

**RUC Recommendations for
CPT 2009
Volume 1**

**RUC Meetings
September 2007, February 2008 and
April 2008**

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2009**

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CPT 2009 RUC Recommendations

CPT Code	Global 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	New Tech/Service
00225 60211	XXX	N	Feb08	07	Intracranial Procedures Anesthesia	N1	Apr08	04	ASA	10	10		<input checked="" type="checkbox"/>		<input type="checkbox"/>
00562	XXX	R	Feb08	08	CABG Pump Oxygenator Anesthesia	O1	Apr08	05	ASA	22	20	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
00567	XXX	N	Feb08	08	CABG Pump Oxygenator Anesthesia	O2	Apr08	05	ASA	20	18		<input checked="" type="checkbox"/>		<input type="checkbox"/>
11001	ZZZ	R	Feb08	11	Skin Surface Measurement		Editorial			0.30	0.30	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
11201	ZZZ	R	Feb08	11	Skin Surface Measurement		Editorial			0.29	0.29	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
11922	ZZZ	R	Feb08	11	Skin Surface Measurement		Editorial			0.49	0.49	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12031	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			2.17	2.17	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12032	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			2.49	2.49	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12034	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			2.94	2.94	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12035	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			3.44	3.44	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12036	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			4.06	4.06	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12037	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			4.68	4.68	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12041	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			2.39	2.39	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12042	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			2.76	2.76	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12044	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			3.16	3.16	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12045	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			3.65	3.65	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>

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12046	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			4.26	4.26	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12047	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			4.66	4.66	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12051	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			2.49	2.49	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12052	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			2.81	2.81	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12053	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			3.14	3.14	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12054	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			3.47	3.47	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12055	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			4.44	4.44	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12056	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			5.25	5.25	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
12057	010	R	Oct07	EC-J	Dermatology Clarifications		Editorial			5.97	5.97	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
15003	ZZZ	R	Feb08	11	Skin Surface Measurement		Editorial			0.80	0.80	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
15005	ZZZ	R	Feb08	11	Skin Surface Measurement		Editorial			1.60	1.60	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
15201	ZZZ	R	Feb08	11	Skin Surface Measurement		Editorial			1.32	1.32	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
15221	ZZZ	R	Feb08	11	Skin Surface Measurement		Editorial			1.19	1.19	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
15241	ZZZ	R	Feb08	11	Skin Surface Measurement		Editorial			1.86	1.86	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
15261	ZZZ	R	Feb08	11	Skin Surface Measurement		Editorial			2.23	2.23	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
15341	ZZZ	R	Feb08	11	Skin Surface Measurement		Editorial			0.50	0.50	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
19296	000	R	Jun07	08	Breast Catheter Placement		Editorial			3.63	3.63	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
19297	ZZZ	R	Jun07	08	Breast Catheter Placement		Editorial			1.72	1.72	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
20696	090	N	Oct07	04	Computer Dependent External Fixation		Apr08	06	AAOS	19.75	17.32		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>

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20697	000	N	Oct07	04	Computer Dependent External Fixation		Apr08	06	AAOS	1.40	0 00		<input checked="" type="checkbox"/>	Practice Expense Only	<input checked="" type="checkbox"/>
22856	090	N	Feb08	72	Cervical Arthroplasty	Q1	Apr08	07	AAOS, NASS, AANS/CNS	23.40	23.90		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
22857	090	R	Feb08	72	Cervical Arthroplasty		Apr08	07	AAOS, NASS, AANS/CNS	26.93	26.93	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
22861	090	N	Feb08	72	Cervical Arthroplasty	Q2	Apr08	07	AAOS, NASS, AANS/CNS	32.71	33.21		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
22862	090	R	Feb08	72	Cervical Arthroplasty		Apr08	07	AAOS, NASS, AANS/CNS	32.43	32.43	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
22864	090	N	Feb08	72	Cervical Arthroplasty	Q3	Apr08	07	AAOS, NASS, AANS/CNS	28.75	29.25		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
22865	090	R	Feb08	72	Cervical Arthroplasty		Apr08	07	AAOS, NASS, AANS/CNS	31 55	31 55	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
23585	090	R	Feb08	14	Scapular Fracture Treatment		Editorial			14.07	14.07	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
27027	090	N	Oct07	12	Buttock Fasciotomy	J1	Feb08	05	ACS, AAOS	15.92	12.90		<input checked="" type="checkbox"/>		<input type="checkbox"/>
27057	090	N	Oct07	12	Buttock Fasciotomy	J2	Feb08	05	ACS, AAOS	18.67	14.77		<input checked="" type="checkbox"/>		<input type="checkbox"/>
27215	090	R	Feb08	15	Pelvic Bone Fracture	R1	Apr08	08	AAOS	10.45	10.45	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
27216	090	R	Feb08	15	Pelvic Bone Fracture	R2	Apr08	08	AAOS	15.73	15.73	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
27217	090	R	Feb08	15	Pelvic Bone Fracture	R3	Apr08	08	AAOS	14.65	14.65	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
27218	090	R	Feb08	15	Pelvic Bone Fracture	R4	Apr08	08	AAOS	20.93	20.93	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
27396	090	R	Oct07	13	Thigh Tendon Transplant		Editorial			8.04	8.04	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
27397	090	R	Oct07	13	Thigh Tendon Transplant		Editorial			12.46	12.46	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
34806	ZZZ	R	Feb08		Aneurysm Press Sensor Add-On		Editorial			2 06	2.06	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
35535	090	N	Feb08	18	Hepatorenal Bypass	S1	Apr08	09	SVS	38.00	38 00		<input checked="" type="checkbox"/>		<input type="checkbox"/>

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35570	090	N	Feb08	19	Tibial-Tibial Bypass with Vein	T1	Apr08	10	SVS	29.00	29.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
35632	090	N	Feb08	20	Ilio-celiac Bypass, Ilio-mesenteric Bypass and Iliorenal Bypass with Other than Vein	U1	Apr08	11	SVS	36.00	36.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
35633	090	N	Feb08	20	Ilio-celiac Bypass, Ilio-mesenteric Bypass and Iliorenal Bypass with Other than Vein	U2	Apr08	11	SVS	38.98	38.98		<input checked="" type="checkbox"/>		<input type="checkbox"/>
35634	090	N	Feb08	20	Ilio-celiac Bypass, Ilio-mesenteric Bypass and Iliorenal Bypass with Other than Vein	U3	Apr08	11	SVS	35.20	35.20		<input checked="" type="checkbox"/>		<input type="checkbox"/>
41512	090	N	Jun07	12	Tongue Suspension	D1	Sep07	08	AAO-HNS	8.65	6.75		<input checked="" type="checkbox"/>		<input type="checkbox"/>
41530	010	N	Jun07	11	Tongue Base Tissue Volume Reduction	C1	Sep07	07	AAO-HNS	6.00	4.38		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43273	ZZZ	N	Feb08	22	Cholangioscopy-Pancreatoscopy	W1	Apr08	13	AGA, ASGE	2.24	2.24		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
43279	090	N	Feb08	21	Laparoscopic Heller Myotomy	V1	Apr08	12	ACS, SAGES	22.00	22.00		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
46930	090	N	Feb08	23	Hemorrhoidectomy	X1	Apr08	14	ACS, ASCRS	1.56	1.56		<input checked="" type="checkbox"/>		<input type="checkbox"/>
46934	090	D	Feb08	23	Hemorrhoidectomy		Apr08	14					<input checked="" type="checkbox"/>		<input type="checkbox"/>
46935	010	D	Feb08	23	Hemorrhoidectomy		Apr08	14					<input checked="" type="checkbox"/>		<input type="checkbox"/>
46936	090	D	Feb08	23	Hemorrhoidectomy		Apr08	14					<input checked="" type="checkbox"/>		<input type="checkbox"/>
49568	ZZZ	R	Jun07	13	Laparoscopic Abdominal Wall Hernia Repair		Sep07	09	ACS, SAGES	4.88	4.88	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
49652	090	N	Jun07	13	Laparoscopic Abdominal Wall Hernia Repair	F1	Sep07	09	ACS, SAGES	14.50	12.80		<input checked="" type="checkbox"/>		<input type="checkbox"/>
49653	090	N	Jun07	13	Laparoscopic Abdominal Wall Hernia Repair	F2	Sep07	09	ACS, SAGES	18.00	16.10		<input checked="" type="checkbox"/>		<input type="checkbox"/>

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49654	090	N	Jun07	13	Laparoscopic Abdominal Wall Hernia Repair	F3	Sep07	09	ACS, SAGES	16.00	14.95		<input checked="" type="checkbox"/>		<input type="checkbox"/>
49655	090	N	Jun07	13	Laparoscopic Abdominal Wall Hernia Repair	F4	Sep07	09	ACS, SAGES	20.00	18.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
49656	090	N	Jun07	13	Laparoscopic Abdominal Wall Hernia Repair	F5	Sep07	09	ACS, SAGES	17.25	15.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
49657	090	N	Jun07	13	Laparoscopic Abdominal Wall Hernia Repair	F6	Sep07	09	ACS, SAGES	22.00	22.00	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
52601	090	R	Feb08	25	Transurethral Prostate Resection		Editorial			15.13	15.13	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
52606	090	D	Feb08	25	Transurethral Prostate Resection		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
52612	090	D	Feb08	25	Transurethral Prostate Resection		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
52614	090	D	Feb08	25	Transurethral Prostate Resection		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
52620	090	D	Feb08	25	Transurethral Prostate Resection		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
52630	090	R	Feb08	25	Transurethral Prostate Resection		Editorial			7.65	7.65	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
53853	090	D	Feb08	26	Thermotherapy Destruction of Prostate		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
55700	000	R	Feb08	68	Saturation Biopsies		Apr08	15	AUA	2.58	2.58	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
55706	010	N	Feb08	68	Saturation Biopsies	Y1	Apr08	15	AUA	6.25	6.15		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
57400	000	R	Oct07	16	ACOG Clarification		Editorial			2.27	2.27	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
57410	000	R	Oct07	16	ACOG Clarification		Editorial			1.75	1.75	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
57415	010	R	Oct07	16	ACOG Clarification		Editorial			2.44	2.44	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
61793	090	D	Feb08	28	Stereotactic Radiosurgery		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
61796	090	N	Feb08	28	Stereotactic Radiosurgery	Z1	Apr08	16	NASS, AANS/CNS	15.75	15.50		<input checked="" type="checkbox"/>		<input type="checkbox"/>
61797	ZZZ	N	Feb08	28	Stereotactic Radiosurgery	Z2	Apr08	16	NASS, AANS/CNS	3.48	3.48		<input checked="" type="checkbox"/>		<input type="checkbox"/>

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61798	090	N	Feb08	28	Stereotactic Radiosurgery	Z3	Apr08	16	NASS, AANS/CNS	19.75	19.75		<input checked="" type="checkbox"/>		<input type="checkbox"/>
61799	ZZZ	N	Feb08	28	Stereotactic Radiosurgery	Z4	Apr08	16	NASS, AANS/CNS	4.81	4.81		<input checked="" type="checkbox"/>		<input type="checkbox"/>
61800	ZZZ	N	Feb08	28	Stereotactic Radiosurgery	Z5	Apr08	16	NASS, AANS/CNS	2.25	2.25		<input checked="" type="checkbox"/>		<input type="checkbox"/>
62267	000	N	Feb08	29	Interdiscal Percutaneous Aspiration	AA1	Apr08	17	AAOS, NASS, AANS/CNS, ASNR	3.00	3.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
62287	090	R	Feb08	29	Interdiscal Percutaneous Aspiration		Apr08	17	AAOS, NASS, AANS/CNS, ASNR	8.88	8.88	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
63020	090	R	Feb08	30	Endoscopic Cervical Discectomy		Editorial			16.05	16.05	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
63030	090	R	Feb08	30	Endoscopic Cervical Discectomy		Editorial			13.03	13.03	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
63035	ZZZ	R	Feb08	30	Endoscopic Cervical Discectomy		Editorial			3.15	3.15	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
63620	090	N	Feb08	28	Stereotactic Radiosurgery	Z6	Apr08	16	NASS, AANS/CNS	18.00	15.50		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
63621	ZZZ	N	Feb08	28	Stereotactic Radiosurgery	Z7	Apr08	16	NASS, AANS/CNS	4.00	4.00		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
64416	000	R	Feb08	31	Anesthetic Agent Nerve Injection	CC1	Apr08	19	ASA	1.90	1.81		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64446	000	R	Feb08	31	Anesthetic Agent Nerve Injection	CC2	Apr08	19	ASA	1.87	1.81		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64448	000	R	Feb08	31	Anesthetic Agent Nerve Injection	CC3	Apr08	19	ASA	1.70	1.63		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64449	000	R	Feb08	31	Anesthetic Agent Nerve Injection	CC4	Apr08	19	ASA	1.90	1.81		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64455	000	N	Feb08	78	Intermetatarsal Neuroma Injection(s) and Destruction by a Neurolytic Agent	BB1	Apr08	18	APMA, AAOS	0.75	0.75		<input checked="" type="checkbox"/>		<input type="checkbox"/>

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64632	010	N	Feb08	78	Intermetatarsal Neuroma Injection(s) and Destruction by a Neurolytic Agent	BB2	Apr08	18	APMA, AAOS	1.20	1.20		<input checked="" type="checkbox"/>		<input type="checkbox"/>
65710	090	R	Feb08	32	Endothelial Keratoplasty	DD1	Apr08	20	AAO	14.09	14.09	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
65730	090	R	Feb08	32	Endothelial Keratoplasty	DD2	Apr08	20	AAO	15.99	15.99	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
65750	090	R	Feb08	32	Endothelial Keratoplasty	DD3	Apr08	20	AAO	16.60	16.60	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
65755	090	R	Feb08	32	Endothelial Keratoplasty	DD4	Apr08	20	AAO	16.49	16.49	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
65756	090	N	Feb08	32	Endothelial Keratoplasty	DD5	Apr08	20	AAO	16.60	16.60		<input checked="" type="checkbox"/>		<input type="checkbox"/>
65757	ZZZ	N	Feb08	32	Endothelial Keratoplasty	DD6	Apr08	20	AAO	2.75	1.44		<input checked="" type="checkbox"/>		<input type="checkbox"/>
74270	XXX	R	Oct07	18	Colon Radiologic Examination		Editorial			0.69	0.69	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
77003	XXX	R	Feb08	29	Interdiscal Percutaneous Aspiration		Apr08	17	AAOS, NASS, AANS/CNS, ASNR	0.60	0.60	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
77432	XXX	R	Feb08	28	Stereotactic Radiosurgery		Apr08	16	NASS, AANS/CNS	7.92	7.92	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
77435	XXX	R	Feb08	28	Stereotactic Radiosurgery		Apr08	16	NASS, AANS/CNS	13.00	13.00	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
77781	XXX	D	Feb08	36	High Dose Rate Brachytherapy		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
77782	XXX	D	Feb08	36	High Dose Rate Brachytherapy		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
77783	XXX	D	Feb08	36	High Dose Rate Brachytherapy		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
77784	XXX	D	Feb08	36	High Dose Rate Brachytherapy		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
77785	XXX	N	Feb08	36	High Dose Rate Brachytherapy	EE1	Apr08	21	ASTRO	1.66	1.42		<input checked="" type="checkbox"/>		<input type="checkbox"/>
77786	XXX	N	Feb08	36	High Dose Rate Brachytherapy	EE2	Apr08	21	ASTRO	3.10	3.25		<input checked="" type="checkbox"/>		<input type="checkbox"/>

