart progress note or report detailing the day's activities, outcomes, and recommendations for further intervention.

Post-Service Clinical Labor Activities:

None

	A	B	C	D	E	F	G	H	I	J	K
1											
2				92626		92627		92630		92633	
3	Meeting Date: April 2005 Specialty: Audiology			Evaluation of auditory rehabilitation status; first hour		Evaluation of auditory rehabilitation status; each additional 15 min		Auditory rehabilitation, pre-lingual hearing loss		Auditory rehabilitation, post-lingual hearing loss	
4	LOCATION	CMS Code	Staff Type	XXX		ZZZ		XXX		XXX	
5	GLOBAL PERIOD										
6	TOTAL CLINICAL LABOR TIME	L052A	Audiologist	82.0		18.0		73.0		77.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L052A	Audiologist	0.0		0.0		0.0		0.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L052A	Audiologist	79.0		18.0		73.0		77.0	
9	TOTAL POST-SERV CLINICAL LABOR TIME	L052A	Audiologist	3.0		0.0		0.0		0.0	
10	<b>PRE-SERVICE</b>										
11	Start. Following visit when decision for surgery or procedure made										
12	Complete pre-service diagnostic & referral forms										
13	Coordinate pre-surgery services										
14	Schedule space and equipment in facility										
15	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	<b>SERVICE PERIOD</b>										
20	Start. When patient enters office/facility for surgery/procedure										
21	<b>Pre-service services</b>										
22	Review chart, cochlear implant programming results	L052A	Audiologist	5				3		3	
23	Greet patient	L052A	Audiologist	2				2		2	
24	Prepare session plan							7		7	
25	Provide pre-service education/obtain consent	L052A	Audiologist	2							
26	Prepare room, equipment, supplies	L052A	Audiologist	2				2		2	
27	Setup scope (non facility setting only)										
28	Prepare and position patient	L052A	Audiologist	2				2		2	
29	Sedate/apply anesthesia										
30	<b>Intra-service</b>										
31	Perform procedure	L052A	Audiologist	50		13		45		50	
32	<b>Post-Service</b>										
33	Education/instruction/counseling	L052A	Audiologist	4		2		7		5	
34	Clean room/equipment	L052A	Audiologist	2		1		2		2	
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 (score tests, write report)	L052A	Audiologist	10		2		3		4	
42	End: Patient leaves office										
43	<b>POST-SERVICE Period</b>										
44	Start: Patient leaves office/facility										
45	Conduct phone calls/call in prescriptions	L052A	Audiologist	3							

	A	B	C	D	E	F	G	H	I	J	K
2				92626		92627		92630		92633	
	Meeting Date: April 2005 Specialty: Audiology			Evaluation of auditory rehabilitation status; first hour		Evaluation of auditory rehabilitation status; each additional 15 min		Auditory rehabilitation, pre-lingual hearing loss		Auditory rehabilitation, post-lingual hearing loss	
3											
4	LOCATION	CMS Code	Staff Type	XXX		ZZZ		XXX		XXX	
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	0	0	0	0
56	Other Activity (please specify)										
57	End: with last office visit before end of global period										
58	<b>MEDICAL SUPPLIES</b>	<b>CMS Code</b>	<b>Unit</b>								
59	Audiology scoring forms	SK008	item	4		4					
60	kit, therapeutic toys-games	SA033	kit	1		1		1			
61	Patient education booklet	SK062	item					1		1	
62											
63											
64											
65											
66	<b>Equipment</b>	<b>CMS Code</b>	<b>Unit</b>								
67	Audiometric soundproof booth (exam and control rooms)	EQ054		1		1					
68	Audiometer, clinical-diagnostic	EQ053		1		1					
69	Sound field speakers	\$1,775 00		1		1					

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Psychological Testing Exam**

The CPT Editorial Panel created codes 96101, 96102 and 96103 to recognize the different modalities of psychological testing. The HCPAC examined the CPT descriptors for the psychological testing exam codes and determined that clarification was needed to specify the psychologist's or physician's time as well as face-to-face time. **The HCPAC requested that CPT amend the code descriptors for 96101, 96102 and 96103 as indicated. The CPT Editorial Panel Executive Committee accepted the descriptor modifications for 96101, 96102 and 96103.**

The HCPAC valued codes 96101, 96102 and 96103 based on the amended descriptors. After extensive examination, the HCPAC crosswalked code 96101 to code 90806 *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;* (Work RVU=1.86) to establish a comparable work RVU for code 96101. The HCPAC also amended the pre-, intra- and post-service time for code 96101 (pre-service time = 7 minutes, intra-service time = 60 minutes and post-service time = zero minutes).

The HCPAC crosswalked code 96102 to 96150 *Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment* (Work RVU=0.50) for the pre-service, intra-service and post-service times. APA also crosswalked 96101 to 90806 to establish a comparable work RVU for code 96101.

Additionally, the HCPAC crosswalked 96103 to codes 93014 *Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time; physician review with interpretation and report only* (Work RVU=0.52, pre = 10 minutes, intra = 20 minutes and post = 12 minutes) and 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (Work RVU=0.17 pre = zero minutes, intra = 5 minutes and post = zero minutes) to develop service times and the work RVU.

**The HCPAC recommends the service times for codes 96101, 96102 and 96103 as indicated in the table below. The HCPAC recommends 1.86 Work RVU for code 96101, 0.50 Work RVU for code 96102 and 0.51 for code 96103.**

Code	Pre-Service	Intra-Service	Post-Service	Work RVU	Reference Code
96101	7	60	0	1.86	90806
96102	3	15	5	0.50	96150
96103	8	8	14	0.51	93000 and 93014

Practice Expense

After extensive discussion, the HCPAC amended the practice expense to reflect PEAC standards.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(D) 96100		<del>Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour (96100 has been deleted. To report, see 96101, 96102, 96103)</del>	XXX	N/A
•96101	DD1	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report	XXX	1.86
•96102	DD2	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS); with report, administered by technician, face-to-face, per hour of technician time	XXX	0.50
•96103	DD3	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI); administered by a computer, with report	XXX	0.51

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

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CPT Code:96101 Tracking Number: DD1 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 3.0

RUC RVU: 1.86

CPT Descriptor: Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities personality and psychopathology, eg, MMPI, Rorschach, WAIS); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report.