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77787	XXX	N	Feb08	36	High Dose Rate Brachytherapy	EE3	Apr08	21	ASTRO	5.60	4.89		<input checked="" type="checkbox"/>		<input type="checkbox"/>
78808	XXX	N	Feb08	37	Radiopharmaceutical Localization Injection	FF1	Apr08	22	ACR, SNM/ACNP	0.18	0.18		<input checked="" type="checkbox"/>		<input type="checkbox"/>
78890	XXX	D	Feb08	38	Nuclear Medicine Deletions		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
78891	XXX	D	Feb08	38	Nuclear Medicine Deletions		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
82040	XXX	R	Feb08	43	Blood Specimen Testing		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
82375	XXX	R	Jun07	29	Transcutaneous Carboxyhemoglobin Measurement and Transcutaneous Methemoglobin Quantitative Testing		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
82376	XXX	R	Jun07	29	Transcutaneous Carboxyhemoglobin Measurement and Transcutaneous Methemoglobin Quantitative Testing		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
83876	XXX	N	Feb08	47	Myeloperoxidase		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
83890	XXX	R	Oct07	20	Molecular Diagnostic Code Revisions		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
83891	XXX	R	Oct07	20	Molecular Diagnostic Code Revisions		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
83892	XXX	R	Oct07	20	Molecular Diagnostic Code Revisions		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
83893	XXX	R	Oct07	20	Molecular Diagnostic Code Revisions		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
83894	XXX	R	Oct07	20	Molecular Diagnostic Code Revisions		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
83897	XXX	R	Oct07	20	Molecular Diagnostic Code Revisions		CLFS						<input type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service
83907	XXX	R	Oct07	20	Molecular Diagnostic Code Revisions		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
83909	XXX	R	Oct07	20	Molecular Diagnostic Code Revisions		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
83925	XXX	R	Feb08	42	Therapeutic Drug Assays		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
83950	XXX	R	Feb08	40	Des-Gamma-Carboxy-Prothrombin		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
83951	XXX	N	Feb08	40	Des-Gamma-Carboxy-Prothrombin		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
84132	XXX	R	Feb08	43	Blood Specimen Testing		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
84155	XXX	R	Feb08	43	Blood Specimen Testing		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
84295	XXX	R	Feb08	43	Blood Specimen Testing		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
85397	XXX	N	Oct07	22	Coagulation Functional Activity		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
86822	XXX	R	Oct07	23	Human Lymphocyte Antigen		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
87810	XXX	R	Oct07	24	Micro Code Revision		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
87905	XXX	N	Feb08	49	Sialidase Activity Test for Bacterial Vaginosis		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
88400	XXX	D	Jun07	29	Transcutaneous Carboxyhemoglobin Measurement and Transcutaneous Methemoglobin Quantitative Testing		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
88720	XXX	N	Jun07	29	Transcutaneous Carboxyhemoglobin Measurement and Transcutaneous Methemoglobin Quantitative Testing		CLFS						<input type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service
88740	XXX	N	Jun07	29	Transcutaneous Carboxyhemoglobin Measurement and Transcutaneous Methemoglobin Quantitative Testing		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
88741	XXX	N	Jun07	29	Transcutaneous Carboxyhemoglobin Measurement and Transcutaneous Methemoglobin Quantitative Testing		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
90650	XXX	N	Jun07	14	Human Papilloma Virus Vaccine		Vaccine						<input type="checkbox"/>		<input type="checkbox"/>
90681	XXX	N	Jun07	15	Rotavirus Vaccine		Vaccine						<input type="checkbox"/>		<input type="checkbox"/>
90699	XXX	N	Jun07	15	Combination DTaP Polio Vaccine		Vaccine						<input type="checkbox"/>		<input type="checkbox"/>
90738	XXX	N	Oct07	26	Japanese Encephalitis Vaccine		Vaccine						<input type="checkbox"/>		<input type="checkbox"/>
90760	XXX	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90761	ZZZ	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90765	XXX	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90766	ZZZ	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90767	ZZZ	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90768	ZZZ	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90769	XXX	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service
90770	ZZZ	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90771	ZZZ	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90772	XXX	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90773	XXX	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90774	XXX	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90775	ZZZ	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90776	ZZZ	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90779	XXX	D	Oct07	27	Infusion Administration Clarification		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90918	XXX	D	Oct07	29	End Stage Renal Disease (ESRD) Services		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90919	XXX	D	Oct07	29	End Stage Renal Disease (ESRD) Services		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90920	XXX	D	Oct07	29	End Stage Renal Disease (ESRD) Services		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90921	XXX	D	Oct07	29	End Stage Renal Disease (ESRD) Services		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90922	XXX	D	Oct07	29	End Stage Renal Disease (ESRD) Services		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90923	XXX	D	Oct07	29	End Stage Renal Disease (ESRD) Services		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service
90924	XXX	D	Oct07	29	End Stage Renal Disease (ESRD) Services		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90925	XXX	D	Oct07	29	End Stage Renal Disease (ESRD) Services		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
90951	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K1	Feb08	06	RPA	18.46	18.46		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90952	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K2	Feb08	06	RPA	Carrier Priced	Carrier Priced		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90953	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K3	Feb08	06	RPA	Carrier Priced	Carrier Priced		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90954	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K4	Feb08	06	RPA	15.98	15.98		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90955	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K5	Feb08	06	RPA	11.25	8.79		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90956	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K6	Feb08	06	RPA	6.75	5.95		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90957	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K7	Feb08	06	RPA	13.50	12.52		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90958	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K8	Feb08	06	RPA	9.00	8.34		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90959	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K9	Feb08	06	RPA	4.50	5.50		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90960	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K10	Feb08	06	RPA	5.76	5.18		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90961	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K11	Feb08	06	RPA	4.26	4.26		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90962	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K12	Feb08	06	RPA	3.47	3.47		<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service
90963	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K13	Feb08	06	RPA	11.00	10.56		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90964	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K14	Feb08	06	RPA	9.63	9 14		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90965	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K15	Feb08	06	RPA	8.25	8.69		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90966	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K16	Feb08	06	RPA	4.32	4.26		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90967	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K17	Feb08	06	RPA	0 35	0.35		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90968	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K18	Feb08	06	RPA	0.30	0.30		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90969	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K19	Feb08	06	RPA	0.29	0.29		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90970	XXX	N	Oct07	29	End Stage Renal Disease (ESRD) Services	K20	Feb08	06	RPA	0.14	0 14		<input checked="" type="checkbox"/>		<input type="checkbox"/>
91100	XXX	D	Oct07	30	Deletion of Code 91100		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93224	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0.52	0.52	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93225	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0.00	0 00	Yes	<input checked="" type="checkbox"/>	Practice Expense Only	<input type="checkbox"/>
93226	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0.00	0 00	Yes	<input checked="" type="checkbox"/>	Practice Expense Only	<input type="checkbox"/>
93227	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0.52	0.52	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93228	XXX	N	Oct07	31	Cardiac Device Monitoring	L22	Apr08	23	ACC	1.20	0.52		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93229	XXX	N	Oct07	31	Cardiac Device Monitoring	L23	Apr08	23	ACC	0.00	0.00		<input checked="" type="checkbox"/>	Practice Expense Only	<input checked="" type="checkbox"/>

CPT Code	Global 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	New Tech/Service
93230	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0.52	0.52	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93231	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0 00	0.00	Yes	<input checked="" type="checkbox"/>	Practice Expense Only	<input type="checkbox"/>
93232	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0 00	0.00	Yes	<input checked="" type="checkbox"/>	Practice Expense Only	<input type="checkbox"/>
93233	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0.52	0.52	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93235	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	Carrier Priced	Carrier Priced	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93236	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	Carrier Priced	Carrier Priced	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93237	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0.45	0.45	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93238	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0.52	0.52	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93270	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0.00	0.00	Yes	<input checked="" type="checkbox"/>	Practice Expense Only	<input type="checkbox"/>
93271	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0.00	0.00	Yes	<input checked="" type="checkbox"/>	Practice Expense Only	<input type="checkbox"/>
93272	XXX	R	Oct07	31	Cardiac Device Monitoring		Editorial		ACC	0.52	0.52	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93279	XXX	N	Oct07	31	Cardiac Device Monitoring	L1	Apr08	23	ACC	0.74	0.65		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93280	XXX	N	Oct07	31	Cardiac Device Monitoring	L2	Apr08	23	ACC	0.92	0.77		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93281	XXX	N	Oct07	31	Cardiac Device Monitoring	L3	Apr08	23	ACC	1.09	0.90		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93282	XXX	N	Oct07	31	Cardiac Device Monitoring	L4	Apr08	23	ACC	0.91	0.85		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93283	XXX	N	Oct07	31	Cardiac Device Monitoring	L5	Apr08	23	ACC	1.20	1.18		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93284	XXX	N	Oct07	31	Cardiac Device Monitoring	L6	Apr08	23	ACC	1.39	1.25		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93285	XXX	N	Oct07	31	Cardiac Device Monitoring	L7	Apr08	23	ACC	0.60	0.52		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>

CPT Code	Global 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	New Tech/Service
93286	XXX	N	Oct07	31	Cardiac Device Monitoring	L8	Apr08	23	ACC	0.60	0.30		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93287	XXX	N	Oct07	31	Cardiac Device Monitoring	L9	Apr08	23	ACC	0.90	0.45		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93288	XXX	N	Oct07	31	Cardiac Device Monitoring	L10	Apr08	23	ACC	0.65	0.43		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93289	XXX	N	Oct07	31	Cardiac Device Monitoring	L11	Apr08	23	ACC	1.03	0.92		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93290	XXX	N	Oct07	31	Cardiac Device Monitoring	L12	Apr08	23	ACC	0.65	0.43		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93291	XXX	N	Oct07	31	Cardiac Device Monitoring	L13	Apr08	23	ACC	0.52	0.43		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93292	XXX	N	Oct07	31	Cardiac Device Monitoring	L14	Apr08	23	ACC	0.75	0.43		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93293	XXX	N	Oct07	31	Cardiac Device Monitoring	L15	Apr08	23	ACC	0.25	0.32		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93294	XXX	N	Oct07	31	Cardiac Device Monitoring	L16	Apr08	23	ACC	0.80	0.65		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93295	XXX	N	Oct07	31	Cardiac Device Monitoring	L17	Apr08	23	ACC	1.28	1.38		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93296	XXX	N	Oct07	31	Cardiac Device Monitoring	L18	Apr08	23	ACC	0.00	0.00		<input checked="" type="checkbox"/>	Practice Expense Inputs Only	<input checked="" type="checkbox"/>
93297	XXX	N	Oct07	31	Cardiac Device Monitoring	L19	Apr08	23	ACC	1.30	0.52		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93298	XXX	N	Oct07	31	Cardiac Device Monitoring	L20	Apr08	23	ACC	1.14	0.52		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
93299	XXX	N	Oct07	31	Cardiac Device Monitoring	L21	Apr08	23	ACC	0.00	0.00		<input checked="" type="checkbox"/>	Practice Expense Inputs Only	<input checked="" type="checkbox"/>
93306	XXX	N	Jun07	18	Echocardiography	G1	Sep07	10	ACC	1.30	1.30		<input checked="" type="checkbox"/>		<input type="checkbox"/>
93307	XXX	R	Jun07	18	Echocardiography		Sep07	10	ACC	0.92	0.92	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93320	ZZZ	R	Jun07	18	Echocardiography		Sep07	10	ACC	0.38	0.38	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93321	ZZZ	R	Jun07	18	Echocardiography		Sep07	10	ACC	0.15	0.15	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
93325	ZZZ	R	Jun07	18	Echocardiography		Sep07	10	ACC	0.07	0.07	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service
93350	XXX	R	Feb08	55	Stress Echo with ECG Monitoring	GG1	Apr08	24	ACC	1.48	1.48	Yes	<input checked="" type="checkbox"/>	RUC to review in October 2008	<input type="checkbox"/>
93351	XXX	N	Feb08	55	Stress Echo with ECG Monitoring	GG2	Apr08	24	ACC	2.00	1.75		<input checked="" type="checkbox"/>		<input type="checkbox"/>
93352	ZZZ	N	Feb08	55	Stress Echo with ECG Monitoring	GG3	Apr08	24	ACC	0.39	0.19		<input checked="" type="checkbox"/>		<input type="checkbox"/>
93727	XXX	D	Oct07	31	Cardiac Device Monitoring		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93731	XXX	D	Oct07	31	Cardiac Device Monitoring		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93732	XXX	D	Oct07	31	Cardiac Device Monitoring		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93733	XXX	D	Oct07	31	Cardiac Device Monitoring		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93734	XXX	D	Oct07	31	Cardiac Device Monitoring		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93735	XXX	D	Oct07	31	Cardiac Device Monitoring		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93736	XXX	D	Oct07	31	Cardiac Device Monitoring		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93741	XXX	D	Oct07	31	Cardiac Device Monitoring		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93742	XXX	D	Oct07	31	Cardiac Device Monitoring		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93743	XXX	D	Oct07	31	Cardiac Device Monitoring		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93744	XXX	D	Oct07	31	Cardiac Device Monitoring		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93760	XXX	D	Feb08	58	Thermography Deletions		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
93762	XXX	D	Feb08	58	Thermography Deletions		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
95010	XXX	R	Jun07	19	Allergy Test and Interpretation		Editorial			0.15	0.15	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
95015	XXX	R	Jun07	19	Allergy Test and Interpretation		Editorial			0.15	0.15	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
95250	XXX	R	Feb08	59	Glucose Monitoring		Editorial			0.00	0.00	Yes	<input checked="" type="checkbox"/>	Practice Expense Only	<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service
95251	XXX	R	Feb08	59	Glucose Monitoring		Editorial			0.85	0.85	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
95803	XXX	N	Feb08	73	Actigraphy Sleep Assessment	HH1	Apr08	25	AAN, AASM, ACCP/ATS	1.00	1.00		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95980	XXX	R	Feb08	67	Gastric Neurostimulator Reprogramming	JJ1	Apr08	27	AGA	0.80	0.80	Yes	<input checked="" type="checkbox"/>	Deletion of 0162T may affect utilization - code added to new technology list	<input checked="" type="checkbox"/>
95981	XXX	R	Feb08	67	Gastric Neurostimulator Reprogramming	JJ2	Apr08	27	AGA	0.30	0.30	Yes	<input checked="" type="checkbox"/>	Deletion of 0162T may affect utilization - code added to new technology list	<input checked="" type="checkbox"/>
95982	XXX	R	Feb08	67	Gastric Neurostimulator Reprogramming	JJ3	Apr08	27	AGA	0.65	0.65	Yes	<input checked="" type="checkbox"/>	Deletion of 0162T may affect utilization - code added to new technology list	<input checked="" type="checkbox"/>
95992	XXX	N	Feb08	62	Canalith Repositioning	II1	Apr08	26	AAN, AASM, ACCP/ATS	0.75	0.75		<input checked="" type="checkbox"/>		<input type="checkbox"/>
96360	XXX	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.17	0.17	Yes	<input checked="" type="checkbox"/>	Renumbered from 90760	<input type="checkbox"/>
96361	ZZZ	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.09	0.09	Yes	<input checked="" type="checkbox"/>	Renumbered from 90761	<input type="checkbox"/>
96365	XXX	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.21	0.21	Yes	<input checked="" type="checkbox"/>	Renumbered from 90765	<input type="checkbox"/>
96366	ZZZ	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.18	0.18	Yes	<input checked="" type="checkbox"/>	Renumbered from 90766	<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service
96367	ZZZ	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.19	0.19	Yes	<input checked="" type="checkbox"/>	Renumbered from 90767	<input type="checkbox"/>
96368	ZZZ	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.17	0.17	Yes	<input checked="" type="checkbox"/>	Renumbered from 96368	<input type="checkbox"/>
96369	XXX	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.21	0.21	Yes	<input checked="" type="checkbox"/>	Renumbered from 90769	<input type="checkbox"/>
96370	ZZZ	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.18	0.18	Yes	<input checked="" type="checkbox"/>	Renumbered from 90770	<input type="checkbox"/>
96371	ZZZ	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.00	0.00	Yes	<input checked="" type="checkbox"/>	Renumbered from 90771 - Practice Expense Only	<input type="checkbox"/>
96372	XXX	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.17	0.17	Yes	<input checked="" type="checkbox"/>	Renumbered from 90772	<input type="checkbox"/>
96373	XXX	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.17	0.17	Yes	<input checked="" type="checkbox"/>	Renumbered from 90773	<input type="checkbox"/>
96374	XXX	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.18	0.18	Yes	<input checked="" type="checkbox"/>	Renumbered from 90774	<input type="checkbox"/>
96375	ZZZ	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.1	0.10	Yes	<input checked="" type="checkbox"/>	Renumbered from 90775	<input type="checkbox"/>
96376	ZZZ	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.00	0.00	Yes	<input checked="" type="checkbox"/>	Renumbered from 90776 - Practice Expense Only	<input type="checkbox"/>
96379	XXX	N	Oct07	27	Infusion Administration Clarification		Renumbered			0.00	0.00	Yes	<input checked="" type="checkbox"/>	Renumbered from 90779 - Practice Expense Only	<input type="checkbox"/>
99289	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service
99290	ZZZ	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99293	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99294	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99295	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99296	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99298	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99299	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99300	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99354	ZZZ	R	Oct07	10	Prolonged Services Revision		Editorial			1.77	1.77	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99355	ZZZ	R	Oct07	10	Prolonged Services Revision		Editorial			1.77	1.77	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99356	ZZZ	R	Oct07	10	Prolonged Services Revision		Editorial			1.71	1.71	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99357	ZZZ	R	Oct07	10	Prolonged Services Revision		Editorial			1.71	1.71	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99381	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.19	1.19	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service
99382	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.36	1.36	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99383	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.36	1.36	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99384	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.53	1.53	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99385	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.53	1.53	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99386	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.88	1.88	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99387	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			2.06	2.06	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99391	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.02	1.02	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99392	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.19	1.19	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99393	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.19	1.19	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99394	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.36	1.36	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99395	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.36	1.36	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99396	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.53	1.53	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99397	XXX	R	Feb08	10	Preventative Medicine Guidelines		Editorial			1.71	1.71	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
99431	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99432	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99433	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service
99435	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99436	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99440	XXX	D	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
99460	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered			1.17	1.17	Yes	<input checked="" type="checkbox"/>	Renumbered from 99431	<input type="checkbox"/>
99461	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered			1.26	1.26	Yes	<input checked="" type="checkbox"/>	Renumbered from 99432	<input type="checkbox"/>
99462	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered			0.62	0.62	Yes	<input checked="" type="checkbox"/>	Renumbered from 99433	<input type="checkbox"/>
99463	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered			1.50	1.50	Yes	<input checked="" type="checkbox"/>	Renumbered from 99435	<input type="checkbox"/>
99464	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered			1.50	1.50	Yes	<input checked="" type="checkbox"/>	Renumbered from 99436	<input type="checkbox"/>
99465	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered			2.93	2.93	Yes	<input checked="" type="checkbox"/>	Renumbered from 99440	<input type="checkbox"/>
99466	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered			4.79	4.79	Yes	<input checked="" type="checkbox"/>	Renumbered from 99289	<input type="checkbox"/>
99467	ZZZ	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered			2.40	2.40	Yes	<input checked="" type="checkbox"/>	Renumbered from 99290	<input type="checkbox"/>

CPT Code	Global 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	New Tech/Service	
99468	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered				18.46	18.46	Yes	<input checked="" type="checkbox"/>	Renumbered from 99295	<input type="checkbox"/>
99469	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered				7.99	7.99	Yes	<input checked="" type="checkbox"/>	Renumbered from 99296	<input type="checkbox"/>
99471	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered				15.98	15.98	Yes	<input checked="" type="checkbox"/>	Renumbered from 99293	<input type="checkbox"/>
99472	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered				7.99	7.99	Yes	<input checked="" type="checkbox"/>	Renumbered from 99294	<input type="checkbox"/>
99475	XXX	N	Oct07	09	Pediatnc Intensive Care	M1	Feb08	08	AAP		15.00	11.25		<input checked="" type="checkbox"/>		<input type="checkbox"/>
99476	XXX	N	Oct07	09	Pediatric Intensive Care	M2	Feb08	08	AAP		7.77	6.75		<input checked="" type="checkbox"/>		<input type="checkbox"/>
99478	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered				2.75	2.75	Yes	<input checked="" type="checkbox"/>	Renumbered from 99298	<input type="checkbox"/>
99479	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered				2.50	2.50	Yes	<input checked="" type="checkbox"/>	Renumbered from 99299	<input type="checkbox"/>
99480	XXX	N	Oct07	09	Neonatal and Pediatric Global Code Set Renumbering		Renumbered				2.40	2.40	Yes	<input checked="" type="checkbox"/>	Renumbered from 99300	<input type="checkbox"/>