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 35-year-old woman is referred by her primary care physician due to significant changes in behavior. A series of tests (standardized and/or projective) is administered to evaluate emotionality, intellectual abilities personality and psychopathology. The administration of the tests is completed by the provider for the purposes of mental health diagnosis.

Percentage of Survey Respondents who found Vignette to be Typical: 57%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The qualified health care professional speaks with the referring source (physician institution, patient, etc.) in order to ascertain the nature of the referral question(s) to be addressed by the assessment. In addition, s/he finds out any special factors or limitations that might affect the testing itself (e.g., language limitations educational deficits, possible resistance to the testing). The qualified health care professional then typically speaks with the patient to set an appointment and to explain the procedures. Prior to meeting with the patient, the qualified health care professional makes a preliminary selection of which tests to be used. This selection depends upon the nature of the clinical questions to be answered as well as certain patient variables (e.g., reading level, visual impairment, language proficiency, etc.).

Description of Intra-Service Work: The qualified health care professional meets with the patient and conducts an interview, including a comprehensive history. In particular, s/he focuses upon the patient's own questions for the assessment in order to shape the assessment process. S/he attempts to establish rapport in order to ensure maximum involvement and cooperation on the part of the patient with the testing procedures. On the basis of the information gathered from the interview, the psychologist may modify the selection of testing instruments (e.g., if the patient raises a question that had not been part of the initial referral, additional instruments may be added to the battery to address this).

The qualified health care professional administers all of the face-to-face or performance-based tests, carefully following appropriate administration procedures in order to ensure valid test results. The psychologist carefully records the patient's responses verbatim during the testing in order to have an accurate record of the test results for later analysis.

The qualified health care professional explains fully the procedures for the paper-and-pencil or self-report inventories that have been selected. The patient is then left alone to complete the inventories; however, the qualified health care professional checks in on her or him periodically in order to ensure that the inventories are being completed correctly.

The psychologist meets again with the patient in order to answer any last questions about the procedures and to inform him or her about the timetable for the results.

Description of Post-Service Work: The qualified health care professional scores all of the test protocols according to the latest methods for each test. The self-report inventories are either hand scored with templates, or are entered into :

computer in order to computer score them. Once the tests are fully scored, the results are analyzed and interpreted. The interpretations from each of the tests is integrated with data from all of the other tests as well as from the clinical interview and whatever collateral information is available (e.g., hospital records, prior assessments, etc.) in order to develop a comprehensive picture of the patient's personality, psychopathology, coping strengths and weaknesses, and cognitive functioning, as well as to answer any specific referral questions.

The qualified health care professional then writes a report for the referring professional and/or for the patient. S/he may then also communicate with either or both orally to discuss the results of the testing.

### SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2005				
Presenter(s):	James Georgoulakis, PhD, Antonio Puente, PhD, Bruce Smith, PhD					
Specialty(s):	Psychology					
CPT Code:	96101					
Sample Size:	117	Resp n:	42	Response:	%	
Sample Type:	Panel					
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:		2.60	2.86	3.01	3.95	11.20
Pre-Service Evaluation Time:				7.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		5.00	20.00	60.00	33.00	67.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>0.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60), 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38), 99213 (23); 99212 (15), 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
96111	XXX	2.60

CPT Descriptor Developmental testing; extended (includes assessment of motor, language, social, adaptive and/cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
90801	XXX	2.80

CPT Descriptor 1 Psychiatric diagnostic interview examination.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 24      % of respondents: 57.1 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 96101</b>	<b>Key Reference CPT Code: 96111</b>
Median Pre-Service Time	7 00	5.00
Median Intra-Service Time	60 00	60 00
Median Immediate Post-service Time	0.00	30 00
Median Critical Care Time	0 0	0 00
Median Other Hospital Visit Time	0 0	0 00
Median Discharge Day Management Time	0 0	0.00
Median Office Visit Time	0 0	0 00
<b>Median Total Time</b>	<b>67.00</b>	<b>95.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.00
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Urgency of medical decision making	4.00	4.00
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	5.00	4.00
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Physical effort required	3.00	2.00
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.00	3.00
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Outcome depends on the skill and judgment of physician	5.00	4.00
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Estimated risk of malpractice suit with poor outcome	3.00	3.00
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
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Intra-Service intensity/complexity	4.00	4.00
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Post-Service intensity/complexity	5.00	4.00
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used a IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

In preparing to survey, APA worked with the Society for Personality Assessment to gather names of individuals who were interested in participating in the survey and would be available during the month of March. From the panel of names that we received, we established a sample size of 120. In addition, the Research Subcommittee at its February 2005 meeting approved our entire survey process, including the instrument, supplemental instructions and our reference service list.

The majority of survey respondents chose 96111 (developmental testing) as the reference service yet 90801 (psychiatric diagnostic interview examination) followed closely behind it in frequency. We compared the pre, intra and post service times for those who selected 96111 and those who selected 90801. The times and recommendations were too close to warrant differentiating between the two reference services.

While the median RVU is higher than that for 90801, it is clear that the complexity of the patients, combined with the number of potential diagnoses exceeds the work required for 90801. While the typical patient might not vary too far from our vignette, each patient's background requires the psychologist to select particular tests from a broad spectrum of options.

Psychological testing often is employed in cases where an interview would not gather enough information to effectively evaluate and treat a patient. Patients tend to focus on recent memories and experiences and testing offers a standardized way to measure a patient's responses leading to a broader evaluation encompassing long-term behaviors and problems. These evaluations require far more time, complexity diagnostic and treatment options than would be determined in a psychiatric diagnostic interview (90801).

The majority of a psychologist's most complex time and work occurs in the post-service period. This is the portion of work when the psychologist reviews data, compares and contrasts results, and then renders a diagnosis. Many survey respondents indicated that their reports and interpretations are integrated into care plans with physicians, or will be used in legal situations such as fitness to stand trial, fitness to parent, or if an elderly parent can live on their own. The long term implications for these diagnoses add to the complexity of providing these services.

APA worked diligently to educate its survey participants about assigning a relative value for the new code given that the code is to be billed on a per hour basis. Our members were advised to consider the total amount of time that they spend providing the service, and then break the total amount of work down to a per hour basis in order to assign a work RVU. In some cases, our respondents listed an RVU and provided the mathematical formula that they used to divide the total time by the ratio that they'd determined between the new code and reference service in order to justify their recommended RVU. In the cases where an extremely high RVU was listed, it is impossible to determine if that was the actual per hour RVU that they proposed, or if they did not break the value down to a per hour basis.

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## 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**

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CPT Code:96102 Tracking Number: DD2 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 2.7

RUC RVU: 0.5

CPT Descriptor: Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS); with report, administered by a technician, face-to-face per hour of technician time.

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 35-year-old woman is referred by her primary care physician due to significant changes in behavior. A series of tests (standardized and/or projective) is administered to evaluate emotionality, intellectual abilities, personality and psychopathology. The administration of the tests is completed by a technician for the purposes of mental health diagnosis.

Percentage of Survey Respondents who found Vignette to be Typical: 60%

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 qualified health care professional speaks with the referring source (e.g., physician, institution, patient, etc.) in order to ascertain the nature of the referral question(s) to be addressed by the assessment. In addition, s/he finds out any special factors or limitations that might affect the testing itself (e.g., language limitations, educational deficits, possible resistance to the testing). The qualified health care professional then typically speaks with the patient to set an appointment and to explain the procedures. Prior to meeting with the patient, the qualified health care professional makes a preliminary selection of which tests to be used. This selection depends upon the nature of the clinical questions to be answered as well as certain patient variables (e.g., reading level, visual impairment, language proficiency, etc.).

Description of Intra-Service Work: The qualified health care professional meets with the patient and conducts a diagnostic interview, including a comprehensive history. In particular, s/he focuses upon the patient's own questions for the assessment in order to shape the assessment process. S/he attempts to establish rapport in order to ensure maximum involvement and cooperation on the part of the patient with the testing procedures. On the basis of the information gathered from the interview, the qualified health care professional may modify the selection of testing instruments (e.g. if the patient raises a question that had not been part of the initial referral, additional instruments may be added to the battery to address this).

The qualified health care professional introduces the patient to the technician who conducts the remainder of the assessment.

The qualified health care professional meets again with the patient in order to answer any last questions about the procedures and to inform him or her about the timetable for the results..

Description of Post-Service Work: The qualified health care professional scores all of the test protocols according to the latest methods for each test. The self-report inventories are either hand scored with templates, or are entered into a computer in order to computer score them. Once the tests are fully scored, the results are analyzed and interpreted. The interpretations from each of the tests is integrated with data from all of the other tests as well as from the clinical interview and whatever collateral information is available (e.g., hospital records, prior assessments, etc.) in order to develop a comprehensive picture of the patient's personality, psychopathology, coping strengths and weaknesses, and cognitive functioning, as well as to answer any specific referral questions.

The qualified health care professional then writes a report for the referring professional and/or for the patient. S/he may then also communicate with either or both orally to discuss the results of the testing.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005				
<b>Presenter(s):</b>		James Georgoulakis, PhD, Antonio Puente, PhD, Bruce Smith, PhD				
<b>Specialty(s):</b>		Psychology				
<b>CPT Code:</b>		96102				
<b>Sample Size:</b>	117	<b>Resp n:</b>	40	<b>Response:</b> 34 18 %		
<b>Sample Type:</b> Panel						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		1.50	2.70	2.93	3.60	8.40
<b>Pre-Service Evaluation Time:</b>				3.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		3.00	10.00	15.00	60.00	180.00
<b>Post-Service</b>		<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>		<u>5.00</u>				
<b>Critical Care time/visit(s):</b>		<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>		<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>		<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>		<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
96111	XXX	2.60

CPT Descriptor Developmental testing; extended (includes assessment of motor, language, social, adaptive and/o cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
90801	XXX	2.8

CPT Descriptor 1 Psychiatric diagnostic interview examination.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
		0.00

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 18      % of respondents: 45.0 %**

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 96102</b>	<b>Key Reference CPT Code: 96111</b>
Median Pre-Service Time	3.00	5 00
Median Intra-Service Time	15.00	60 00
Median Immediate Post-service Time	5 00	30 00
Median Critical Care Time	0 0	0 00
Median Other Hospital Visit Time	0 0	0.00
Median Discharge Day Management Time	0 0	0 00
Median Office Visit Time	0.0	0 00
<b>Median Total Time</b>	<b>23.00</b>	<b>95.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
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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
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	4.00
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Physical effort required	2.00	2.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.00	3.00
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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	2.00
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Intra-Service intensity/complexity	3.00	4.00
------------------------------------	------	------

Post-Service intensity/complexity	4.00	4.00
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**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used a IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We are recommending the 25<sup>th</sup> percentile work value of 2.70 work RVUs. This recommendation is based on the fact that the use of technicians for psychological testing occurs only occasionally compared to the base code where the psychologist does the testing, interpretation and report (currently noted as 96101).





**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

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CPT Code:96103 Tracking Number: DD3 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 2.5

RUC RVU: 0.51

CPT Descriptor: Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities personality and psychopathology, eg, MMPI); administered by a computer, with report.

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 35-year-old woman is referred by her primary care physician due to significant changes in behavior. A series of tests (standardized and/or projective) is administered to evaluate emotionality, intellectual abilities personality and psychopathology. The administration of the tests is completed by a computer for the purpose of a mental health diagnosis.

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 qualified health care professional speaks with the referring source (physician institution, patient, etc.) in order to ascertain the nature of the referral question(s) to be addressed by the assessment. In addition, s/he finds out any special factors or limitations that might affect the testing itself (e.g., language limitations educational deficits, possible resistance to the testing). The qualified health care professional then typically speaks with the patient to set an appointment and to explain the procedures. Prior to meeting with the patient, the qualified health care professional makes a preliminary selection of which tests to be used. This selection depends upon the nature of the clinical questions to be answered as well as certain patient variables (e.g., reading level, visual impairment, language proficiency, etc.).

Description of Intra-Service Work: The qualified health care professional meets with the patient and conducts an interview, including a comprehensive history. In particular, s/he focuses upon the patient's own questions for the assessment in order to shape the assessment process. S/he attempts to establish rapport in order to ensure maximum involvement and cooperation on the part of the patient with the testing procedures. On the basis of the information gathered from the interview, the psychologist may modify the selection of testing instruments (e.g., if the patient raises a question that had not been part of the initial referral, additional instruments may be added to the battery to address this).

The qualified health care professional sets up the computer program and instructs the patient on the use of the computer. The psychologist then checks frequently with the patient to ensure that s/he is completing the test correctly. The psychologist then sets up the next instrument and continues as before until all tests are completed.