Specialty and Acronym

<u>Society</u>	<u>Acronym</u>
AMA CPT Editorial Panel	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 & Investigators	AAPPI
American Academy of Physical Medicine & Rehabilitation	AAPMR
American Academy of Physician Assistants	AAPA
American Academy of Sleep Medicine	AASM
American Association of Clinical Endocrinologists	AACE
American Association of Hip and Knee Surgeons	AAHKS
American Association of Neurological Surgeons	AANS
American Association of Neuromuscular & Electrodiagnostic	AANEM
American Association of Oral and Maxillofacial Surgeons	AAOMS
American Association of Plastic Surgeons	AAPS
American Burn Association	ABA
American Chiropractic Association	ACA
American Clinical Neurophysiology Society	ACNS

Society**Acronym**

American College of Cardiology	ACC
American College of Chest Physicians	ACCP
American College of Emergency-Physicians	ACEP
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	ACRr
American College of Surgeons	ACS
American Dental Association	ADA
American Dietetic Association	ADiA
American Gastroenterological Association	AGA
American Geriatrics Society	AGS
American Institute of Ultrasound in Medicine	AIUM
American Medical Association	AMA
American Medical Directors Association	AMDA
American Nurses Association	ANA
American Occupational Therapy Association	AOTA
American Optometric Association	AOA
American Orthopaedic Association	AOA-Ortho
American Orthopaedic Foot and Ankle Society	AOFAS
American Osteopathic Association	AOA
American Pediatric Surgical Association	APSA
American Physical Therapy Association	APTA
American Podiatric Medical Association	APMA
American Psychiatric Association	APA
American Psychological Association	APA
American Roentgen Ray Society	ARRS

Society**Acronym**

American Society for Aesthetic Plastic Surgery	ASAPS
American Society for Clinical Pathology	ASCP
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	ASCRS(cat)
American Society of Clinical Oncology	ASCO
American Society of Colon and Rectal Surgeons	ASCRS(col)
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 Ophthalmic Plastic and Reconstructive	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
Association of University Radiologists	AUR
Centers for Medicare and Medicaid Services	CMS
CMD	CMD
College of American Pathologists	CAP

Society**Acronym**

Congress of Neurological Surgeons	CNS
Contact Lens Society of America	CLSA
Infectious Diseases Society of America	IDSA
International Spinal Injection Society	ISIS
International Spine Intervention Society	ISIS
Joint Council of Allergy Asthma and Immunology	JCAAI
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
Practice Expense Review Committee (PERC)	PERC
Radiological Society of North America	RSNA
Renal Physicians Association	RPA
Society for Vascular Surgery	SVS
Society of American Gastrointestinal and Endoscopic Surgeons	SAGES
Society of Critical Care Medicine	SCCM
Society of Interventional Radiology	SIR
Society of Nuclear Medicine	SNM
Society of Thoracic Surgeons	STS
The Endocrine Society	TES
The Triological Society	TTS

AMA/Specialty Society RVS Update Committee Physician Time Recommendations
September 2007, February 2008, and April 2008

CPT Code	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	99291	Total Time	Time Date
00225	20		15	120	20										175	April 2008 New/Revised
00562	30		30	270	30										360	April 2008 New/Revised
00567	30		30	247.5	30										337.5	April 2008 New/Revised
20696	33	15	15	180	30		3	3		2			1		468	April 2008 New/Revised
20697																April 2008 New/Revised
22856	40	20	20	120	30			3			1		1		377	April 2008 New/Revised
22861	40	20	20	180	30			3			2		1		477	April 2008 New/Revised
22864	40	20	20	150	40			3			2		1		457	April 2008 New/Revised
27027	43	12	5	60	30		3	1		3	1		1		359	February 2008 New/Revised
27057	43	12	5	90	30		3	1		3	1		1		389	February 2008 New/Revised
27215	40	15	20	120	20		2	1		2	1		1		388	April 2008 New/Revised
27216	40	25	20	60	25		1	3		3	1		1		393	April 2008 New/Revised
27217	40	15	20	120	25		1	3		3	1		1		443	April 2008 New/Revised
27218	40	40	20	150	30		1	3		5	1		1		543	April 2008 New/Revised
35535	40	15	20	240	30		1	2		2	2	1	1	1	690	April 2008 New/Revised
35570	40	15	20	240	30			3		2	3	1	1		667	April 2008 New/Revised
35632	40	15	20	240	30		1	2		2	2	1	1	1	690	April 2008 New/Revised
35633	40	15	20	240	30		1	2		2	2		1	2	705	April 2008 New/Revised
35634	40	15	20	230	30		1	2		2	2	1	1	1	680	April 2008 New/Revised
41512	15	15	15	60	30		2	1					0.5		209	September 2007 New/Revised
41530	15	10	15	30	20			1	1				1		167	September 2007 New/Revised
43273				45											45	April 2008 New/Revised
43279	40	20	20	150	30			2		1	1		1		404	April 2008 New/Revised
46930	8	5		5	5			1							46	April 2008 New/Revised
49652	45	15	15	90	30		1	1		1			1		292	September 2007 New/Revised
49653	45	15	15	120	30		2	1		1	1		1		378	September 2007 New/Revised
49654	45	15	15	120	30		1	1		1	1		1		362	September 2007 New/Revised
49655	50	15	15	150	30		2	1		1	1		1		413	September 2007 New/Revised
49656	45	15	15	120	30		1	1		1	1		1		362	September 2007 New/Revised
49657	60	15	15	180	30		2	1		1	2		1		493	September 2007 New/Revised
55706	33	5	15	45	15			1	1				0.5		195	April 2008 New/Revised
61796	18	1	6	90	15			2					0.5		195	April 2008 New/Revised
61797				30											30	April 2008 New/Revised
61798	18	1	6	120	15			2					0.5		225	April 2008 New/Revised
61799				60											60	April 2008 New/Revised
61800	10	1		20	10										41	April 2008 New/Revised
62267	14	10	10	30	15										79	April 2008 New/Revised
63620	18	1	6	90	15			2					0.5		195	April 2008 New/Revised
63621				60											60	April 2008 New/Revised
64416	19	1	5	20	15										60	April 2008 New/Revised
64446	19	5	5	20	15										64	April 2008 New/Revised
64448	19	1	5	15	15										55	April 2008 New/Revised
64449	19	5	5	20	11										60	April 2008 New/Revised
64455	10			5	5										20	April 2008 New/Revised
64632	10			5	5		1								36	April 2008 New/Revised
65756	33	1	5	60	20		3	3					0.5		255	April 2008 New/Revised
65757				15											15	April 2008 New/Revised
77785	10	1		30	10										51	April 2008 New/Revised
77786	13	1		60	15										89	April 2008 New/Revised
77787	19	1		90	20										130	April 2008 New/Revised
78808	5			5	3										13	April 2008 New/Revised
90951				274											274	February 2008 New/Revised
90952																carrier pr February 2008 New/Revised
90953																carrier pr February 2008 New/Revised
90954				240											240	February 2008 New/Revised
90955				198											198	February 2008 New/Revised
90956				148											148	February 2008 New/Revised
90957				253											253	February 2008 New/Revised
90958				183											183	February 2008 New/Revised
90959				133											133	February 2008 New/Revised
90960				90											90	February 2008 New/Revised
90961				75											75	February 2008 New/Revised
90962				63											63	February 2008 New/Revised
90963				258											258	February 2008 New/Revised
90964				233											233	February 2008 New/Revised
90965				218											218	February 2008 New/Revised
90966				75											75	February 2008 New/Revised
90967				86											86	February 2008 New/Revised

AMA/Specialty Society RVS Update Committee Physician Time Recommendations
September 2007, February 2008, and April 2008

CPT Code	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	99291	Total Time	Time Date
90968				7 77											7 77	February 2008 New/Revised
90969				7 27											7.27	February 2008 New/Revised
90970				2.5											2 5	February 2008 New/Revised
93228	5			12	8										25	April 2008 New/Revised
93279	5			10	5										20	April 2008 New/Revised
93280	5			17	5										27	April 2008 New/Revised
93281	5			20	5										30	April 2008 New/Revised
93282	8			15	5										28	April 2008 New/Revised
93283	8			15	10										33	April 2008 New/Revised
93284	8 5			15	10										33 5	April 2008 New/Revised
93285	5			12	5										22	April 2008 New/Revised
93286	5			12	5										22	April 2008 New/Revised
93287	7.5			13 5	5										26	April 2008 New/Revised
93288	5			10	5										20	April 2008 New/Revised
93289	5			15	5										25	April 2008 New/Revised
93290	5			12	8										25	April 2008 New/Revised
93291	5			12	5										22	April 2008 New/Revised
93292	5			10	5										20	April 2008 New/Revised
93293	9.5			19	9 5										38	April 2008 New/Revised
93294	7 5			15	7 5										30	April 2008 New/Revised
93295	7 5			22 5	7 5										37 5	April 2008 New/Revised
93297	10			24	16										50	April 2008 New/Revised
93298	10			24	10										44	April 2008 New/Revised
93306	5			20	6 5										31 5	September 2007 New/Revised
93351	5			20	10										35	April 2008 New/Revised
93352				5											5	April 2008 New/Revised
95803	5			20	5										30	April 2008 New/Revised
95992				20	10										30	April 2008 New/Revised
99475	30			105	30										165	February 2008 New/Revised
99476	20			65	20										105	February 2008 New/Revised

Detailed Description of Pre-Service Time Packages (Minutes)

		FACILITY						NON-FAC	
		1A	1B*	2A	2B*	3	4	5	6
	Total Pre-Service Time	20	25	25	39	51	63	7	23

CATEGORY SUBTOTALS

A	Pre-Service Evaluation (IWPUT =0.0224)	13	19	18	33	33	40	7	17
B	Pre-Service Positioning (IWPUT = 0.0224)	1	1	1	1	3	3	0	1
C	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	6	5	6	5	15	20	0	5

DETAILS

A	History and Exam (Performance and review of appropriate Pre-Tests)	5	5	10	10	10	15	4	9
A	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2	2	2	2	2	4	1	1
A	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3	3	3	5	5	5	2	3
A	Communicate with other professionals	0	1	0	3	5	5	0	2
A	Check/set-up room, supplies and equipment	1	1	1	1	5	5	0	1
A	Check/ prepare patient readiness (Gown, drape, prep, mark)	1	1	1	1	5	5	0	1
A	Prepare/ review/ confirm procedure	1	1	1	1	1	1	0	0
A	Administer moderate sedation/observe (wait) anesthesia care	0	5	0	10	0	0	0	0
B	Perform/ supervise patient positioning	1	1	1	1	3	3	0	1
C	Administer local anesthesia	1	0	1	0	0	0	0	5
C	Observe (wait anesthesia care)	0	0	0	0	10	15	0	0
C	Dress and scrub for procedure	5	5	5	5	5	5	0	0

* Indicates packages that contain moderate sedation

- 1A** Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)
- 1B*** Straightforward Patient/Straightforward Procedure (With sedation/anesthesia care)
- 2A** Difficult Patient/Straightforward Procedure (No sedation/anesthesia care)
- 2B*** Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)
- 3** Straightforward Patient/Difficult Procedure
- 4** Difficult Patient/Difficult Procedure
- 5** Procedure without sedation/anesthesia care
- 6** Procedure with sedation/anesthesia care

Notes:

*Roll-over cells for additional detail where available

*Straightforward procedure: Integument, Non-incisional endoscopy, natural orifice

*For building block IWPUT purposes whenever the procedure is on Appendix G – (Summary of CPT codes that include moderate (conscious) sedation) the IWPUT should be .0224 for the administration of moderate sedation line item because the physician is responsible for the administration of conscious sedation. If the procedure is one where conscious sedation is not inherent the same line item should have an IWPUT of .0081.

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Apr-06	Fibroadenoma Cryoablation	11	September 2010	CPT 2007
20696	Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment, assessment, and computation of adjustment schedule	Apr-08	Computer Dependent External Fixation	6	September 2012	CPT 2009
20697	Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	Apr-08	Computer Dependent External Fixation	6	September 2012	CPT 2009
20985	Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)	Apr-07	Computer Navigation	7	September 2011	CPT 2008
20986	Computer assisted surgical navigational procedure for musculoskeletal procedures; with image-guidance based on intra-operatively obtained images (eg fluoroscopy, ultrasound), (List separately in addition to code for primary procedure)	Apr-07	Computer Navigation	7	September 2011	CPT 2008
20987	Computer assisted surgical navigational procedure for musculoskeletal procedures; with image-guidance based on pre-operative images (eg, CT, MRI), (List separately in addition to code for primary procedure)	Apr-07	Computer Navigation	7	September 2011	CPT 2008
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Apr-06	Percutaneous Intradiscal Annuloplast	13	September 2010	CPT 2007
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels	Apr-06	Percutaneous Intradiscal Annuloplast	13	September 2010	CPT 2007
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical	Apr-08	Cervical Arthroplasty	7	September 2012	CPT 2009

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
22857	Total disc arthroplasty (artificial disc), including anterior approach, including disectomy to prepare interspace (other than for decompression), lumbar, single interspace	Feb-06	Lumbar Arthroplasty	8	September 2010	CPT 2007
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical	Apr-08	Cervical Arthroplasty	7	September 2012	CPT 2009
22862	Revision including replacement of total disc arthroplasty (artificial disc) including anterior approach, lumbar, single interspace (includes approach)	Feb-06	Lumbar Arthroplasty	8	September 2010	CPT 2007
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical	Apr-08	Cervical Arthroplasty	7	September 2012	CPT 2009
22865	Removal of total disc arthroplasty (artificial disc), including anterior approach, lumbar, single interspace	Feb-06	Lumbar Arthroplasty	8	September 2010	CPT 2007
29828	Tenodesis of long tendon of biceps	Apr-07	Arthroscopic Biceps Tenodesis	17	September 2011	CPT 2008
32998	Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleur or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral	Apr-06	Percutaneous RF Pulmonary Tumor Ablation	15	September 2010	CPT 2007
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33257	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure); performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)	Apr-07	Add-on Maze Procedures	23	September 2011	CPT 2008

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
33258	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass, performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)	Apr-07	Add-on Maze Procedures	23	September 2011	CPT 2008
33259	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass, performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)	Apr-07	Add-on Maze Procedures	23	September 2011	CPT 2008
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension; with coronary reconstruction and valve sparing aortic annulus remodeling (eg, David Procedure, Yacoub Procedure)	Apr-07	Valve Sparing Aortic Annulus Reconstruction	24	September 2011	CPT 2008
34806	Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration and collection of pressure data (List in addition to the code for the primary procedure)	Apr-07	Wireless Pressure Sensor Implantation	25	September 2011	CPT 2008
43273	Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)		Cholangioscopy-Pancreatotomy	13		
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	Apr-08	Laparoscopic Heller Myotomy	12	September 2012	CPT 2009
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007
43648	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum; revision or removal of gastric neurostimulator electrodes, antrum	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Apr-07	Percutaneous Renal Tumor Cryotherapy	A	September 2011	CPT 2008
55706	Biopsies, prostate; needle, transperineal, stereotactic template guided saturation sampling including image guidance	Apr-08	Saturation Biopsies	15	September 2012	CPT 2009
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Apr-07	Laparoscopic Paravaginal Defect Repair	C	September 2011	CPT 2008
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less;	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams;	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
58571	Laparoscopy, surgical, with total hysterectomy for uterus 250 grams or less; with removal of tubes and/or ovary(s)	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
58572	Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 gram	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
58573	Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 grams; with removal of tubes and/or ovary(s)	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
63620	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one spinal lesion	Apr-08	Stereotactic Radiosurgery	16	September 2012	CPT 2009

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
63621	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)	Apr-08	Stereotactic Radiosurgery	16	September 2012	CPT 2009
65756	Keratoplasty (corneal transplant); endothelial		Endothelial Keratoplasty	20		
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure) (Use 65757 in conjunction with 65756)		Endothelial Keratoplasty	20		
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	Apr-07	Nasolacrimal Duct Balloon Catheter Dilation	E	September 2011	CPT 2008
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	Feb-06	Functional MRI	15	September 2010	CPT 2007
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Feb-06	Functional MRI	15	September 2010	CPT 2007
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75558	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75560	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75562	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification	Apr-07	Cardiac MRI	F	September 2011	CPT 2008

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75564	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); multi-source Cobalt 60 based	Sep-05	Stereotactic Radiation Tx Delivery	7	September 2010	CPT 2007
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); linear accelerator based	Sep-05	Stereotactic Radiation Tx Delivery	7	September 2010	CPT 2007
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr-06	Stereotactic Body Radiation Therapy	B	September 2010	CPT 2007
77435	Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)	Apr-06	Stereotactic Body Radiation Therapy	B	September 2010	CPT 2007
78811	Positron emission tomography (PET) <u>imaging</u> ; limited area (eg, chest, head/neck)	Apr-07	PET Imaging	G	September 2011	CPT 2008
78812	Positron emission tomography (PET) <u>imaging</u> ; skull base to mid-thigh	Apr-07	PET Imaging	G	September 2011	CPT 2008
78813	Positron emission tomography (PET) <u>imaging</u> ; whole body	Apr-07	PET Imaging	G	September 2011	CPT 2008
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization <u>imaging</u> ; limited area (eg, chest, head/neck)	Apr-07	PET Imaging	G	September 2011	CPT 2008
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization <u>imaging</u> ; skull base to mid-thigh	Apr-07	PET Imaging	G	September 2011	CPT 2008