The qualified health care professional meets again with the patient in order to answer any last questions about the procedures and to inform him or her about the timetable for the results.

Description of Post-Service Work: The qualified health care professional scores all of the test protocols according to the latest methods for each test. The self-report inventories are either hand scored with templates, or are entered into a computer in order to computer score them. Once the tests are fully scored, the results are analyzed and interpreted. The interpretations from each of the tests is integrated with data from all of the other tests as well as from the clinical interview and whatever collateral information is available (e.g., hospital records, prior assessments, etc.) in order to develop a comprehensive picture of the patient's personality, psychopathology, coping strengths and weaknesses, and cognitive functioning, as well as to answer any specific referral questions.

The psychologist then writes a report for the referring professional and/or for the patient. S/he may then also communicate with either or both orally to discuss the results of the testing.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2005				
Presenter(s):	James Georgoulakis, PhD; Antonio Puente, PhD; Bruce Smith, PhD					
Specialty(s):	Psychology					
CPT Code:	96103					
Sample Size:	117	Resp n:	37	Response:	31.62 %	
Sample Type:	Panel					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:		1.50	2.55	2.80	3.25	8.40
Pre-Service Evaluation Time:				8.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		4.00	12.00	8.00	60.00	216.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>14.00</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>
96111	XXX	2.60

CPT Descriptor Developmental testing; extended (includes assessment of motor, language, social, adaptive and/cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
90801	XXX	2.8

CPT Descriptor 1 Psychiatric diagnostic interview evaluation.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC 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: 96103	Key Reference CPT Code: 96111
Median Pre-Service Time	8.00	5.00
Median Intra-Service Time	8.00	60.00
Median Immediate Post-service Time	14.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>30.00</b>	<b>95.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	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	3.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	4.00
Physical effort required	2.00	2.00

**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	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	3.00	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 a IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We are recommending the 25th percentile work value of 2.70 work RVUs. This recommendation is based on the fact that the use of computers for psychological testing rarely rarely compared to the base code where the psychologist does the testing, interpretation and report (currently noted as 96101).

The frequency of providing this service varied widely but much more heavily toward numbers fewer than 50. Only 27% of our respondents performed the service more than 50 times in the last year. 60 percent performed it more than 20 times in the last year. The occasional nature of this service makes us much more confident about the data in the 25th percentile.

In addition, the total service time is much lower than for the base code. The median work value did not reflect the reduction in intra-service work time while the 25th percentile comes much closer to doing that plus recognizing the pre and post-service work that is required of the qualified health professional.

APA worked diligently to educate survey participants about assigning a relative value for the new code. Our members were advised to consider the total amount of time that they spent providing the service, and then break the total amount of work down to a per hour basis in order to assign a work RVU. In some cases, our respondents listed an RVU and provided the mathematical formula that they used to divide the total time by the ratio that they'd determined between the new code and reference service in order to justify their recommended RVU. In the cases where an extremely high RVU was listed, it is impossible to determine if that was the actual per hour RVU that they proposed, or if they did not break the value down to a per hour basis.

### 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) 96100

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychology                      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? 18000  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Psychology	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
6,100 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk?

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor:

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:

Our practice expense committee included 20 psychologists who focus on testing services in their practices. The group received the practice expense survey as a standardized approach to determining the clinical staff time, supplies and equipment required to provide the service. Discussions were conducted among the group via email, and consensus data was developed.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff greets the patient and educates him/her about the components of the testing process. The technician also reviews the patient's chart to verify the instruments that will be needed for the status exam and prepares the testing area.

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

Staff cleans the testing area.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: 96102 - Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS); administered by a technician, face-to-face with the patient, with qualified health care professional interpretation and report, per hour.

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:

Our practice expense committee included 20 psychologists who focus on testing services in their practices. The group received the practice expense survey as a standardized approach to determining the clinical staff time, supplies and equipment required to provide the service. Discussions were conducted among the group via email, and consensus data was developed.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff greets the patient and educates her/him about the components of the testing process. The technician also reviews the patient's chart to verify the tests that will be performed, instruments that will be needed for the testing process and prepares the testing area.

Intra-Service Clinical Labor Activities:

The technician explains each test to the patient, providing information about the tests' purposes, and instructions for completing them. The technician answers questions that the patient may have about the tests. The technician also records the patient's test-taking behaviors. Throughout the process, the technician also discusses the testing progress with the qualified health care professional.

Post-Service Clinical Labor Activities:

The technician scores the tests, gathers all of the data and meets with the qualified health care professional to discuss the testing process and his/her observations of the patient.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: 96103 - Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI); administered by a computer, with qualified health care professional interpretation and report, per hour.

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:

Our practice expense committee included 20 psychologists who focus on testing services in their practices. The group received the practice expense survey as a standardized approach to determining the clinical staff time, supplies and equipment required to provide the service. Discussions were conducted among the group via email, and consensus data was developed.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff reviews the patient's chart, greets the patient and educates them about the testing process and use of the computer. The technician also prepares the testing area.

Intra-Service Clinical Labor Activities:

The clinical staff answers questions that the patient may have during the computerized testing.

Post-Service Clinical Labor Activities:

Staff gathers the data, cleans the testing area and offers information regarding the patient's test-taking behavior to the qualified health care professional that will be interpreting the results and writing reports.







AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2005

**Neurobehavioral Status Exam**

The CPT Editorial Panel created four new codes to recognize the different modalities of neurobehavioral and neuropsychological testing. The HCPAC examined the CPT descriptors for the neurobehavioral status exam codes and determined that clarification was needed to specify the psychologist's or physician's time as well as face-to-face time. **The HCPAC requested that CPT amend the code descriptors for 96116, 96118, 96119 and 96120 as indicated. The CPT Editorial Panel Executive Committee accepted the descriptor modifications for 96116, 96118, 96119 and 96120.**

The HCPAC valued codes 96116-96120 based on the amended descriptors. After examination, the HCPAC used the same methodology as associated with codes 9610X-9610X2 when developing the service times and work RVUs. The HCPAC agreed that a 10% increase in the IWPUT from codes 9610X-9610X1 would appropriately reflect an increase the Work RVUs for codes 96116-96119 due to the increased mental effort, technical skill and physical effort associated with these codes. The Work RVU for 96120 was directly crosswalked from 9610X2. Additionally, the pre-, intra- and post- service times for 96116-96120 were crosswalked from 9610X-9610X2.

**The HCPAC recommends the service times for codes 96116, 96118, 96119 and 96120 as indicated in the table below. The HCPAC recommends 2.05 work RVU for code 96116, 2.05 for code 96118, 0.55 for code 96119 and 0.51 for code 96120.**

Code	Pre-Service	Intra-Service	Post-Service	Work RVU	Crosswalk
96116	7	60	0	2.05	9610X
96118	7	60	0	2.05	9610X
96119	3	15	5	0.55	9610X1
96120	8	8	14	0.51	9610X2

Practice Expense

After extensive discussion, **the HCPAC amended the practice expense to reflect PEAC standards.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(D) 96115		<p>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour</p> <p><i>(96115 has been deleted. To report, use 96116)</i></p> <p><i>(For mini-mental status examination performed by a physician, see <b>Evaluation and Management</b> service codes)</i></p>	XXX	N/A
● 96116	EE1	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report	XXX	2.05
(D) 96117		<p>Neuropsychological testing battery (eg, Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour</p> <p><i>(96117 has been deleted. To report, see 96118, 96119, 96120)</i></p>	XXX	N/A
● 96118	EE2	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report	XXX	2.05
● 96119	EE3	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); with report, administered by technician, face-to-face per hour of technician time	XXX	0.55

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 96120	EE4	Neuropsychological testing (eg, Wisconsin Card Sorting Test); administered by a computer, with report	XXX	0.51

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:96116 Tracking Number: EE1 Global Period. XXX

Specialty Society RVU: **3.00**

RUC RVU: **2.05**

CPT Descriptor: Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old woman is referred by her neurologist due to family reports of changes in her behavior including attentional difficulties, memory problems and difficulties with problem-solving. A neurobehavioral status exam is completed for the purpose of making a medical diagnosis.

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? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review referral and accompanying records. Select methods to evaluate neurobehavioral status.

Description of Intra-Service Work: Meet with patient and, if appropriate, significant others; perform neurobehavioral status exam, which includes screening for impairments in acquired knowledge, attention, language, learning, memory, problem solving, and visual-spatial abilities. Observe behavior and record responses.

Description of Post-Service Work: Review findings of neurobehavioral status examination; develop clinical impression and produce written summary of findings, including recommendations for further assessment, treatment and/or follow up. Arrange for additional services as needed.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	James Georgoulakis, PhD; Antonio Puente, PhD, Robert McCaffrey, PhD, Neil Pliskin, PhD, Michael Westerveld, PhD				
<b>Specialty(s):</b>	Psychology				
<b>CPT Code:</b>	96116				
<b>Sample Size:</b>	120	<b>Resp n:</b>	78	<b>Response:</b>	65.00 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.50	2.83	<b>3.00</b>	3.50	6.02
<b>Pre-Service Evaluation Time:</b>			7.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	7.00	17.00	<b>60.00</b>	40.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>0.00</u>				

<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60), 99292 (30); 99233 (41); 99232 (30), 99231 (19); 99238 (36); 99215 (59), 99214 (38); 99213 (23), 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
90801	XXX	2.80

CPT Descriptor Psychiatric diagnostic interview evaluation.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
96111	XXX	2.60

CPT Descriptor Developmental testing; extended (includes assessment of motor, language, social, adaptive and/cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35      % of respondents: 44.8 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96116	Key Reference CPT Code: 90801
Median Pre-Service Time	7.00	10.00
Median Intra-Service Time	60.00	60.00
Median Immediate Post-service Time	0.00	55.00
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
<b>Median Total Time</b>	<b>67.00</b>	<b>125.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	5.00	4.00
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
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Urgency of medical decision making	4.00	3.00
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	5.00	4.00
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Physical effort required	3.00	2.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.00	3.00
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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
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
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Intra-Service intensity/complexity	4.00	4.00
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Post-Service intensity/complexity	3.00	3.00
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**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 majority of respondents chose 90801 (psychiatric diagnostic interview examination). While the median RVU for 9611X is slightly higher than that for 90801, our survey results indicate that the time required, and complexity of the patients combined with the number of potential diagnoses (ICD versus DSM) exceed the work required for 90801. Our 78 respondents indicated that the number of possible diagnoses and management options, and the technical skill required

to perform a neurobehavioral status exam rank higher than for a psychiatric diagnostic interview. Plus, the median intraservice and post-service times for the new code are at least double the median times for the reference service.

Recognizing that the code is reimbursed on a per hour basis, APA took worked diligently to educate its survey participants about assigning a relative value for the new code. Our members were advised to consider the total amount of time that they spent providing the service, and then break the total amount of work down to a per hour basis in order to assign a work RVU. In some case, our respondents listed an RVU and provided the mathematical formula that they use to divide the total time by the ratio that they'd determined between the new code and reference service in order to justify their recommended RVU. In the cases where an extremely high RVU was listed, it is impossible to determine if that was the actual per hour RVU that they proposed, or if they did not break the value down to a per hour basis.

## 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) 96115

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychology                      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? 280000

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?  
96,068 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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96118 Tracking Number: EE2 Global Period: XXX

**Recommended Work Relative Value**Specialty Society RVU: **3.0**RUC RVU: **2.05**

CPT Descriptor: Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scale and Wisconsin Card Sorting Test); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 23-year old man is referred by his neurologist due to post-concussion symptoms secondary to a motor vehicle accident. A series of neuropsychological tests is administered by a provider for the purpose of making medical diagnosis.

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: Consult with referring clinician regarding referral questions; review history; select appropriate procedures needed to address referral question, and select appropriate neuropsychological test instruments.

Description of Intra-Service Work: Administration of standardized test procedures by qualified health professional includes observation of test-taking behavior and recording observations, and creating a record of patient responses to test questions and procedures.