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization <u>imaging</u> ; whole body	Apr-07	PET Imaging	G	September 2011	CPT 2008
88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	Feb-07	Manual Microdissection	12	September 2011	CPT 2008
88381	Microdissection (ie, sample preparation of microscopically identified target); manual	Feb-07	Manual Microdissection	12	September 2011	CPT 2008
88384	Array-based evaluation of multiple molecular probes; 11 through 50 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	September 2010	CPT 2006
88385	Array-based evaluation of multiple molecular probes; 51 through 250 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	September 2010	CPT 2006
88386	Array-based evaluation of multiple molecular probes; 251 through 500 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	September 2010	CPT 2006
90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour including pump set up and establishment of subcutaneous infusion site(s)	Apr-07	Immune Globulin Subcutaneous Infusion	H	September 2011	CPT 2008
90770	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure)	Apr-07	Immune Globulin Subcutaneous Infusion	H	September 2011	CPT 2008
90771	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set up with establishment of new subcutaneous infusion site(s)	Apr-07	Immune Globulin Subcutaneous Infusion	H	September 2011	CPT 2008
93228	Mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
93229	Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report; technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93279	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; single lead pacemaker system (Do not report 93279 in conjunction with 93286 or 93288)	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93280	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead pacemaker system	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93281	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; multiple lead pacemaker system	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93282	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; single lead implantable cardioverter defibrillator system	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93283	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead implantable cardioverter defibrillator system	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93284	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; multiple lead implantable cardioverter defibrillator system	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
93285	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; implantable loop recorder system	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93286	Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead pacemaker system	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93287	Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead implantable cardioverter defibrillator system	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93288	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead pacemaker system	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93289	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead implantable cardioverter defibrillator system, including analysis of heart rhythm derived data elements	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93290	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93291	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm data derived analysis	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
93292	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual or multiple lead pacemaker system, includes recording with and without magnet application with report(s) up to 90 days	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead pacemaker system with interim physician analysis and physician review and report(s)	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead implantable cardioverter defibrillator system with interim physician analysis and physician review and report(s)	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead pacemaker system with interim physician analysis and physician review and report(s); single, dual, or multiple lead pacemaker system or implantable cardioverter defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s)	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s)	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s); implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr-08	Cardiac Device Monitoring	23	September 2012	CPT 2009
93982	Non-invasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report	Apr-07	Wireless Pressure Sensor Implantation	25	September 2011	CPT 2008
95803	Actigraphy testing, recording, analysis, interpretation and report (minimum of 72 hours to 14 consecutive days of recording)	Apr-08	Actigraphy Sleep Assessment	25	September 2012	CPT 2009
95966	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 5-10 minutes of medical discussion	Apr-07	Non Face-to-Face Qualified Healthcare Professional Services	U	September 2011	CPT 2008
95967	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 11-20 minutes of medical discussion	Apr-07	Non Face-to-Face Qualified Healthcare Professional Services	U	September 2011	CPT 2008
95968	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 21-30 minutes of medical discussion	Apr-07	Non Face-to-Face Qualified Healthcare Professional Services	U	September 2011	CPT 2008
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Apr-07	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	September 2011	CPT 2008

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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Apr-07	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	September 2011	CPT 2008
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	Apr-07	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	September 2011	CPT 2008
96020	Neurofunctional testing selection and administration during non-invasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report	Feb-06	Functional MRI	15	September 2010	CPT 2007
96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Feb-06	Whole Body Integumentary Photography	19	September 2010	CPT 2007
99363	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements	Apr-06	Anticoagulant Management Services	I	September 2010	CPT 2007
99364	Anticoagulant management for a patient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of three INR measurements)	Apr-06	Anticoagulant Management Services	I	September 2010	CPT 2007
99441	Telephone Evaluation and Management, 5-10 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	September 2011	CPT 2008

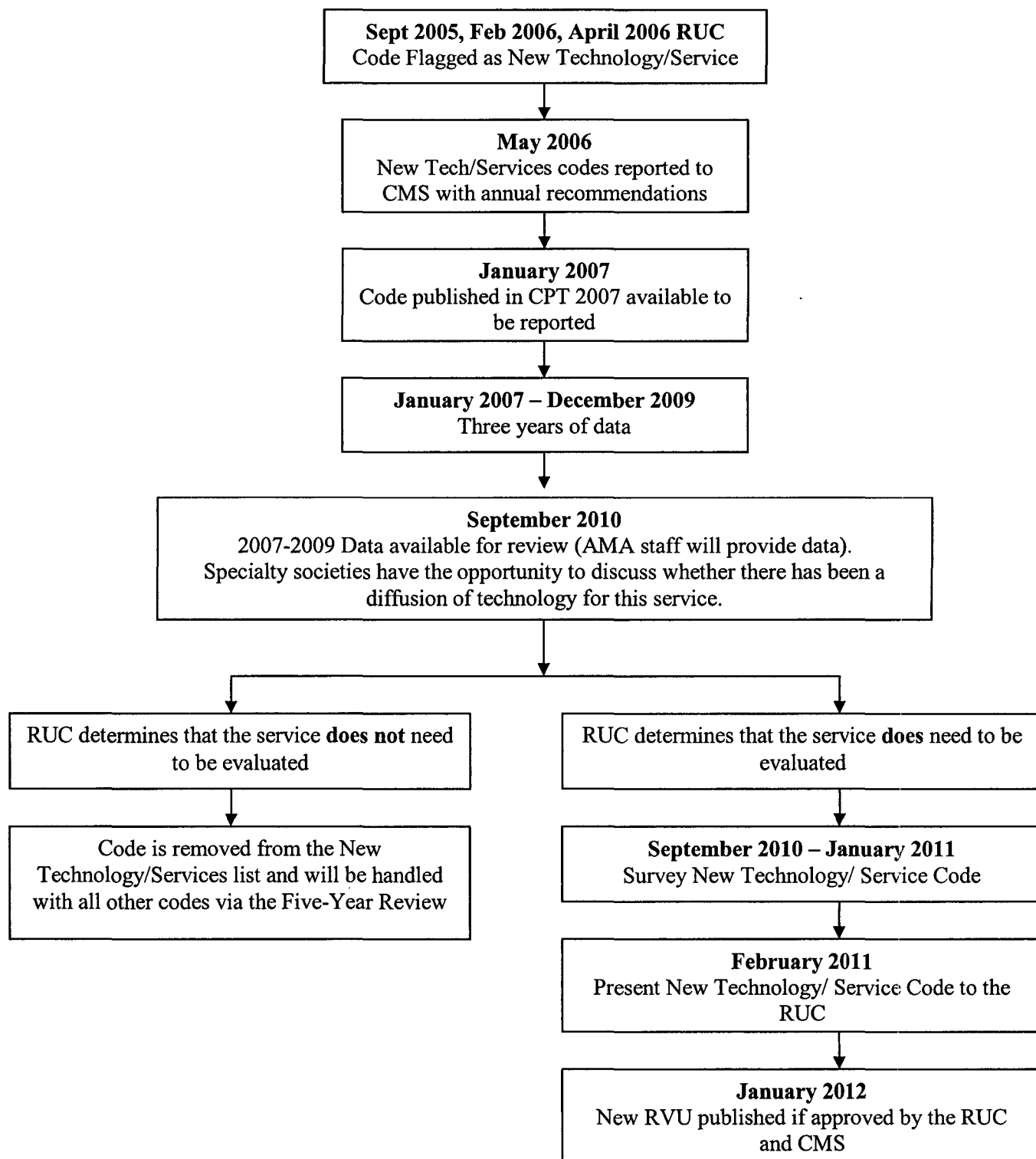
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CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
99442	Telephone Evaluation and Management, 11-20 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	September 2011	CPT 2008
99443	Telephone Evaluation and Management, 21-30 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	September 2011	CPT 2008

New Technology/Services Timeline

1. Code is identified as a new technology/service at the RUC meeting in which it is initially reviewed.
2. Code is flagged in the next version of the RUC database with date to be reviewed
3. Code will be reviewed in 5 years (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available.

Example



AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Intracranial Procedures Anesthesia

Code 00225 *Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma* was created by the CPT Editorial Panel to address concerns expressed regarding the heterogeneity of the surgical procedures within code 00210 *Anesthesia for intracranial procedures; not otherwise specified* (Base Units = 11). The Panel created 00225 to extract the most common anesthesia procedures within 00210, craniotomy or craniectomy for evacuation of a hematoma, into its own code during the RUC's 5-Year review of anesthesia.

The RUC reviewed the survey data for CPT code 00225 from 41 anesthesiologists who indicated the complexity/intensity measures for new code 00225 are equal to or slightly less than those for the key reference service 00210 (Base Units = 11). The survey data indicated that the total physician time was less for code 00225 at 175 minutes compared to its key reference code of 268 minutes, yet the specialty maintained the intensity was comparable to 00210. The RUC also reviewed code 00220 *Anesthesia for intracranial procedures; cerebrospinal fluid shunting procedures* (Base units = 10, total physician time = 171.50) in comparison to the new code and agreed that the physician work was similar. The RUC and the specialty society concurred that the value of 00225 should be valued at 10 base units, the 25th percentile of the specialty's survey data. **The RUC recommends a value of 10 Base Units for CPT code 00225.**

Practice Expense:

The RUC recommends the anesthesiology practice expense standard of 8 minutes of clinical labor time consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination and completion of forms in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
•00225	N1	Anesthesia for intracranial procedures, craniotomy or craniectomy for evacuation of hematoma	XXX	10

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

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CPT Code:00225 Tracking Number: N1
Global Period:XXX

Specialty Society Recommended Base Unit Value: 10
RUC Recommended Base Unit Value: 10

CPT Descriptor: Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63-year old man presents with headach, nausea, left-sided weakness and mental status changes after a recent fall. His past medical history is notable for hypertension. Medications include labetalol and aspirin. Current clotting studies are normal. Initial CT scan shows a large hematoma on the right with midline shift. A craniotomy is scheduled for urgent evacuation of the hematoma.

Percentage of Survey Respondents who found Vignette to be Typical: 95.12%

Description of Pre-Service Work:

The patient is evaluated in the hospital typically the day of surgery for urgent cases, and occasionally the day prior to surgery. The anesthesiologist performs a history including significant past medical and surgical history, previous anesthetics or significant events and a review of systems with emphasis on the cardiovascular, coagulation, respiratory and neurological systems. Clinically indicated laboratory studies are ordered, and additional studies that are already available are reviewed, assessed and recorded including a chest x-ray and electrocardiogram. The electrocardiogram demonstrated sinus bradycardia, QTc prolongation, and T-wave inversion in leads V4-6. Increased lung markings were noted on the chest x-ray. The anesthesiologist performs a physical examination to evaluate the patient's airway, neurologic status, IV access, and heart and lung status. General anesthesia with its options and associated risks including potential complications, the possibility of prolonged ventilation and critical care unit stay, and post-operative pain management options are discussed with the patient/legal guardian and family. If lucid, the patient's questions are answered and informed consent is obtained. More often, the patient's family will be contacted and included in the pre-service discussions, and they will provide the specific anesthesia-related informed consent to proceed. If clinical strategies for correction of coagulation and hemodynamic aberrations are necessary prior to OR, the anesthesiologist will discuss and coordinate directly with the surgeon and/or the involved consultants.

On the morning of surgery the patient's chart was reviewed for additional information including the results of the previous day's blood tests. The anesthesiologist confirmed four units of blood were available in the operating room. The patient was examined with no interval changes noted. The patient and family were given the opportunity to again ask questions and all were answered to their satisfaction.

The operating room was prepared for administration of general anesthesia. This includes preparing the anesthesia machine and circuit, as well as medications and airway and monitoring equipment including preparation of pressure transducers for arterial and central venous pressure monitoring. Anesthetic drugs are selected and prepared. A tower of intravenous medication pumps was prepared for the administration of cardio- and vaso-active.

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

Description of Intra-Service Work:

In the preanesthesia holding area, secure intravenous access with a large bore catheter is established and the patient may receive light sedation, if needed. Central venous access (CVP) may be selected either for certainty of intravenous access, or in anticipation of the need to monitor intravascular volume, utilize vasoactive infusions and possibly diuretics. Arterial cannulation (Art line) for direct and continuous monitoring of blood pressure is used for most procedures to

allow careful monitoring of and control of blood pressure. When either a CVP or an arterial line is placed, placement is separately reported. Interpretation of the information obtained from these monitors is included in the anesthetic work.

The patient is transferred to the operating room and appropriate monitoring devices are applied. The JCAHO mandated "time out" is performed, confirming the correct patient, correct site and correct surgery. The anesthesiologist confirms the preoperative antibiotic order with the surgeon and administers the prescribed medication before incision. After preoxygenation with 100% oxygen, anesthesia is carefully induced in a way such as to minimize alteration in intracranial pressure while rapidly securing the airway to avoid opportunity for aspiration of gastric contents. Once adequate neuromuscular blockade is confirmed with a nerve blockade monitor, the anesthesiologist performs direct laryngoscopy and intubates the trachea, with careful titration of anesthetic agents to avoid any vasomotor perturbation. Proper tracheal placement is confirmed via capnography and the endotracheal tube is secured. An esophageal stethoscope with a temperature probe is placed. The anesthesiologist confirms the drug and dose of the prophylactic antibiotic with the surgeon, and administers this prior to skin incision.

The patient is carefully positioned for the surgical procedure, often in a slightly head up position and possibly in the lateral position to allow appropriate surgical access. A head holder involving the placement of pins through the scalp and into the skull may be used; its placement is intensely stimulating and therefore requires careful titration of anesthesia to attenuate changes in intracranial pressure. The OR table is most often turned, with the anesthesiologist positioned at the patient's side or feet rather than the head of the table. After positioning the table to facilitate the surgical procedures, bilateral breath sounds are auscultated again, proper functioning of the monitors and vascular access is confirmed, and pressure points are padded. A warm air heating blanket is positioned on the patient unless the patient is febrile, or there is a deliberate desire to cool the patient during the surgery.

Narcotics and muscle relaxants are intermittently administered as necessary and anesthetic level is titrated with inhaled isoflurane. During the procedure, the anesthesiologist adjusts the ventilator to assure adequate ventilation as determined by capnography, without compromising cerebral blood flow. The surgeon may request hyperventilation to a specific arterial partial pressure of carbon dioxide to decompress the brain. Similarly, the anesthesiologist and surgeon may specify a rather narrow range of blood pressure measurements to target during the procedure to ensure adequate cerebral perfusion pressure (CCP) without adversely increasing cerebral blood flow, intracranial pressure (ICP) and the risk for additional bleeding. The anesthesiologist carefully monitors the patient's oxygenation status with pulse oximetry and may obtain serial arterial blood samples as indicated to assess ventilation (PaCO₂) and pH. Coordinating with the surgeon, a variety of medications may be administered including anti-convulsants, osmotic diuretics, calcium antagonists and corticosteroids in an attempt to regulate ICP. It may also be necessary to employ carefully titrated vasoactive medication, such as nitroglycerin, nitroprusside, vasopressin, dopamine, dobutamine, or phenylephrine in an attempt to maintain CPP at an appropriate level..

These procedures can result in significant blood loss, especially if the patient was using anticoagulants or platelet-inhibiting medications prior to surgery. In those circumstances, the anesthesiologist carefully monitors the volume of lost blood, the central venous pressure and urine output. When appropriate and after communication and agreement with the surgeon, blood component therapy is initiated after verifying that the blood products are appropriately matched and intended for the patient.

Arterial blood gas samples may be obtained to determine blood gas findings, particularly PaCO₂, hemoglobin and certain electrolytes. Coagulation studies may be obtained when the patient has a pre-existing coagulopathy or develops excessive intraoperative bleeding. The results of these tests are interpreted and therapeutic decisions are made to guide fluid, blood and electrolyte therapy.

At the conclusion of the procedure the anesthetic agents are discontinued and residual neuromuscular blockade is reversed pharmacologically. The anesthesiologist evaluates the patient's respiratory effort, oxygenation, level of consciousness and the reversal of neuromuscular agents. If the patient meets acceptable criteria, the anesthesiologist extubates the patient's trachea. Patients undergoing these procedures are at risk for changes in ICP and possible pulmonary aspiration during tracheal extubation, so caution and careful assessment is necessary. If the patient is unstable or neurologically impaired, tracheal extubation may not be appropriate. Under this circumstance, a portable monitor and ventilation circuit are connected to the patient for transport and the patient is taken to the recovery room (PACU) or intensive care unit (ICU) while ventilated en route by the anesthesiologist.

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When the surgeon determines that a CT scan be performed immediately post-operatively, the anesthesiologist transports the patient to the scanner and then to the ICU or PACU. And during these transports and scanning the anesthesiologist maintains the same level of monitoring and life support functions as are required in the operating room. Careful monitoring of the patient's vital signs is continuously performed during transport, hemodynamic infusions are maintained and manipulated if necessary. If continued airway and ventilatory control is chosen rather than immediate extubation, sedation is usually continued to avoid coughing and straining which may promote a recurrence of intracranial bleeding or increase in ICP. It is considered optimal to design an anesthetic plan that, although maintaining a significantly deep level of anesthesia during the procedure, allows a quick a return to baseline consciousness and alertness as quickly possible to allow early assessment of the patient's neurological function after the trespass of surgery.

Description of Post-Service Work:

When the ICU or PACU is reached, the anesthesiologist provides initial ventilator settings. The anesthesiologist provides a report of the patient's history and anesthetic course to the post-anesthesia nurse or critical care nurse. The anesthesiologist orders initial analgesics, sedatives and anti-emetics as well as any indicated laboratory test. When the anesthesiologist's final assessment of the patient is completed and report given, the patient's care is transferred to recovery room or ICU personnel.

A post-procedure visit is performed. Findings are documented in the medical record, including evidence of recovery from anesthesia or any complications associated with anesthetic management.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):	Tripti Kataria, MD, MPH					
Specialty(s):	American Society of Anesthesiologists					
CPT Code:	00225 211					
Sample Size:	96	Resp n:	41	Resp %: 42.7%		
Sample Type:	Panel					
		Low	25 th pctl	Median*	75 th pctl	High
Service Performance Rate		0.00	2.00	10.00	15.00	50.00
Survey Base Unit Values:		6.00	10.00	11.00	11.00	45.00
Pre-Anesthesia Time:						
Evaluation		10.00	15.00	20.00	25.00	90.00
Equipment/Supply Preparation		5.00	15.00	15.00	20.00	45.00
Intra-op Anesthesia Time:						
Induction Period		7.00	10.00	15.00	20.00	30.00
Post-Induction Period		10.00	80.00	105.00	120.00	180.00
Post-Anesthesia Time:				20.00		

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than following table.