Description of Post-Service Work: Score and compare test procedures. Interpret individual tests and aggregate battery of tests to formulate clinical and diagnostic impression. Create a written report summarizing observations of test behavior interpretation of test results and findings that includes diagnostic formulation and overall clinical impression, develop clinical impression and produce written summary of findings, including recommendations for further assessment treatment and/or follow-up, feedback to patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	James Georgoulakis, PhD; Antonio Puente, PhD, Robert McCaffrey, PhD; Neil Pliskin, PhD, Michael Westerveld, PhD				
<b>Specialty(s):</b>	Psychology				
<b>CPT Code:</b>	96118				
<b>Sample Size:</b>	120	<b>Resp n:</b>	58	<b>Response:</b>	48.33 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.50	2.80	3.00	3.23	9.80
<b>Pre-Service Evaluation Time:</b>			7.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	6.00	29.00	60.00	50.00	63.00

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>
96111	XXX	2.60

CPT Descriptor Developmental testing; extended (includes assessment of motor, language, social, adaptive and/o cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) wit interpretation and report

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
90801	XXX	2.80

CPT Descriptor Psychiatric diagnostic interview evaluation

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC i available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 38      % of respondents: 65.5 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 96118</u>	<u>Key Reference CPT Code: 96111</u>
Median Pre-Service Time	7 00	5.00
Median Intra-Service Time	60.00	60.00
Median Immediate Post-service Time	0 00	30 00
Median Critical Care Time	0.0	0 00
Median Other Hospital Visit Time	0 0	0 00
Median Discharge Day Management Time	0 0	0.00
Median Office Visit Time	0 0	0 00
<b>Median Total Time</b>	<b>67.00</b>	<b>95.00</b>

**INTENSITY/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
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.00
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Urgency of medical decision making	4.00	3.00
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	5.00	4.00
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Physical effort required	3.00	3.00
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.00	3.00
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Outcome depends on the skill and judgment of physician	5.00	4.00
--	------	------

Estimated risk of malpractice suit with poor outcome	3.00	3.00
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
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Intra-Service intensity/complexity	4.00	4.00
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Post-Service intensity/complexity	5.00	4.00
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**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 majority of respondents chose 96111 (developmental testing) as the reference service. Comparing the median pre, intra and post service times for the new code with those for the reference services indicates that a neurobehavioral status exam is far more time intensive than developmental testing. In addition, our respondents indicated that the overall skill, and mental effort and judgement associated with the new code is greater than for the reference service.

APA worked diligently to educate its survey participants about assigning a relative value for the new code. Our members were advised to consider the total amount of time that they spent providing the service, and then break the total amount of work down to a per hour basis in order to assign a work RVU. In some cases, our respondents listed an RVU and provided the mathematical formula that they used to divide the total time by the ratio that they'd determined between the new code and reference service in order to justify their recommended RVU. In the cases where an extremely high RVU was listed, it is impossible to determine if that was the actual per hour RVU that they proposed, or if they did not break the value down to a per hour basis.

**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) 96117

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychology                      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? 658500  
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?  
219,504 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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96119 Tracking Number: EE3 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: **2.21**  
RUC RVU: **0.55**

CPT Descriptor: Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scale; and Wisconsin Card Sorting Test); with report, administered by technician, face-to-face per hour of technician time.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 23-year old man is referred by his neurologist due to post-concussion symptoms secondary to a motor vehicle accident. A series of neuropsychological tests is administered by a technician for the purpose of making a medical diagnosis.

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: The qualified health care professional reviews the complete medical and developmental records provided by the referring physician and selects a comprehensive battery of neuropsychological tests.

Description of Intra-Service Work: The patient arrives for the appointment and meets with the qualified health care professional, who conducts a comprehensive clinical interview. The qualified health care professional gathers additional information from the patient about the nature of the complaint and the history of the presenting problems. Based on the clinical history, final selection of tests to be administered is made. The procedures are explained to the patient, and the patient is introduced to the technician, who administers the objective tests. During testing, the qualified health care professional frequently checks with the technician to monitor the patient's performance and make any necessary modifications to the test battery or assessment plan. When all tests have been administered, the qualified health care professional meets with the patient again to answer any questions.

Description of Post-Service Work: After completion of the assessment, all standardized test procedures are reviewed and scored. Scoring tests that require a verbal responses requires reviewing the responses (which are recorded verbatim during the examination as part of the intra-service activity) and comparing the responses with the standardization sample responses and assigning a score. Since there is virtually an infinite combination of possible responses, assignment of an accurate score requires judgment and experience on the part of the examiner.

After all tests are scored, the results are reviewed to identify the areas in which the patient demonstrated intact performance or clinically significant impairments. Taking into account the patient's history and clinical information, a diagnostic impression is formed, and a written report is prepared. A follow-up session is scheduled with the patient to provide feedback about the test results, and recommendations for follow-up that may include referral to another medical specialist or working with the referring physician to develop a rehabilitation plan.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2005		
<b>Presenter(s):</b>	James Georgoulakis, PhD; Antonio Puente, PhD, Robert McCaffrey, PhD, Neil Pliskin, PhD, Michael Westerveld, PhD		
<b>Specialty(s):</b>	Psychology		
<b>CPT Code:</b>	96119		
<b>Sample Size:</b>	120	<b>Resp n:</b>	54
		<b>Response:</b>	45.00 %

Sample Type: Panel					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:	1.00	2 21	2.60	3 00	6 02
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	16.00	15.00	32.00	128.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>5.00</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

Sample Type: Panel					
	Low	25 <sup>th</sup> pctl	Median*	75th pctl	High
Survey RVW:	1.00	2.21	2.60	3.00	6.02
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	16.00	15.00	32.00	128.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>5.00</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23), 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
96111	XXX	2.60

CPT Descriptor Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
90801	XXX	2.8

CPT Descriptor 1 Psychiatric diagnostic interview evaluation

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 41      % of respondents: 75.9 %**

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96119	Key Reference CPT Code: 96111
Median Pre-Service Time	3.00	5.00
Median Intra-Service Time	15.00	30.00
Median Immediate Post-service Time	5.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	23.00	65.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.00
Urgency of medical decision making	4.00	3.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	4.00
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 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	3.00	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.*

We are recommending the 25th percentile work value of 2.70 work RVUs. This recommendation is based on the fact that the use of technicians for neuropsychological testing occurs less frequently compared to the base code where the psychologist does the testing, interpretation and report (currently noted as 96101).

Fifty-nine percent of our respondents reported performing the service 50 or more times in a year. Of that 59%, the median work RVU was 2.7; the same as the 25<sup>th</sup> percentile value for the total population of respondents. Because of this comparison and the less common nature of this service we are much more confident about the data in the 25th percentile.

In addition, the total service time is much lower than for the base code. The median work value did not reflect the reduction in intra-service work time while the 25th percentile comes much closer to doing that plus recognizing the pre and post-service work that is required of the qualified health professional.