CPT Code: 00225	
	<u>Specialty Recommended</u>
Base Unit Value:	10.00
Pre-Anesthesia Time:	
Evaluation	20.00
Equipment/Supply Preparation	15.00
Intra-op Anesthesia Time:	
Induction Period	15.00
Pos-Induction Period	105.00
Post-Anesthesia Time:	20.00

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Base Unit Value</u>	<u>Time Source</u>
00210		11	Other

CPT Descriptor Anesthesia for intracranial procedures; not otherwise specified

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Base Unit Value</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Base Unit Value</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Base Unit Value</u>	<u>Time Source</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

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TIME ESTIMATES (Median)New/Revised
CPT Code:
00225Key Reference
CPT Code:
00210Time Source:
Other

Median Pre-Service Time		0.00
Evaluation	20.00	
Equipment/Supply Preparation	15.00	
Median Intra-Service Time		267.50
Induction Period	15.00	
Post-Induction Period	105.00	
Median Post-service Time	20.00	0.00
Median Total Time	175.00	268.00

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

The number of possible diagnosis and/or the number of management options that must be considered	3.56	3.72
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.56
Urgency of medical decision making	4.33	4.06

Technical Skill/Physical Effort (Mean)

Technical skill required	3.83	3.83
Physical effort required	3.39	3.39

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.28	4.17
Outcome depends on the skill and judgement of physician	4.11	4.11
Estimated risk of malpractice suit with poor outcome	3.50	3.50

INTENSITY/COMPLEXITY MEASURESCPT CodeReference
Service 1Time Segments (Mean)

Pre-Anesthesia intensity/complexity	3.72	3.56
Intra-Op Anesthesia intensity/complexity	3.72	3.78
Post-Anesthesia intensity/complexity	3.50	3.56

Post-Induction Anesthesia Time-Intensity Allocation

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	Percentage of Time (%)
Level 1 Presenting Problems are self-limited or minor; Straightforward medical decision making and treatment	19.15
Level 2 Presenting Problems are of low severity; Medical decision making and treatment of low complexity	23.78
Level 3 Presenting Problems are of moderate severity; Medical decision making of moderate complexity and treatment of high complexity	32.05
Level 4 Presenting Problems are moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity	17.37
Level 5 Presenting problems are of high severity; Medical decision making and treatment of high complexity; Critically ill or critically injured patient	7.66
Total (must total 100%)	100.00%

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.*

Code 00225 was created to address concerns expressed about code 00210 during the RUC's review of anesthesia work as part of the third Five Year Review. Much of the concern expressed dealt with the heterogeneity of surgical procedures reported under 00210. The new code extracts the most common anesthesia procedures previously associated with 00210, craniotomy or craniectomy for evacuation of hematoma into their own code.

The survey times and complexity/intensity measures for new code 00225 are mainly equal to or slightly less than those for the reference service 00210 (base unit value = 11). The main exception is the metric on "Urgency of medical decision making" where the reference service measure is 4.06 and the new code comes in at 4.33. This is not unexpected given

- the urgent/emergent nature of most cases of intracranial hematoma;
- these patients often present with worsening neurologic symptoms and
- they will often have coagulation issues or concomitant trauma.

Based on review of the survey results as well as comparison to the reference service, we recommend the survey's median times and the 25th percentile for valuation: 10 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) 00210

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? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 25000

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

Please explain the rationale for this estimate.

Specialty Anesthesiology	Frequency 25000	Percentage	100%
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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?

12000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty Anesthesiology	Frequency 12000	Percentage	100.00%
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Specialty	Frequency	Percentage
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CPT Code: 00225

Specialty

Frequency

Percentage

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

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

CPT Long Descriptor:

00225 – Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma

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

Please describe the clinical activities of your staff:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

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

CPT Long Descriptor:

00225 – Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma

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

We are requesting the standard anesthesia PE package as approved by the PERC/RUC in April 2006

CMS requested the PERC discuss the appropriateness of direct practice expense of clinical labor employed by the physician as a cost in the facility setting. The PERC carefully discussed the recommendation by the American Society of Anesthesiology of 11 minutes and agreed that this was a direct practice expense however 8 minutes of clinical labor time was more appropriate. The PERC recommends 8 minutes of clinical labor time for all anesthesia codes consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination, and completion of forms.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

3 minutes – anesthesia scheduling

5 minutes – case assignment, scheduling coordination, and completion of forms

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

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	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation			00225	
2	Meeting Date: April 2008			Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD			XXX	XXX
5	TOTAL CLINICAL LABOR TIME			0.0	8.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	8.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms				
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	Anesthesia Scheduling	L037D	RN/LPN/MTA	N/A	3
18	Case assignment, scheduling coordination and completion of forms	L037D	RN/LPN/MTA	N/A	5
19	End: When patient enters office/facility for surgery/procedure				
20	SERVICE PERIOD				
21	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
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				
41	Other Clinical Activity (please specify)				
42	End: Patient leaves office				
43	POST-SERVICE Period				
44	Start: Patient leaves office/facility				
45	Conduct phone calls/call in prescriptions				
46	Office visits				
47	List Number and Level of Office Visits				
48	99211 16 minutes		16		
49	99212 27 minutes		27		
50	99213 36 minutes		36		
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54	Total Office Visit Time			0	0
55	Other Activity (please specify)				
56	End: with last office visit before end of global period				
57	MEDICAL SUPPLIES	CMS Code	Unit		
58					
59					
60	Equipment	CMS Code			
61					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

CABG Pump Oxygenator Anesthesia

In February 2008 the CPT Editorial Panel revised one CPT code and created a new code to address concerns regarding the heterogeneity of surgical procedures reported under code 00562 (pre CPT Editorial Panel change definition - *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator* (2008 Base Units = 20).

Code 00562 was developed when the number of cardiac surgery codes was limited. Over the years, this code has been reported for an increasing number of more complex cardiac cases that are performed with pump oxygenator. New code 00567 *Anesthesia for direct coronary artery bypass grafting; with pump oxygenator* was established to encompass surgical CPT codes involving coronary artery bypass with pump oxygenator, preserving code 00562 for more complex surgical procedures including valvular repairs and rework procedures. To capture the physician anesthesia services for these more complex surgical procedures, CPT code 00562 was revised as; *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age one year or older, for all non-coronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than one month after original operation.*

00562

The RUC reviewed the survey results from 52 anesthesiologists who indicated code 00563 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest* (Base Units = 25) as the key reference in revaluing this service. The specialty survey indicated a median base unit value of 25 however in comparison to its intensity and complexity measures with the key reference service, though high, were not as high as the 00563. The specialty society noted that most of the respondents (78.85%) indicated that they agreed with the typical patient description presented in the survey, those that did not agree with the vignette noted that the patient is usually significantly more complex. It was the survey respondents opinion that the case described in the survey represents the easiest patient and not the typical patient scenario. The specialty society recommended a value of 22 base units which lies between the 25th percentile and the median survey results. RUC disagreed because the survey results appeared overvalued in comparison to the key reference service, code 00563. The RUC concurred that if the value for the code had been 20 base units in the past there was no compelling evidence presented to increase the value as the specialty had recommended for this revised service. **The RUC recommends maintaining the physician work value of CPT code 00562 at 20 Base Units.**

00567

The RUC reviewed the survey results from 50 anesthesiologists who chose code 00566 *Anesthesia for direct coronary artery bypass grafting without pump oxygenator* (Base Units = 25) as the key reference in valuing this service. The specialty society's typical patient listed on their survey instrument was one undergoing direct coronary bypass grafting with pump oxygenator for ischemic heart disease. The specialty noted that coronary artery bypass patients are at greater risk for perioperative myocardial infarction. Anesthesia care must include special attention to maintaining an appropriate myocardial oxygen supply/demand balance and to aggressively treat myocardial ischemia when it occurs.

The specialty survey indicated a median base unit value of 21 Base Units. However, in comparison to its intensity and complexity measures with the key reference service, though high, were not as high as the 00566. The specialty society recommended a base unit value of 20 which was the survey's 25th percentile result. The RUC disagreed with this value, as the survey results were too high in comparison to the key reference service, code 00566. The RUC agreed that code 00566 is a different service than 00567 and the value of code 00567 should be below CPT code 00562 at a value between the specialty society's survey low and its 25th percentile, at a value of 18 base units. The specialty and the RUC agreed on the value of 18 Base Units for 00567 and the rank order base unit increment between 00567 and 00562. **The RUC recommends 18 Base Units for 00567.**

Practice Expense:

The RUC recommends the anesthesiology practice expense standard of 8 minutes of clinical labor time consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination and completion of forms in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
00560		Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	XXX	15 (No Change)
00561		with pump oxygenator, younger than one year of age	XXX	25 (No Change)
▲00562	O1	with pump oxygenator, age one year or older, for all non-coronary bypass procedures (eg, valve procedures) or for re-operation for	XXX	20

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		coronary bypass more than one month after original operation		(No Change)
00563		with pump oxygenator with hypothermic circulatory arrest	XXX	25 (No Change)
00566		Anesthesia for direct coronary artery bypass grafting; without pump oxygenator	XXX	25 (No Change)
●00567	O2	with pump oxygenator	XXX	18

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

CPT Code:00562
Global Period:XXX

Tracking Number: O1

Specialty Society Recommended Base Unit Value: **22**

RUC Recommended Base Unit Value: **20**

CPT Descriptor: Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age one year or older, for all non-coronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than one month after original operation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 66 year old male who presents for an aortic valve replacement for critical aortic stenosis

Percentage of Survey Respondents who found Vignette to be Typical: 78.85%

Description of Pre-Service Work:

The patient is evaluated in the hospital typically the day of surgery for urgent cases, and occasionally the day prior to surgery. The anesthesiologist performs a history including significant past medical and surgical history, previous anesthetics or significant events and a review of systems with emphasis on the cardiovascular, coagulation, respiratory and neurological systems. A detailed history is completed with special attention to any cardiac symptoms/arrhythmias/exercise tolerance. A review of systems is performed. The patient's medications are reviewed. Any history of prior anesthesia complications from the patient's past or family history is solicited. A limited physical exam is performed, which at minimum includes an airway exam as well as auscultation of the heart and lungs. Lab values are reviewed and missing values or values that warrant repeating are ordered. A type and screen is also ordered.

The anesthetic plan including anesthetic agents for induction, monitors, vascular access requirements (peripheral and central venous access/PA catheter and arterial access) is discussed. Trans-esophageal echocardiography (separately reported) when performed, is also discussed. The maintenance of anesthesia and the plan to maintain endotracheal intubation into the post-operative period are discussed. The possible need for blood transfusion and potential risks with blood transfusion are described. The need for post operative intensive care and hemodynamic support/arrhythmia monitoring and treatment are reviewed. Finally, plans for pain management in the postoperative period are reviewed with the patient. After discussing the total anesthetic plan, the patient is given the opportunity to ask any questions they may have.

Informed consent for the anesthetic is obtained. Preoperative medications are ordered and instructions are given as to which medications that patient is to take the morning of surgery. NPO orders are reviewed. . The anesthesiologist consults with other providers when needed.

Day of Surgery: The patient's chart is reviewed on the day of surgery for additional information including the results of the previously ordered labs. The patient is examined with no interval changes noted. NPO status is confirmed and medications taken that morning are verified. Blood availability is confirmed with the blood bank. The patient is given the opportunity to again ask questions and all are answered to their satisfaction. The operating room is prepared for administration of general anesthesia. This includes preparing the anesthesia machine, as well as a wide variety of anesthetic and cardiovascular medications. The anesthesiologist prepares airway and monitoring equipment including preparation of pressure transducers for arterial and central venous and pulmonary artery pressure monitoring. The anesthesia equipment, supplies, and monitors are checked and calibrated. Multiple intravenous medication pumps are prepared for the titration of cardio- and vaso-active medications as well as an anti-fibrinolytic for aid in hemostasis. The anesthesiologist confirms four units of blood are available in the operating room. Antibiotic orders are reviewed and prepared if needed.

Description of Intra-Service Work:

In the preanesthesia holding area, the patient is identified, secure intravenous access with a large bore catheter is established, and IV sedation is carefully titrated as needed. An intravenous large bore catheter is placed and infusion begins. Further medication is administered as needed. The patient is brought into the operating room and monitors are placed for five lead electrocardiogram, pulse oximetry and blood pressure. The JCAHO mandated "time out" is performed, confirming the correct patient, correct site and correct surgery. The anesthesiologist confirms the preoperative antibiotic order with the surgeon and administers the prescribed medication before incision. Monitors are placed and vital signs obtained. If invasive lines (arterial, central venous pressure, or pulmonary artery catheter) have previously been placed (separately reported) the transducers are zeroed, calibrated and connected to the OR cardiac monitor. Blood samples are drawn for blood gas analysis, as well as point of care blood coagulation analysis (e.g. activated clotting time (ACT). A thromboelastogram (TEG) is used as needed). The vasoactive infusions are readied to be infused into the central line but not started until their need is determined by the anesthesiologist. Anesthesia charting is performed. Baseline and subsequent hemodynamic parameters are documented.

A baseline arterial blood gas is drawn prior to induction. Manual ventilation with 100% oxygen is provided. The anesthesiologist determines the medications for induction of anesthesia. Careful titration of medication is essential to maintain hemodynamic stability throughout induction and intubation. A warming blanket is placed for use after cardiopulmonary bypass.

The patient is carefully positioned for the surgical procedure. After preoxygenation with 100% oxygen, general anesthesia is administered and the patient is paralyzed with muscle relaxants with close attention to the patient's hemodynamic status as immediate intervention is often necessary for a patient with coronary artery disease. This intervention may include rapid titration of hemodynamic medication infusions during the induction process, or resuscitation in the case of severe cardiovascular response to the induction of general anesthesia. Once adequate neuromuscular blockade is confirmed with a nerve blockade monitor, the patient's trachea is intubated, breath sounds are confirmed and hemodynamic parameters are reassessed after intubation. Ventilation is adjusted according to the blood gas results. Other tasks performed include padding of all pressure points, placement of an oral-gastric tube, esophageal stethoscope with temperature probe, neuromuscular monitor, non-invasive level of consciousness monitor, and a cerebral oximeter as indicated. Intermittent blood gas and blood coagulation analysis, are measured throughout the surgery.

The anesthetic is maintained with the intravenous and inhalation agents as deemed appropriate by the anesthesiologist, in order to best optimize coronary perfusion, cardiac output and hemodynamic stability, while carefully considering the pathophysiology associated with the patient's valvular disease. Episodes of hemodynamic instability commonly occur at multiple times prior to cardiopulmonary bypass. Appropriate interventions are vital to optimize coronary perfusion. Arrhythmias are treated as needed. Careful efforts to maintain hemodynamic, glucose, and acid-base stability and to prevent myocardial ischemia may require the use of vasodilators, vasopressors, insulin and/or inotropes. Episodes of hemodynamic instability are common due to sudden changes in intra-vascular volume, aortic artery clamping, contractile dysfunction, ischemia, and physical manipulation of the heart and great vessels. Continuous monitoring for sudden hemodynamic alterations including hypotension, hypertension, tachycardia, bradycardia, dysrhythmias, myocardial ischemia and ventricular dysfunction is therefore required. Anti-coagulating doses of heparin (or an alternative anticoagulant such as a direct thrombin inhibitor) are administered.

Once surgery has begun, ventilation is momentarily stopped during sternotomy.

Baseline check of coagulation is performed (ACT, or TEG). After the surgeon adequately dissects the great vessels, heparin is administered intravenously and a repeat clotting time is measured. The aorta and right atrium or vena cavae are cannulated when the ACT indicates adequate anticoagulation for cardio-pulmonary bypass. Ventilation is discontinued with the establishment of cardiopulmonary bypass.

During bypass;

During cardio-pulmonary bypass the anesthesiologist maintains the anesthetized state and muscular paralysis of the patient, while continuously monitoring, interpreting, and documenting blood pressure, kidney perfusion, brain wave activity, and brain oxygenation. Adjustments are made to the anesthetic depth, acid-base status, and to correct any deviations from adequate tissue perfusion, particularly to the brain, kidney, spinal cord and heart, while not permitting an undesirable blood pressure that could contribute to increased bronchial-coronary collateral blood flow and thereby disrupting the coronary artery bypass surgical field. The anesthesiologist also works to avoid increased sheering forces on the occluded aorta, which might potentiate ischemia and/or bleeding. Acid – base status, electrolytes, blood glucose,

anticoagulation status, anesthesia, and neuromuscular relaxation status are all closely monitored. This part of the procedure requires continual assessment and treatment of the patient.

Preparation is made to separate from bypass after the completion of cardiac intervention. The length of bypass time generally indicates the severity of the insult to the heart, complexity of the procedure (i.e. valve repairs, failed repairs, combination valve and coronary bypass, or intramyocardial coronaries), and serves as an indicator of difficulty in separation from cardiopulmonary bypass, as well as the instability of the patient following bypass. Careful observation of the adequacy of repair is done to predict the need for exogenous circulatory support to separate from bypass. Near the anticipated end of bypass and after adequate re-warming, ventilation is re-started, de-airing maneuvers are initiated, and an assessment of cardiac rhythm is made. The anesthesiologist establishes the pacemaker settings and temporary epicardial pacing is initiated. In addition, inotropic cardiac support and afterload reduction allow safe separation from CPB. Antibiotic re-dosing occurs according to institution standards.

Post CPB;

Once cardiac and pulmonary parameters are stabilized, reversal of anticoagulation is confirmed with an ACT and TEG as needed, and blood products may be checked and administered as indicated. Blood gases and labs are intermittently checked and treatment of acid-base, electrolyte and metabolic abnormalities ensues. Cardiac function, brain activity, and tissue perfusion continue to be monitored, as the anesthetic is adjusted based on the hemodynamic response.

At the conclusion of surgery, transport monitors and infusion pumps are checked for proper function and then connected to the patient for transport to the intensive care unit. The patient is carefully placed on the ICU/transport bed with all monitors and infusions. Manual ventilation is begun and the patient is transported to the intensive care unit, with treatment continuing along the way as necessary to assure stable respiratory and hemodynamic parameters. On arrival in the ICU, hemodynamic and respiratory monitor connections are transferred to the unit's systems. Ventilation is transferred to a bedside ventilator and parameters adjusted to satisfactory patient outcomes as determined by oximetry, respirator indices, end-tidal CO₂ monitoring, examination, and arterial blood gas monitoring.