APA worked diligently to educate survey participants about assigning a relative value for the new code. Our members were advised to consider the total amount of time that they spent providing the service, and then break the total amount of work down to a per hour basis in order to assign a work RVU. In some cases, our respondents listed an RVU and provided the mathematical formula that they used to divide the total time by the ratio that they'd determined between the new code and reference service in order to justify their recommended RVU. In the cases where an extremely high RVU was listed, it is impossible to determine if that was the actual per hour RVU that they proposed, or if they did not break the value down to a per hour basis.

### 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) 96117

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychology                      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? 384000  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
128,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes  
If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96120 Tracking Number: EE4 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: **2.6**  
RUC RVU: **0.51**

CPT Descriptor: Neuropsychological testing (eg, Wisconsin Card Sorting Test); administered by a computer, with report

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 23-year old man is referred by his neurologist due to post-concussion symptoms secondary to a motor vehicle accident. A series of individualized set of neuropsychological tests are administered by a computer for the purpose of making a medical diagnosis.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The qualified health care professional reviews the complete medical and developmental records provided by the referring physician or party and selects a comprehensive battery of neuropsychological tests.

Description of Intra-Service Work: The patient arrives for the appointment and meets with the qualified health care professional who conducts a comprehensive clinical interview and review of the presenting complaints. The qualified health care professional explains the computerized testing procedures as part of a more comprehensive test battery that also includes face-to-face testing. The computer test is explained to the patient, and a practice trial is administered to assure adequate understanding of the test, and response requirements. The computer test is administered under the supervision of the qualified health care professional who monitors performance to assure continued engagement in the task. Upon completion, the next test is introduced and the procedures repeated, until all tests are administered.

Description of Post-Service Work: After all computer-administered tests are completed, the qualified health care professional obtains the results from the computer and integrates the findings with the results of other tests. After all tests are scored, the results are reviewed to identify the areas in which the patient demonstrated intact performance or clinically significant impairments. Taking into account the patient's history and clinical information, a diagnostic impression is formed, and a written report is prepared. A follow-up session is scheduled with the patient to provide feedback about the test results, and recommendations for follow-up that may include referral to another medical specialist or working with the referring physician to develop a rehabilitation plan.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2005			
<b>Presenter(s):</b>	James Georgoulakis, PhD; Antonio Puente, PhD, Robert McCaffrey, PhD; Neil Pliskin, PhD, Michael Westerveld, PhD				
<b>Specialty(s):</b>	Psychology				
<b>CPT Code:</b>	96120				
<b>Sample Size:</b>	120	<b>Resp n:</b>	49	<b>Response:</b>	40.83 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.60	2.00	<b>2.60</b>	2.99	5.20
<b>Pre-Service Evaluation Time:</b>			<b>8.0</b>		

Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		1 00	9.00	8.00	34.00	154 00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>14.00</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>
96111	XXX	2.60

CPT Descriptor Developmental testing; extended (includes assessment of motor, language, social, adaptive and/o cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
90801	XXX	2.8

CPT Descriptor 1 Psychiatric diagnostic interview evaluation.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
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CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 36      % of respondents: 73.4 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96120	Key Reference CPT Code: 96111
Median Pre-Service Time	8 00	5.00
Median Intra-Service Time	8.00	60.00
Median Immediate Post-service Time	14 00	30 00
Median Critical Care Time	0 0	0.00
Median Other Hospital Visit Time	0.0	0 00
Median Discharge Day Management Time	0 0	0.00
Median Office Visit Time	0 0	0 00
Median Total Time	30.00	95.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	0.00
Urgency of medical decision making	4.00	3.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.00	4.00
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 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	3.00	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.*

We are recommending the 25th percentile work value of 2.70 work RVUs. This recommendation is based on the fact that the use of computers for neuropsychological testing much less frequently than compared to the base code where the psychologist does the testing, interpretation and report (currently noted as 9611X), or when testing is administered by a technician (currently noted as 96118). Thirty-two percent of our respondents performed computer-assisted testing 50 or

more times in the last year. Sixteen percent reported having performed it between only 20 and 45 times in the past year. The occasional nature of this service makes us much more confident about the data in the 25th percentile.

In addition, the total service time is much lower than for the base code. The median work value did not reflect the reduction in intra-service work time while the 25th percentile comes much closer to doing that plus recognizing the pre and post-service work that is required of the qualified health professional.

APA worked diligently to educate survey participants about assigning a relative value for the new code. Our members were advised to consider the total amount of time that they spent providing the service, and then break the total amount of work down to a per hour basis in order to assign a work RVU. In some cases, our respondents listed an RVU and provided the mathematical formula that they used to divide the total time by the ratio that they'd determined between the new code and reference service in order to justify their recommended RVU. In the cases where an extremely high RVU was listed, it is impossible to determine if that was the actual per hour RVU that they proposed, or if they did not break the value down to a per hour basis.

### 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) 96117

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychology                      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? 54000

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?**  
18,000 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

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: 96116 - Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report.

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:

Our practice expense committee included 20 psychologists who focus on testing services in their practices. The group received the practice expense survey as a standardized approach to determining the clinical staff time, supplies and equipment required to provide the service. Discussions were conducted among the group via email, and consensus data was developed.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff greets the patient and educates her/him about the components of the testing process. The technician also reviews the patient's chart to verify the instruments that will be needed for the status exam and prepares the testing area.

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

Staff cleans the testing area.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: 96118 - Neuropsychological testing (e.g. Halsted-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); per hour of the psychologist's time, both face-to-face time with the patient and time preparing the report.

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:

Our practice expense committee included 20 psychologists who focus on testing services in their practices. The group received the practice expense survey as a standardized approach to determining the clinical staff time, supplies and equipment required to provide the service. Discussions were conducted among the group via email, and consensus data was developed.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff greets the patient and educates him/her about the components of the testing process. The technician also reviews the patient's chart to verify the instruments that will be needed for the status exam and prepares the testing area.

Intra-Service Clinical Labor Activities:

None.

Post-Service Clinical Labor Activities:

Staff cleans the testing area.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: 96119 - Neuropsychological testing (e.g. Halsted-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); with report administered by a technician, face-to-face per hour of technician time.

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:

Our practice expense committee included 20 psychologists who focus on testing services in their practices. The group received the practice expense survey as a standardized approach to determining the clinical staff time, supplies and equipment required to provide the service. Discussions were conducted among the group via email, and consensus data was developed.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff greets the patient and educates her/him about the components of the testing process. The technician also reviews the patient's chart to verify the tests that will be performed, instruments that will be needed for the testing process and prepares the testing area.

Intra-Service Clinical Labor Activities:

The technician explains each test to the patient, providing information about the tests' purposes, and instructions for completing them. The technician answers questions that the patient may have about the tests. The technician also records the patient's test-taking behaviors. Throughout the process, the technician also discusses the testing progress with the qualified health care professional.

Post-Service Clinical Labor Activities:

The technician scores the tests, gathers all of the data and meets with the qualified health care professional to discuss the testing process and his/her observations of the patient.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Non Facility Direct Inputs**

CPT Long Descriptor: Neuropsychological testing (e.g. Wisconsin Card Sorting Test); administered by a computer, with report.

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:

Our practice expense committee included 20 psychologists who focus on testing services in their practices. The group received the practice expense survey as a standardized approach to determining the clinical staff time, supplies and equipment required to provide the service. Discussions were conducted among the group via email, and consensus data was developed.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff review the patient's chart, greet the patient and education them about the testing process. The technician also prepares the testing area.

Intra-Service Clinical Labor Activities:

The clinical staff answer questions that the patient may have during the computerized testing.

Post-Service Clinical Labor Activities:

Staff gather the data, clean the testing area and offer information regarding the patient's test-taking behavior to the qualified health care professional who will be interpreting the results and writing reports.

	A	B	C	D	E	F	G
1							
2				9611X		9611X1	
	Meeting Date: Specialty:			Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report		Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report.	
3							
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD	None					
6	TOTAL CLINICAL LABOR TIME	Assigned	Psychometrist	0.0		0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	Assigned	Psychometrist	0.0		0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	Assigned	Psychometrist	0.0		0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	None					
10	PRE-SERVICE	Assigned	Psychometrist	0.0		0.0	0.0
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	None					
		Assigned	Psychometrist				
23	Greet patient and provide gowning	None					
24	Obtain vital signs	Assigned	Psychometrist				
25	Provide pre-service education/obtain consent/explain tests and procedures	None					
		Assigned	Psychometrist				
26	Prepare room, equipment, supplies	None					
27	Setup scope (non facility setting only)	Assigned	Psychometrist				
28	Prepare and position patient/ monitor patient/ set up IV						

	A	B	C	D	E	F	G	
1								
2				9611X		9611X1		
	Meeting Date: Specialty:			Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report		Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report.		
3								
4	<b>LOCATION</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	
29	Sedate/apply anesthesia	None Assigned	Psychometrist					
30	<b>Intra-service</b>							
31	Assist physician in performing procedure							
32	<b>Post-Service</b>							
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 data and 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) Gathering data and scoring tests							
42	<b>End: Patient leaves office</b>							
43	<b>POST-SERVICE Period</b>							
44	<b>Start: Patient leaves office/facility</b>							
45	Conduct phone calls/call in prescriptions							
46	<i>Office visits</i> 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	<i>List Number and Level of Office Visits</i>							
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

	A	B	C	D	E	F	G
1							
2				9611X		9611X1	
3	Meeting Date: Specialty:			Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report		Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report.	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
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	<b>MEDICAL SUPPLIES</b>						
59	Neurobehavioral status forms	SK050	item	0.25		0.25	0.25
60	Aphasia Assessment forms	SK003	item	0.25		0.25	0.25
61	Audiocassette	SK007	item	0.25		0.25	0.25
62	Battery, AA	SK095	item	0.25		0.25	0.25
63							
64							
65							
66	Equipment	CMS Code	Unit				
67							
68	Neurobehavioral Status Equipment	E12002	pkg	0.25		0.25	0.25
69	Computer, desktop w/ monitor	ED021	item	0.25		0.25	0.25
70	Printer laser, paper	ED032	item	0.25		0.25	0.25
71							

	A	B	C	H	I	J	K
1				9611X2		9611X3	
2	Meeting Date: Specialty:			Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); with report, administered by technician, face-to-face per hour of technician time.		Neuropsychological testing (eg, Wisconsin Card Sorting Test); administered by a computer, with report.	
3							
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD	None					
6	TOTAL CLINICAL LABOR TIME	Assigned None	Psychometrist	60.0	0.0	20.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	Assigned None	Psychometrist	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	Assigned None	Psychometrist	60.0	0.0	20.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	Assigned	Psychometrist	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	None Assigned None	Psychometrist			3	
23	Greet patient and provide gowning	Assigned	Psychometrist	2		1	
24	Obtain vital signs						
25	Provide pre-service education/obtain consent/explain tests and procedures	None Assigned None	Psychometrist			1	
26	Prepare room, equipment, supplies	Assigned	Psychometrist			1	
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV						

	A	B	C	H	I	J	K
1							
2				9611X2		9611X3	
	Meeting Date: Specialty:			Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); with report, administered by technician, face-to-face per hour of technician time.		Neuropsychological testing (eg, Wisconsin Card Sorting Test); administered by a computer, with report.	
3							
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
29	Sedate/apply anesthesia						
30	Intra-service						
31	Assist physician in performing procedure			51		4	
32	Post-Service						
33	Monitor pt following service/check tubes, monitors, drains						
34	Clean room/equipment by physician staff	None	Psychometrist			1	
35	Clean Scope	Assigned					
36	Clean Surgical Instrument Package						
37	Complete diagnostic forms, lab & X-ray requisitions						
38	Review data and 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) Gathering data and scoring tests			7		9	
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				

	A	B	C	H	I	J	K
1							
2				9611X2		9611X3	
3	Meeting Date: Specialty:			Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); with report, administered by technician, face-to-face per hour of technician time.		Neuropsychological testing (eg, Wisconsin Card Sorting Test); administered by a computer, with report.	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
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	CMS Code	Unit				
59	Neurobehavioral status forms	SK050	item	03		0.3	
60	Aphasia Assessment forms	SK003	item	03		0.3	
61	Audiocassette	SK007	item	03		0.3	
62	Battery, AA	SK095	item	03		0.3	
63							
64							
65							
66	Equipment	CMS Code	Unit				
67							
68	Neurobehavioral Status Equipment	E12002	pkg	03		0.3	
69	Computer, desktop w/ monitor	ED021	item	03		0.3	
70	Printer, laser, paper	ED032	item	03		0.3	
71							