A written record of vital signs, drugs and fluids administered, procedures performed and a narrative of important intraoperative events is maintained throughout the anesthetic.

Description of Post-Service Work:

When the ICU or PACU is reached, the anesthesiologist provides initial ventilator settings. Report is given to the ICU staff/nursing personnel. The anesthesiologist orders initial analgesics and sedatives as well as any indicated laboratory test. The care of the patient is transferred to the SICU team when stable. The anesthetic record is completed and a copy placed in the medical record.

A post-procedure visit is performed. Findings are documented in the medical record, including evidence of recovery from anesthesia or any complications associated with anesthetic management.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Tripti Kataria, MD, MPH				
Specialty(s):	American Society of Anesthesiologists				
CPT Code:	00562				
Sample Size:	135	Resp n:	52	Resp %: 38.5%	
Sample Type:	Panel				
		Low	25 th pctl	Median*	75 th pctl
Service Performance Rate		0.00	0.00	24.50	50.00
					180.00

Survey Base Unit Values:	16.00	20.00	25.00	25.00	49.00
Pre-Anesthesia Time:					
Evaluation	10.00	20.00	30.00	30.00	90.00
Equipment/Supply Preparation	10.00	20.00	30.00	30.00	60.00
Intra-op Anesthesia Time:					
Induction Period	10.00	20.00	30.00	41.25	85.00
Post-Induction Period	20.00	180.00	240.00	270.00	420.00
Post-Anesthesia Time:			30.00		

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than following table.

CPT Code: 00562	
	<u>Specialty Recommended</u>
Base Unit Value:	22.00
Pre-Anesthesia Time:	
Evaluation	30.00
Equipment/Supply Preparation	30.00
Intra-op Anesthesia Time:	
Induction Period	30.00
Pos-Induction Period	240.00
Post-Anesthesia Time:	30.00

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Base Unit Value</u>	<u>Time Source</u>
00563		25	RUC Time

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

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Base Unit Value</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Base Unit Value</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Base Unit Value</u>	<u>Time Source</u>
00566		25	RUC Time

CPT Descriptor Anesthesia for direct coronary artery bypass grafting without pump oxygenator

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

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

TIME ESTIMATES (Median)

	New/Revised CPT Code: 00562	Key Reference CPT Code: 00563	Time Source: RUC Time
Median Pre-Service Time		60.00	
Evaluation	30.00		
Equipment/Supply Preparation	30.00		
Median Intra-Service Time		300.00	
Induction Period	30.00		
Post-Induction Period	240.00		
Median Post-service Time	30.00	30.00	
Median Total Time	360.00	390.00	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.26	4.37
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.32	4.37
Urgency of medical decision making	4.47	4.47

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Technical Skill/Physical Effort (Mean)

Technical skill required	4.74	4.63
Physical effort required	4.21	4.32
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.74	4.58
Outcome depends on the skill and judgement of physician	4.68	4.58
Estimated risk of malpractice suit with poor outcome	3.95	4.00

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Anesthesia intensity/complexity	4.00	4.00
Intra-Op Anesthesia intensity/complexity	4.63	4.74
Post-Anesthesia intensity/complexity	4.00	4.00

Post-Induction Anesthesia Time-Intensity Allocation

	Percentage of Time (%)
Level 1 Presenting Problems are self-limited or minor; Straightforward medical decision making and treatment	10.60
Level 2 Presenting Problems are of low severity; Medical decision making and treatment of low complexity	18.33
Level 3 Presenting Problems are of moderate severity; Medical decision making of moderate complexity and treatment of high complexity	20.33
Level 4 Presenting Problems are moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity	24.27
Level 5 Presenting problems are of high severity; Medical decision making and treatment of high complexity; Critically ill or critically injured patient	26.48
Total (must total 100%)	99.00%

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.*

Code 00562 was revised and new code 0056X was created to address concerns expressed about code 00562 during the RUC's review of anesthesia work as part of the third Five Year Review. Much of the concern expressed dealt with the heterogeneity of surgical procedures reported under 00562.

Code 00562 was developed when number of cardiac surgery codes was limited. Over the years, this code has been used for an increasing number of more complex cardiac cases that are performed with pump oxygenator. Code 0056X was established to encompass surgical CPT codes involving coronary artery bypass with pump oxygenator, preserving code 00562 for more complex surgical procedures including valvular repairs and redo procedures

- Patients undergoing redo procedures have increased risk for acute heart injury and bleeding during sternotomy and during dissection of the heart from the pericardium, and occasionally must undergo emergent initiation of cardiopulmonary bypass. This increases the risk of hemodynamic instability. In addition, patients undergoing redo procedures often are older with more comorbidities.
- Valvular surgery, unlike bypass grafting, requires opening the heart or great vessels to facilitate surgical exposure. Open heart procedures have a much higher risk for air embolism, neurocognitive dysfunction and hemodynamic alterations. Valvular repair procedures may require more than one bypass run, increasing the risk for coagulation

disorders, myocardial dysfunction, difficulty separating from cardiopulmonary bypass, and hemodynamic instability following bypass. The pathophysiology of the specific valvular disorder complicates hemodynamic management, impacting anesthesia care, particularly if more than one valve, or more than one type of valve lesion (i.e. stenosis and regurgitation) is encountered.

While most of our respondents (78.85%) indicated that they agreed with the typical patient description presented in the survey, those that did not noted that the patient is usually significantly more complex. It was their opinion that the case described in the survey represents the easiest end of the spectrum of cases in this category. The aortic valve is generally an easier case to manage than other valves and stenosis is generally easier to treat than regurgitation. Further, many of the patients in this category have multiple valve disease. Many have requirements for great vessel surgery which can add significantly more complexity to the case. Other factors that commonly occur are other comorbid diseases, especially diabetes, vascular and renal disease, as well as redo bypass.

A review of the intensity/complexity associated with the service as well as the quintile breakdown that shows half the time to be at Level 4 and 5, we are recommending 22 base units - value that fall between the 25th percentile and the median

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 00562

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? Commonly

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 250000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Anesthesiology	Frequency 250000	Percentage 100.00%
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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?
100000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Anesthesiology	Frequency 100000	Percentage 100.00%
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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

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

CPT Code:00567
Global Period:XXX

Tracking Number: O2

Specialty Society Recommended Base Unit Value: 20

RUC Recommended Base Unit Value: 18

CPT Descriptor: Anesthesia for direct coronary artery bypass grafting with pump oxygenator

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 62 year old male undergoing direct coronary bypass grafting with pump oxygenator for ischemic heart disease. He has diabetes requiring insulin or oral agents

Percentage of Survey Respondents who found Vignette to be Typical: 78.00%

Description of Pre-Service Work:

The patient is evaluated in the hospital typically the day of surgery for urgent cases, and occasionally the day prior to surgery. The anesthesiologist performs a history including significant past medical and surgical history, previous anesthetics or significant events and a review of systems with emphasis on the cardiovascular, coagulation, respiratory and neurological systems. Current medications are reviewed. Clinically indicated laboratory studies are ordered, and additional studies that are already available are reviewed, assessed and recorded including a chest x-ray, electrocardiogram, echocardiogram, angiogram and all reports of cardiac function evaluation. The electrocardiogram demonstrates sinus bradycardia, ST segment elevation and T-wave inversion in leads V1-3. Increased lung markings are noted on the chest x-ray. The anesthesiologist performs a physical examination to evaluate the patient's airway, peripheral pulses, neck anatomy neurologic status, IV access, and cardiopulmonary status.

The anesthetic plan for pre-, intra-op, and post operative management and invasive monitoring and attendant risks are explained to the patient and his family. A discussion about blood transfusion and risks takes place and the patient's consent for blood transfusion is obtained. The potential for post-operative mechanical ventilation and admission into the ICU are reviewed with the patient. Plans for sedation and pain medications in the immediate post operative period are also explained. The patient's questions are answered. The patient is given instructions on medications to take the morning of surgery and these instructions are documented in the medical record. Pre operative medications are ordered. The anesthesiologist consults with other providers when needed.

Day of Surgery:

On the morning of surgery the patient's chart is reviewed for additional information including the results of the previous day's blood tests. The patient is examined with no interval changes noted. NPO status is confirmed and medications taken that morning are verified. The patient and family are given the opportunity to again ask questions and all are answered to their satisfaction.

The operating room is prepared for administration of general anesthesia. This includes preparing the anesthesia machine, as well as a wide variety of anesthetic and cardiovascular medications. The anesthesiologist prepares airway and monitoring equipment including preparation of pressure transducers for arterial and central venous and pulmonary artery pressure monitoring. The anesthesia equipment, supplies, and monitors are checked and calibrated. Multiple intravenous medication pumps are prepared for the titration of cardio- and vaso-active medications as well as an anti-fibrinolytic to aid in hemostasis, and an insulin infusion for perioperative blood glucose management. The anesthesiologist confirms four units of blood are available in the operating room. Antibiotic orders are reviewed and prepared if needed.

Description of Intra-Service Work:

In the preanesthesia holding area, the patient is identified, intravenous access with a large bore catheter is established, and IV sedation is carefully titrated as needed. An intravenous large bore catheter is placed and the IV infusion begins. Further medication is administered as needed. The patient is transferred to the operating room and appropriate monitoring devices are applied. The JCAHO mandated "time out" is performed, confirming the correct patient, correct site and correct surgery. The anesthesiologist confirms the preoperative antibiotic order with the surgeon and administers the prescribed medication before incision. Monitors are placed and vital signs obtained. If invasive lines (arterial, central venous pressure, or pulmonary artery catheter) have previously been placed (separately reported) the transducers are zeroed, calibrated and connected to the OR cardiac monitor. Blood samples are drawn for blood gas analysis, as well as point of care blood coagulation analysis (e.g. activated clotting time (ACT)). A thromboelastogram (TEG) is used as needed). The vasoactive infusions are readied to be infused into the central line but not started until their need is determined by the anesthesiologist. Anesthesia charting is performed. Baseline and subsequent hemodynamic parameters are documented.

The patient is carefully positioned for the surgical procedure. After preoxygenation with 100% oxygen, general anesthesia is administered and the patient is paralyzed with muscle relaxants with close attention to the patient's hemodynamic status as immediate intervention is often necessary for a patient with coronary artery disease. This intervention may include rapid titration of hemodynamic medication infusions during the induction process, or resuscitation in the case of severe cardiovascular response to the induction of general anesthesia. Once adequate neuromuscular blockade is confirmed with a nerve blockade monitor, the patient is intubated, breath sounds confirmed and hemodynamic parameters reassessed post intubation. Ventilation is adjusted as indicated by the blood gas results. Other tasks performed include pressure points are padded, placement of an oral-gastric tube, esophageal stethoscope with temperature probe, neuromuscular monitor, non-invasive level of consciousness monitor, and a cerebral oximeter as indicated. Intermittent blood gas and blood coagulation analysis, are measured throughout the surgery.

The anesthetic is maintained with the intravenous and inhalation agents as deemed appropriate by the anesthesiologist. Careful efforts to maintain hemodynamic, glucose, and acid-base stability and to prevent myocardial ischemia may require the use of vasodilators, vasopressors, insulin and/or inotropes. Episodes of hemodynamic instability are common due to sudden changes in intra-vascular volume, aortic artery clamping, contractile dysfunction, ischemia, and physical manipulation of the heart and great vessels. Continuous monitoring for sudden hemodynamic alterations including hypotension, hypertension, tachycardia, bradycardia, dysrhythmias, myocardial ischemia and ventricular dysfunction is therefore required. Anti-coagulating doses of heparin (or an alternative anticoagulant such as a direct thrombin inhibitor) are administered.

It is desirable to monitor neurological function to ensure adequate perfusion during the procedure. The anesthesiologist administers drugs to facilitate organ protection as well as maintain adequate perfusion to the brain, kidney, spinal cord and heart. Intermittent blood gas analysis, compressed EEG activity, cerebral oximetry, muscle relaxation, glucose, acid- base status, and coagulation status are interpreted in order to guide treatment throughout the surgery. Opioids, benzodiazepines and muscle relaxants are intermittently administered as necessary.

During bypass;

During cardio-pulmonary bypass the anesthesiologist maintains the anesthetized state and muscular paralysis of the patient, while continuously monitoring, interpreting, and documenting blood pressure, kidney perfusion, brain wave activity, and brain oxygenation. Adjustments are made to the anesthetic depth, acid-base status, and to correct any deviations from adequate tissue perfusion, particularly to the brain, kidney, spinal cord and heart, while not permitting an undesirable blood pressure that could contribute to increased bronchial-coronary collateral blood flow and thereby disrupting the coronary artery bypass surgical field. The anesthesiologist also works to avoid increased sheering forces on the occluded aorta, which might potentiate ischemia and/or bleeding. Acid – base status, electrolytes, blood glucose, anticoagulation status, anesthesia, and neuromuscular relaxation status are all closely monitored. This part of the procedure requires continual assessment and treatment of the patient.

During bypass, preparation is made to come off bypass. The length of bypass time generally indicates the severity of the insult to the heart, complexity of the procedure (i.e. intramyocardial coronaries), and serves as an indicator of difficulty in separation from cardiopulmonary bypass, as well as the instability of the patient following bypass. Careful observation of the adequacy of repair is done to predict the need for exogenous circulatory support separate from bypass. Near the anticipated end of bypass and after adequate re-warming, ventilation is re-started; de-airing maneuvers are initiated, and

assessment of cardiac rhythm is made. When indicated, the anesthesiologist establishes the pacemaker settings and begins temporary epicardial pacing. In addition, the anesthesiologist initiates inotropic cardiac support and afterload reduction, to allow safe separation from CPB. Antibiotic re-dosing occurs according to institution standards.

Post CPB;

Once cardiac and pulmonary parameters are stabilized, reversal of anticoagulation is confirmed with an ACT and TEG as needed, and blood products may be checked and administered as indicated. Blood gases and labs are intermittently checked and treatment of acid-base, electrolyte and metabolic abnormalities ensues. Cardiac function, brain activity, and tissue perfusion continue to be monitored, as the anesthetic is adjusted based on the hemodynamic response.

At the conclusion of surgery, transport monitors and infusion pumps are checked for proper function and then connected to the patient for transport to the intensive care unit. The patient is carefully placed on the ICU/transport bed with all monitors and infusions. Manual ventilation is begun and the patient is transported to the intensive care unit, with treatment continuing along the way as necessary to assure stable respiratory and hemodynamic parameters. On arrival in the ICU, hemodynamic and respiratory monitor connections are transferred to the unit's systems. Ventilation is transferred to a bedside ventilator and parameters adjusted to satisfactory patient outcomes as determined by oximetry, respirator indices, end-tidal CO₂ monitoring, examination, and arterial blood gas monitoring.

Description of Post-Service Work:

When the anesthesiologist transports the patient to the ICU or PACU, he or she provides initial ventilator settings. Report is given to the ICU staff/nursing personnel. The anesthesiologist orders initial analgesics and sedatives, as well as any indicated laboratory test. When stable, the care of the patient is transferred to the SICU team. The anesthetic record is completed and a copy placed in the medical record.

A post-procedure visit is performed. Findings are documented in the medical record, including evidence of recovery from anesthesia or any complications associated with anesthetic management.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):	Tripti Kataria, MD, MPH					
Specialty(s):	American Society of Anesthesiologists					
CPT Code:	00567					
Sample Size:	135	Resp n:	50	Resp %: 37.0%		
Sample Type:	Panel					
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.00	24.50	72.50	200.00
Survey Base Unit Values:		15.00	20.00	21.00	25.00	49.00
Pre-Anesthesia Time:						
Evaluation		10.00	20.00	30.00	30.00	90.00
Equipment/Supply Preparation		10.00	20.00	30.00	33.72	60.00
Intra-op Anesthesia Time:						
Induction Period		10.00	25.00	30.00	42.50	90.00
Post-Induction Period		20.00	180.00	217.50	240.00	420.00
Post-Anesthesia Time:				30.00		

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than following table.

CPT Code: 00567	
	<u>Specialty Recommended</u>
Base Unit Value:	20.00
Pre-Anesthesia Time:	
Evaluation	30.00
Equipment/Supply Preparation	30.00
Intra-op Anesthesia Time:	
Induction Period	30.00
Pos-Induction Period	217.50
Post-Anesthesia Time:	30.00

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Base Unit Value</u>	<u>Time Source</u>
00566		25	RUC Time

CPT Descriptor Anesthesia for direct coronary artery bypass grafting without pump oxygenator

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Base Unit Value</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Base Unit Value</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Base Unit Value</u>	<u>Time Source</u>
00563		25	RUC Time

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

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

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

TIME ESTIMATES (Median)

	New/Revised CPT Code: 00567	Key Reference CPT Code: 00566	Time Source: RUC Time
Median Pre-Service Time		20.00	
Evaluation	30.00		
Equipment/Supply Preparation	30.00		
Median Intra-Service Time		180.00	
Induction Period	30.00		
Post-Induction Period	218.00		
Median Post-service Time	30.00	27.50	
Median Total Time	338.00	228.00	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.14	4.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	4.29
Urgency of medical decision making	4.29	4.52

Technical Skill/Physical Effort (Mean)

Technical skill required	4.52	4.57
Physical effort required	4.00	4.38

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.43	4.52
Outcome depends on the skill and judgement of physician	4.57	4.67
Estimated risk of malpractice suit with poor outcome	4.14	4.19

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Anesthesia intensity/complexity	4.05	4.10
Intra-Op Anesthesia intensity/complexity	4.24	4.52
Post-Anesthesia intensity/complexity	4.00	4.05

Post-Induction Anesthesia Time-Intensity Allocation

	Percentage of Time (%)
Level 1 Presenting Problems are self-limited or minor; Straightforward medical decision making and treatment	12.26
Level 2 Presenting Problems are of low severity; Medical decision making and treatment of low complexity	18.02
Level 3 Presenting Problems are of moderate severity; Medical decision making of moderate complexity and treatment of high complexity	20.44
Level 4 Presenting Problems are moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity	24.94
Level 5 Presenting problems are of high severity; Medical decision making and treatment of high complexity; Critically ill or critically injured patient	24.34
Total (must total 100%)	99.00%

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.*

Code 00562 was revised and new code 00567 was created to address concerns expressed about code 00562 during the RUC's review of anesthesia work as part of the third Five Year Review. Much of the concern expressed dealt with the heterogeneity of surgical procedures reported under 00562.

Code 00562 was developed when number of cardiac surgery codes was limited. Over the years, this code has been used for an increasing number of more complex cardiac cases that are performed with pump oxygenator. Code 0056X was established to encompass surgical CPT codes involving coronary artery bypass with pump oxygenator, preserving code 00562 for more complex surgical procedures including valvular repairs and redo procedures

Coronary artery bypass patients are at greater risk for perioperative myocardial infarction. Anesthetic care must include special attention to maintaining an appropriate myocardial oxygen supply/demand balance and to aggressively treat myocardial ischemia when it occurs

While 78% of our respondents agreed that the patient described in the survey was typical, almost ¼ did not. These respondents stated that the patient would be older and have more co-morbidities such as

- hypertension (systolic and / or pulse pressure hyt),
- mild to moderate renal insufficiency,
- a history of a previous therapeutic cath procedure such as a PCI with or without a stent,
- CHF,

- COPD
- hypercholesterolemia,
- obesity.

The complexity/intensity measures for 00567 are lower than those for the reference service at a rate commensurate with our recommended base unit value.

We recommend a base unit value of 20 (the survey's 25th percentile).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 00562

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? Commonly

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 250000

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

Please explain the rationale for this estimate.

Specialty Anesthesiology

Frequency 250000

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?
 223000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Anesthesiology

Frequency 223000

Percentage

100.00%

Specialty

Frequency

Percentage

Specialty

Frequency

Percentage

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

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs**

CPT Long Descriptor:

00562 – Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age one year or older, for all non-coronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than one month after original operation

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

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

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

CPT Long Descriptor:

00562 – Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age one year or older, for all non-coronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than one month after original operation

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

We are requesting the standard anesthesia PE package as approved by the PERC/RUC in April 2006

CMS requested the PERC discuss the appropriateness of direct practice expense of clinical labor employed by the physician as a cost in the facility setting. The PERC carefully discussed the recommendation by the American Society of Anesthesiology of 11 minutes and agreed that this was a direct practice expense however 8 minutes of clinical labor time was more appropriate. The PERC recommends 8 minutes of clinical labor time for all anesthesia codes consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination, and completion of forms.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

3 minutes – anesthesia scheduling

5 minutes – case assignment, scheduling coordination, and completion of forms

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs**

CPT Long Descriptor:

00567 – Anesthesia for direct coronary artery bypass grafting with pump oxygenator

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

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

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

CPT Long Descriptor:

00567 – Anesthesia for direct coronary artery bypass grafting with pump oxygenator

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

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

We are requesting the standard anesthesia PE package as approved by the PERC/RUC in April 2006

CMS requested the PERC discuss the appropriateness of direct practice expense of clinical labor employed by the physician as a cost in the facility setting. The PERC carefully discussed the recommendation by the American Society of Anesthesiology of 11 minutes and agreed that this was a direct practice expense however 8 minutes of clinical labor time was more appropriate. The PERC recommends 8 minutes of clinical labor time for all anesthesia codes consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination, and completion of forms.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

3 minutes – anesthesia scheduling

5 minutes – case assignment, scheduling coordination, and completion of forms

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			00562		00567	
2	Meeting Date: April 2008			Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age one year or older, for all non-coronary bypass procedures (eg, valve procedures) or for re-operation for coronary artery bypass more than one month after original operation		Anesthesia for direct coronary artery bypass grafting with pump oxygenator	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			XXX	XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME			0.0	8.0	0.0	8.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	8.0	0.0	8.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure made						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity (please specify)						
17	Anesthesia Scheduling	L037D	RN/LPN/MTA	N/A	3	N/A	3
18	Case assignment, scheduling coordination and completion of forms	L037D	RN/LPN/MTA	N/A	5	N/A	5
19	End: When patient enters office/facility for surgery/procedure						
20	SERVICE PERIOD						
21	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure						
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						
41	Other Clinical Activity (please specify)						
42	End: Patient leaves office						
43	POST-SERVICE Period						
44	Start: Patient leaves office/facility						
45	Conduct phone calls/call in prescriptions						
46	Office visits						
47	List Number and Level of Office Visits						
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes		36				
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	Other						
54	Total Office Visit Time			0	0	0	0
55	Other Activity (please specify)						
56	End: with last office visit before end of global period						
57	MEDICAL SUPPLIES	CMS Code	Unit				
58							
59	Equipment	CMS Code					
60							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Computer Dependent External Fixation

The CPT Editorial Panel created two new codes to describe a unique external fixation system that requires specific resources and physician interventions that are not required for standard, non-computer dependent external fixators. The two new codes include one service for the initial application of the fixation system and a second for the replacement of the strut.

20696

The specialty society provided a thorough explanation of the physician work and intensity of computer dependent external fixation services 20696, *Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment, assessment, and computation of adjustment schedule*. The specialty society and the RUC agreed that survey pre-service time was too high and changed the pre-service time to package number 3 (straightforward patient/difficult procedure). The RUC also added 12 minutes of positioning time to the 3 minutes within the package for a total of 15 minutes because the service requires positioning of the patient's thigh and heel to allow for open access. The RUC agreed that the surveyed median intra-service time was too high, and instead found the surveyed 25th percentile intra-service time to be accurate. The RUC compared another reference service, 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)* (work RVU=16.00, IWPUT=.044, intra-service time = 120), to 20696 and agreed that its intra-service work per unit of time (IWPUT) was appropriate to compare to the survey code. In addition, the physician work relative value of 16.00 for 20692 appeared in line for this service except for the intra-service time. The RUC determined that the survey 25th percentile intra-service time of 150 minutes was appropriate and then used a building block methodology to value the service. The RUC began with 16.00 work RVUs from code 20692 and added 30 minutes at an intensity of 0.044 to reflect total 150 minutes of intra service time for 20696. This 1.32 RVU increment was added resulting in a final recommendation of 17.32 RVUs. 17.32 work RVUs for code 20696 was supported through the comparison and review of key reference code 27724 *Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)* (work RVU=19.18), 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2* (work RVU=17.54), and 22610 *Arthrodesis, posterior or posterolateral technique, single level; thoracic (with or without lateral transverse technique)* (work RVU=17.08). **The RUC recommends an intra-service time of 150 minutes (25th percentile survey) and a relative work value of 17.32 for code 20696.**

20697

The specialty society requested and the RUC agreed that 20697, *Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each*, should be assigned a 000 global period. The specialty society presenters discussed the physician work and practice expense involved in code 20697. The presenters and the RUC concurred that the physician work for the change of the strut typically occurs within the 090 day global time period of code 20696 and is performed during one of the follow up visits. If the change of the strut occurs after the 090 day time period an evaluation and management code may be billed along with code 20697. The committee believed the purpose of code 20697 is to provide for the additional practice expense component associated with the change of the strut rather than the physician work. **The RUC, therefore, recommended 0.00 work relative units for 20697.**

Practice Expense

The RUC recommends the standard 090 day global practice expense packages for 20696 as it is only performed in the facility setting. The RUC agreed that the clinical labor time associated with code 20697 should be reduced from a total of 36 minutes to 21 minutes as the service would be reported with an E/M service either as part of a 090 day global or reported separately after 90 days. The RUC further agreed that the time for the equipment should be reduced from 36 minutes to 21 minutes.

New Technology

The RUC recommended that 20696 and 20697 be added to the New Technology list.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●20696	I1	Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment, assessment, and computation of adjustment schedule (Do not report 20696 in conjunction with 20692, 20697)	090	17.32
Ø●20697	I2	exchange (ie, removal and replacement) of strut, each (Do not report code 20697 in conjunction with 20696, 20692)	000	0.00 (PE Inputs Only)

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

CPT Code:20696

Tracking Number II

Specialty Society Recommended RVU: **19.75**

Global Period: 090

RUC Recommended RVU: **17.32**

CPT Descriptor: Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)

(Do not report 20696 in conjunction with 20692, 20697)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 33-year-old female with a biplanar deformity and acquired limb length discrepancy with tibial non-union undergoes reconstructive surgery using a computer-dependent multiplanar, tensioned wire external fixation system designed for gradual deformity correction and controlled mechanical distraction osteogenesis.

[Please NOTE: Code 20696 includes application of the dynamic fixation device and all follow up hospital and/or office patient work through the 90-day global period except the changing of a strut. A strut change, if necessary, is separately reported using new code 20697.]

Percentage of Survey Respondents who found Vignette to be Typical: 77%

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

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

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

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

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- ? Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Obtain preoperative AP and LAT x-rays to accurately measure the deformity and analyze the deformity
- Perform H&P, including a physical examination to properly assess for any rotational deformity
- Determine the deformity parameters—Varus/valgus angulation, recurvatum or procurvatum, translation, and rotation
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- Position patient's leg with a bump under the thigh and a second bump under the heel to provide an open access to the entire limb for application of the circular fixator.
- Indicate areas of skin to be prepped and mark surgical incisions
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, the external fixator is mounted orthogonal to each segment of bone. Each ring is mounted perpendicular to the bone on the AP and LAT fluoroscopic projections as well as orthogonal in the axial plane with the centering bolts on the AP and LAT projections overlapping when the leg is held in the same "patella forward" position. This is accomplished by mounting the ring on an intraosseous wire placed perpendicular to the bone on the AP projection and a half pin placed perpendicular to the bone on the lateral projection. Each segment of bone has a ring mounted in this way with a wire and half pin. Additional wires and half pins (minimum 3 per segment) are added to each bone segment once both rings are mounted to each segment. The bone is examined under fluoroscopy to assess whether the correction can be performed without cutting the bone. Once the frame is mounted with intraosseous wires and half pins the six struts are connected. The mounting parameters are then assessed by determining where the LAT and AP centering bolts are in reference to the center of the ring. Radiographs are taken in the operating room while the surgeon positions the limb(s) to ensure complete accuracy of the mounting radiographs. The intra-operative mounting parameters, deformity parameters and initial strut settings are inserted into a computer program prior to the patient's discharge. The rate of correction is determined from the "greatest structure at risk" while the deformity is correcting. This rate of correction is also placed into the computer program to generate a safe daily schedule for the patient to perform gradual deformity correction, which would begin on post-op day 5-7.

Description of Post-Service Work:

Post-service work: in facility

- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring
- Order physical therapy for the use of crutches or walker is ordered
- Discharge day:
- The circulation, sensation and motor function of the extremity are assessed.
- The patient's vital signs are checked.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Review of home instructions for gradual deformity correction.
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office through 90 day global period

- Examine and talk with patient
- Answer patient/family questions
- Assess of circulation, sensation and motor function of the operated extremity
- Determine if any joints above and below the frame are becoming contracted and address these concerns with additional physical therapy prescriptions or splinting.
- Continue radiographic analysis of the deformity using AP and LAT projections, to assess the rate of correction and quality of bone regenerated while the deformity is correcting as well as any residual deformity
- Determining if there is any residual deformity after the completion of the schedule and using the computer program, as necessary, to generate a new schedule for completing the correction.
- Assess physical and occupational therapy progress
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD; LTC, MC Romney Anderson, MD					
Specialty(s):	AAOS, OTA					
CPT Code:	20696					
Sample Size:	250	Resp N:	31	Response: 12.4 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75 th pctl	High
Service Performance Rate		1.00	5.00	12.00	23.00	100.00
Survey RVW:		15.00	19.75	21.00	23.75	30.50
Pre-Service Evaluation Time:				75.00		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				15.00		
Intra-Service Time:		90.00	150.00	180.00	180.00	240.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00				
Other Hospital time/visit(s):	40.00	99231x 2.00 99232x 0.00 99233x 0.00				
Discharge Day Mgmt:	38.00	99238x 1.00 99239x 0.00				
Office time/visit(s):	117.00	99211x 0.00 12x 3.00 13x 3.00 14x 0.00 15x 0.00				
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	20696	Recommended Physician Work RVU: 19.75		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		180.00		
Immediate Post Service-Time:	30.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	40.00	99231x 2.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	38.00	99238x 1.0 99239x 0.0		
Office time/visit(s):	117.00	99211x 0.00 12x 3.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
27724	090	19.18	RUC Time

CPT Descriptor Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 58.0 %

TIME ESTIMATES (Median)

	CPT Code: 20696	Key Reference CPT Code: 27724	Source of Time RUC Time
Median Pre-Service Time	63.00	90.00	
Median Intra-Service Time	180.00	180.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	117.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	468.00	460.00	
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	4.39	3.81
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.44	3.88
Urgency of medical decision making	3.00	2.63

Technical Skill/Physical Effort (Mean)

Technical skill required	4.72	4.00
Physical effort required	4.06	3.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.28	4.00
Outcome depends on the skill and judgment of physician	4.78	4.25
Estimated risk of malpractice suit with poor outcome	4.06	3.75

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

Pre-Service intensity/complexity	4.50	3.69
Intra-Service intensity/complexity	4.28	3.81
Post-Service intensity/complexity	4.11	3.13

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20999, 29799

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

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

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4000

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

Please explain the rationale for this estimate. Estimate based on reported device sales

Specialty orthopaedic surgery Frequency 4000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty expert consensus estimate that less than 5% of total would be Medicare patients.

Specialty orthopaedic surgery Frequency 200 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code: 20697 Tracking Number I2

Specialty Society Recommended RVU: **1.40**

Global Period: 000

RUC Recommended RVU: **0.00**

CPT Descriptor: Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each

(Do not report 20697 in conjunction with 20692, 20696)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 33-year-old female with a biplanar deformity and acquired limb length discrepancy with tibial non-union while undergoing deformity correction requires exchange of strut.

[Please NOTE: Initial placement of the dynamic external fixation system is separately reported using code 20696. When completing this survey, only consider work directly related to subsequent removal and replacement of one strut.]

Percentage of Survey Respondents who found Vignette to be Typical: 84%

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

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

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

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

Description of Pre-Service Work:

- Using the patient's computer schedule for deformity correction, determine which strut will require a change because it has reached maximum length.
- Verify that all required instruments and supplies are available
- Position patient's leg with a bump under the thigh and a second bump under the heel to provide an open access to the entire limb
- Scrub and gown

Description of Intra-Service Work:

Place a spanning strut onto the frame to stabilize the frame at the site of the strut change. Remove the old strut and place a new strut with larger/smaller numbers. Once the new strut is secured, the temporary strut can be removed..

Description of Post-Service Work:

Immediate Post Service:

Monitoring of patient

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD; LTC, MC Romney Anderson, MD				
Specialty(s):	orthopaedic surgery				
CPT Code:	20697				
Sample Size:	250	Resp N:	32	Response: 12.8 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	4.00	10.00	23.00	43.00	250.00
Survey RVW:	1.00	1.80	2.00	3.00	4.50
Pre-Service Evaluation Time:			12.00		
Pre-Service Positioning Time:			3.00		
Pre-Service Scrub, Dress, Wait Time:			2.00		
Intra-Service Time:	10.00	15.00	20.00	20.00	60.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

CPT Code:	20697	Recommended Physician Work RVU: 0.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		0.00		
Immediate Post Service-Time:	<u>0.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
29450	000	2.08	RUC Time

CPT Descriptor Application of clubfoot cast with molding or manipulation, long or short leg**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99214	XXX	1.42	RUC Time	62,901,327

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A 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>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 15 % of respondents: 46.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 20697	<u>Key Reference CPT Code:</u> 29450	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	10.00	
Median Intra-Service Time	0.00	20.00	
Median Immediate Post-service Time	0.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	0.00	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	2.07	1.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	1.53
Urgency of medical decision making	2.00	1.33

Technical Skill/Physical Effort (Mean)

Technical skill required	2.20	1.93
Physical effort required	2.13	1.87

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.73	1.67
Outcome depends on the skill and judgment of physician	1.93	1.80
Estimated risk of malpractice suit with poor outcome	1.80	1.93

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

Pre-Service intensity/complexity	2.21	1.87
Intra-Service intensity/complexity	2.20	1.87
Post-Service intensity/complexity	1.86	1.29

Additional Rationale

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20999 and 29799

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

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

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Sales of primary device are reported at 4000. The estimate of 7200 struts changed is based on 30% require 1 strut change; 60 percent require 2 struts changed; 10% require 3 struts changed at one subsequent office visit (within and outside 90-day global period) and then a very few (children) will require one more additional change (1 or 2 struts) at another office visit because of growth (outside of global period).

Specialty orthopaedic surgery Frequency 7200 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? 360

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty expert consensus estimate that less than 5% of total would be Medicare patients.

Specialty orthopaedic surgery Frequency 360 Percentage 100.00 %

Specialty	Frequency	Percentage	%
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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. No physician work

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

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

CPT Long Descriptor:

20696: Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)

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

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

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

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

Post-Service Clinical Labor Activities:

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

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000 Day Global Periods
Facility and Non-Facility Direct Inputs**

CPT Long Descriptor: 20697: exchange (ie, removal and replacement) of strut, each

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

A consensus panel of experts representing orthopaedics reviewed the practice expense details for the survey codes relative to other 0-day global codes. Our specific allocation of time is found in the attached excel spreadsheet.

We are also attaching a PDF form that indicates the manufacturer's price for the strut replacement which is estimated at \$1151.00 (see attached)

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

0697 is performed either inside 90-day global for 20696 or billed with EM. Pre work would be part of 90-day global for 20696 EM for this 0-day code.

Intra-Service Clinical Labor Activities:

2 minutes to review procedure with patient/family and explain potential risks (including bleeding at pin sites)

2 minutes to be sure the MD has the right size struts available and any additional parts that might be necessary.

2 minutes to assist MD positioning of leg elevated and exposed for procedure (and imaging) - and padding for a 20+ min procedure.

10 minutes to assist physician in performing the procedure

3 minutes to monitor patient following services (includes checking tubes, monitors, and drains). Patient has been lying on back with leg positioned for 20 minutes and as a result, staff need to be certain of vestibular stability and physical stability.

2 minutes to check patient's dressings and provide wound care instructions, coordinate future office visits and write prescriptions.

Post-Service Clinical Labor Activities:

None

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation Meeting Date: April 2008			20696 Application of multiplane (pins or wires in more than one plane); unilateral; external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)	20697 Application of multiplane exchange (ie, removal and replacement) of strut, each		
2							
3	LOCATION	Code	Staff Type	Office	Facility	Office	Facility
4	GLOBAL PERIOD			090	090	000	000
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	261	21	0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60	0	0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	21	0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	189	0	0
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure made						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5	0	0
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20	0	0
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8	0	0
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20	0	0
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7	0	0
17	End: When patient enters office/facility for surgery/procedure						
18	SERVICE PERIOD						
19	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure						
20	Review charts	L037D	RN/LPN/MTA				
21	Greet patient and provide gowning	L037D	RN/LPN/MTA				
22	Obtain vital signs	L037D	RN/LPN/MTA				
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			2	
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			2	
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA				
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			2	
27	Sedate/apply anesthesia	L037D	RN/LPN/MTA				
28	Intra-service						
29	Assist physician in performing procedure	L037D	RN/LPN/MTA			10	
30	Post-Service						
31	Monitor pt following service/check tubes, monitors, drains	L037D	RN/LPN/MTA			3	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA				
33	Clean Scope	L037D	RN/LPN/MTA				
34	Clean Surgical Instrument Package	L037D	RN/LPN/MTA				
35	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
36	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
37	Check dressings & wound/ home care instructions /coordinate	L037D	RN/LPN/MTA			2	
38	Discharge day management 99238 --12 minutes, 99239 --15 minutes	L037D	RN/LPN/MTA		12		
40	End: Patient leaves office						
41	POST-SERVICE Period						
42	Start: Patient leaves office/facility						
43	Conduct phone calls/call in prescriptions						
45	List Number and Level of Office Visits						
46	99211 16 minutes		16				
47	99212 27 minutes		27		3		
48	99213 36 minutes		36		3		
49	99214 53 minutes		53				
50	99215 63 minutes		63				
51	Other						
52	Total Office Visit Time	L037D	RN/LPN/MTA	0	189	0	0
54	End: with last office visit before end of global period						
55	MEDICAL SUPPLIES	Code	Unit				

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			20696		20697	
2	Meeting Date: April 2008			Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging, initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)		Application of multiplane exchange (ie, removal and replacement) of strut, each	
3	LOCATION	Code	Staff Type	Office	Facility	Office	Facility
56	pack, minimum multi-specialty visit	SA048	pack		6		
57	drape, sterile, three-quarter sheet	SB014	item			1	
58	underpad 2ft x 3ft (Chux)	SB044	item			1	
59	replacement strut, dynamic external fixation	new	item			1	
60							
61	Equipment:	Code					
62	table, power	EF031		0	189	21	0
63	light, exam	EQ168		0	189	21	0
64							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Cervical Arthroplasty

Total disc arthroplasty represents a treatment option for patients requiring surgical treatment of symptomatic degenerative disc disease which has been refractory to conservative measures. Until this procedure was introduced, open surgical treatments were limited to either decompression or fusion using a variety of techniques. This technique allows for the preservation of nearly normal motion in the operated segment. Cervical arthroplasty received FDA approval last year and in February 2008 the CPT Editorial Panel deleted three and revised six Category III codes, and created three and revised three Category I CPT codes, for cervical total disc arthroplasty (artificial disc), anterior approach. The RUC reviewed the three newly created Category I CPT codes that involve the total disc arthroplasty, the revision or replacement, and the removal of the disc.

22856 - Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical

The RUC reviewed the survey results of 92 physicians and viewed them as robust both in physician time, complexity, and intensity for this new service. The RUC also compared three related services in order to value this service: the specialty's key reference service, code 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, single interspace* (Work RVU = 19.47, 90 minutes intra service time); 22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace* (work RVU = 26.93, intra-service time = 180 minutes); and 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2* (work RVU = 17.54, Intra service time = 90 minutes). The median survey results indicated a intra-service time of 120 minutes for new code 22856. Based on the specialty survey results and these comparison of codes, the RUC and the specialty agreed that the value of 22856 should be between the value of 63075 (19.47) and 22857 (26.93).

The specialty had a good survey response for new code 22856, however they concurred that the respondents had over valued the service at a median survey RVU of 30.00. The RUC understood that the work of new code 22856 consisted of all the work of code 63075 plus the preparation of the end plates and the placement of the device in the spine, for this stand alone co-surgeon code. The complexity and intensity is realized when the surgeon mobilizes the great vessels around the spine and the exact placement of the

device. The RUC constructed a work value of 23.90 based on the added time and intensity from its key reference service, 63075. The calculated value is the sum of the work RVU for 63075 plus 30 minutes additional intra-operative time at the same intensity, plus the difference of one post-operative office visit between a 99212 vs. 99213 [$19.47 + (30 \times 0.132) + 0.47 = 23.90$]. The RUC agreed with the specialty's rationale and calculated value. **The RUC recommends a relative work value of 23.90 for code 22856.**

22864 Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical

22864 describes the removal of a previously implanted cervical artificial disc. The RUC and specialty agreed that the value of this code will be inextricably linked to the value of 22856 which is the code for insertion of the cervical artificial disc. With this code as with 22856 the RUC agreed with the specialty's rationale and calculated a value that is lower than the 25 percentile of our survey but is appropriately linked to the recommended value of 22856. The survey indicated 22864 had 30 minutes of additional intra time beyond 22856 and otherwise had essentially identical time and visit data except for one additional level 2 hospital visit. The calculated value is equal to (22856 recommended RVW) + (30 minutes x IWPUT of base code 63075) + (one additional 99232 hospital visit). [$23.90 + (0.132 \times 30) + 1.39 = 29.25$]

In addition to maintaining appropriate relativity to the base code of 22856, the recommended value also maintains relativity to the key reference code of 22865 Removal of total disc arthroplasty (artificial disc), anterior approach, lumbar, single interspace (work RVU = 31.55, intra service time = 210 minutes) which is also the removal of an artificial disc but in the lumbar spine. This key reference code has a work relative value of 31.55 which is 2.30 RVUs greater than the survey code. Code 22865 has 60 minutes more intra time which is accounted for by the tediousness of dissecting through the previously operated abdominal and retroperitoneal space. However the psychological stress and technical skill was rated higher by the survey respondents than the key reference code within the intra-service period of 150 minutes of new code 22856. **The RUC recommends 29.25 relative value units for code 22864.**

22861 Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical

Code 22861 is the removal and replacement of a previously implanted cervical artificial disc. The value of this code will be inextricably linked to the value of 22856 which is the code for insertion of the cervical artificial disc and 22864 which is the code for the removal of an artificial cervical disc. With this code, as with 22856 and 22864, the RUC and the specialty agreed in the development of a calculated value that is lower than the 25th percentile of the survey, similar to its key reference service code 22862 Revision including replacement of total disc arthroplasty (artificial disc) anterior approach, lumbar, single interspace (work RVU = 32.43, intra-service time = 240). The survey indicated 22861 had 30 minutes of additional intra time beyond 22864 for the revision and replacement rather than just the removal, otherwise the two codes are essentially identical time and visit data. The RUC calculated and recommended relative value is equal to 22864 plus 30 minutes x IWPUT of base code 63075 [$29.25 + (0.132 \times 30) = 33.21$]

In addition to maintaining appropriate relativity to the base code of 22856 and 22864, the recommended value also maintains relativity to the key reference code of 22862) which is also the removal and replacement of an artificial disc, but in the lumbar spine. Code 22862 has 60 minutes more intra time which is accounted for by the tediousness of dissecting through the previously operated and now scarred abdominal and retroperitoneal space. **The RUC recommends a relative work value of 33.21 for CPT code 22861.**

Practice Expense:

The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

New Technology:

The RUC recommends that 22856, 22864, and 22861 be added to the new technology list as this procedure utilizes new techniques.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●22856	Q1	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical (Do not report 22856 with 22554, 22845, 22851, 63075 when performed at the same level) (Do not report 22856 in conjunction with 69990) (For additional interspace cervical total disc arthroplasty, report 0092T)	090	23.90
22857		Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar, single interspace (Do not report 22856 , 22857 in conjunction with 22558, 22845, 22851,	090	26.93 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		49010 when performed at the same level) (For additional interspace, use Category III code 0163T)		
●22861	Q2	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical (Do not report 22861 with 22845, 22851, 22864, 63075 when performed at the same level) (For additional interspace revision of cervical total disc arthroplasty, report 0098T)	090	33.21
22862		Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace lumbar, single interspace (Do not report 22861 , 22862 in conjunction with 22558, 22845, 22851, 22865, 49010 when performed at the same level) (For additional interspace, use Category III code 0165T)	090	32.43 (No Change)
●22864	Q3	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical (Do not report 22864 in conjunction with 22861, 69990) (For additional interspace removal of cervical total disc arthroplasty, report 0095T)	090	29.25
22865		Removal including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar, single interspace (Do not report 22864 , 22865 in conjunction with 22558, 22845, 22851,	090	31.55 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		22865, 49010 when performed at the same level (For additional interspace, use Category III code 0164T)		
Category III				
D 0090T		Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression) cervical; single interspace (0090T has been deleted. To report total disc cervical arthroplasty and lumbar arthroplasty , use 22856, 22857)		N/A
✚▲0092T		Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes discectomy or osteophylectomy for nerve root or spinal cord decompression and microdissection, to prepare interspace (other than for decompression), cervical; each additional interspace, cervical (List separately in addition to code for primary procedure) (Use 0092T in conjunction with 0090T 22856) (Do not report 0090T 0092T, 0095T, 0098T in conjunction with 22851, 49010 when performed at the same level) (For total disc lumbar arthroplasty of additional interspaces, use 0163T) (Do not report 0092T in conjunction with 22857)		N/A
D 0093T		Removal of total disc arthroplasty, anterior approach cervical; single interspace (0093T has been deleted. To report removal of total disc cervical and		N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		lumbar arthroplasty, use 22864, 22865)		
✚▲0095T		<p>Removal of total disc arthroplasty (artificial disc), anterior approach, cervical; each additional interspace, cervical (List separately in addition to code for primary procedure)</p> <p>(Use 0095T in conjunction with 0095T 22864)</p> <p><i>(For removal of total disc lumbar arthroplasty additional interspaces, use 0164T)</i></p> <p><i>(Do not report 0095T in conjunction with 22865)</i></p>		N/A
D 0096T		<p>Revision of total disc arthroplasty, anterior approach, cervical</p> <p>(0096T has been deleted. To report revision of total disc cervical and lumbar arthroplasty, use 22861, 22862)</p>		N/A
✚▲0098T		<p>Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, cervical; each additional interspace, cervical (List separately in addition to code for primary procedure)</p> <p>(Use 0098T in conjunction with 0096T 22861)</p> <p><i>(For revision of total disc lumbar arthroplasty additional interspaces, use 0165T)</i></p> <p><i>(Do not report 0098T in conjunction with 22862, 0095T)</i></p> <p>(0090T 0092T, 0095T, 0098T include fluoroscopy when performed)</p> <p>(Do not report 0090T 0092T, 0095T, 0098T in conjunction with 22851,</p>		N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		49010 when performed at the same level)		
✚▲0163T		Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar , each additional interspace, lumbar (List separately in addition to code for primary procedure) (Use 0163T in conjunction with 22857)		N/A
✚▲0164T		Removal of total disc arthroplasty (artificial disc), anterior approach, lumbar , each additional interspace, each additional interspace lumbar (List separately in addition to code for primary procedure) (Use 0164T in conjunction with 22865)		N/A
✚▲0165T		Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, cervical ; each additional interspace, lumbar (List separately in addition to code for primary procedure) (Use 0165T in conjunction with 22862) (0163T-0165T include fluoroscopy when performed) (Do not report 0163T-0165T in conjunction with 22851, 49010, when performed at the same level) (For cervical total disc arthroplasty procedures, see 0090T-22856-22861, 0092T, 0095T, 0098T)		N/A

Surgery
Operating Microscope

The surgical microscope is employed when the surgical services are performed using the techniques of microsurgery. Code 69990 should be reported (without modifier 51 appended) in addition to the code for the primary procedure performed. Do not use 69990 for visualization with

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
magnifying loupes or corrected vision. Do not report code 69990 in addition to procedures where use of the operating microscope is an inclusive component (15756-15758, 15842, 19364, 19368, 20955-20962, 20969-20973, <u>22856-22861</u> , 26551-26554, 26556, 31526, 31531, 31536, 31541, 31545, 31546, 31561, 31571, 43116, 43496, 49906, 61548, 63075-63078, 64727, 64820-64823, 65091-68850, <u>0184T</u>).				
69990		<i>Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)</i>	ZZZ	3.46 (No Change)

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

CPT Code: 22856 Tracking Number Q1

Specialty Society Recommended RVU: **23.90**

Global Period: 090

RUC Recommended RVU: **23.90**

CPT Descriptor: Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical

(Do not report with 22554, 22845, 22851, 63075 when performed at the same level)

(Do not report 228X1 with 69990)

(For additional interspace cervical total disc arthroplasty, report 0092T)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male presents with right-sided cervical brachial pain refractory to multimodality conservative therapy. Examination shows findings of nerve root compression with cervical motion, C6 radiculopathy on neurologic examination along with an MRI scan showing a single degenerative C5-6 disc with focal right paracentral disc herniation and associated osteophyte formation with foraminal and canal compromise.

Percentage of Survey Respondents who found Vignette to be Typical: 93 %

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

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

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

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

Description of Pre-Service Work: The results of preadmission testing are reviewed. The preoperative imaging is examined with special attention to the vascular anatomy of the cervical spine and appropriate templating for the arthroplasty device. The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The preoperative history and physical examination is updated. Preoperative orders for antibiotics and sequential compression devices are written. Select and order the appropriate antibiotic(s) and confirm timing and administration. Meet with patient and family to review planned procedure and post-operative management. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Verify correct configuration and balance of surgical microscope. Monitor/assist with positioning the patient in cervical lordotic traction. Monitor/assist with positioning of c-arm fluoroscopy and confirm appropriate fluoroscopic visualization. Indicate areas surrounding skin incision to be prepped and draped. Scrub and gown. Perform surgical "time out" with operating surgical team and anesthesia team.

Description of Intra-Service Work: A skin incision is made and sharp and blunt dissection is used to dissect between the carotid sheath laterally and the esophagus and trachea medially exposing the prevertebral space. Vertebral level is identified using fluoroscopy and the edges of the longus coli muscles are dissected and elevated from the vertebral bodies. Self-retaining retractors are inserted beneath the edge of the longus coli. The disc space is incised and the disc material is removed with curettes and rongeurs to the posterior longitudinal ligament. Disc space distractor pins are introduced into the C5 and C6 vertebral bodies, the distractor is applied and the space is open up with end plates parallel to each other. The operating microscope is sterilely draped and brought the field. The remainder of the procedure is performed utilizing standard microdissection techniques. The posterior ligament is opened and resected. The disc

herniation is identified and removed from the epidural space decompressing the nerve root. A micro Kerrison punch and/or the high speed air powered drill is used to perform a foraminotomy on both sides to remove uncovertebral osteophytes. Hemostasis is achieved, the cartilaginous end plate is removed sparing the bone. The implant trial is introduced into the disc space between the uncinat processes. The trial is then confirmed to be appropriately sized and located utilizing AP and Lateral plane fluoroscopy. A drill guide is then introduced over the implant trial and tracts are created in the inferior and superior end plates and cleaned of bone debris. The trial is removed and the final implant is inserted into the tracts previously cut and tapped into position. Fluoroscopy is used to confirm position in AP and Lateral projections, adjustments are made as necessary. Hemostasis is achieved, the retractors are removed and the incision is closed in layers and a sterile dressing is placed.

Description of Post-Service Work:

Immediate post-service: Apply sterile dressings. Obtain final AP and lateral imaging postoperatively to document arthroplasty position. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note. Write postoperative note in the recovery room. Evaluate and document postoperative neurologic status Dictate operative report and copy referring physician(s). Patient is discharged from recovery room. Write orders for transferring to floor and discuss postoperative plan with floor nurses.

Daily hospital post-service work: Monitor and document patient progress: evaluate for swallowing or airway compromise, sepsis, bowel function, cardio respiratory function, and neurologic function. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function. Begin diet with return of bowel function. Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection. Examine lower limbs for swelling. Maintain DVT prophylaxis with SCDs and/or additional add low-dose subcutaneous anticoagulant. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films after patient upright; review images to determine arthroplasty positioning and appropriate spine alignment. Write orders for physiotherapy. Activity parameters are modified to advance the patient's ambulation and mobility. Chart patient progress notes, daily. Answer patient and family questions. Answer nursing/other staff questions.

Discharge day management: The patient is discharged when there is return of bowel function, adequate nutrition intake, adequate pain control with oral analgesics, and independent ambulation. Write prescriptions for medications needed after discharge. Home restrictions (i.e., diet, activity, bathing, driving) are discussed with the patient, family members and discharging nurse. Write orders for outpatient physiotherapy. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Office post-discharge work: Examine and talk with patient. Perform wound check.. Remove sutures/staples if placed. Order and review x-rays of the spine. Review activity and restrictions. Perform neurological exam and confirm normal strength, reflexes and sensation. Answer patient/family questions. Write medication prescriptions. Order continued physiotherapy, as necessary, monitor rehabilitation. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	John Wilson, MD, Frederick Boop, MD, Alexander Mason, MD, Charles Mick, MD, Dale Blaiser, MD				
Specialty(s):	neurosurgery, orthopaedic surgery, spine surgery				
CPT Code:	22856				
Sample Size:	200	Resp N:	92	Response: 46.0 %	
Sample Type:	Random				
	<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate	1.00	2.00	5.00	10.00	160.00
Survey RVW:	19.00	25.00	30.00	36.87	64.00
Pre-Service Evaluation Time:			60.00		
Pre-Service Positioning Time:			20.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	60.00	90.00	120.00	120.00	180.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>40.00</u>	99231x 0.00 99232x 1.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>69.00</u>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	22856	Recommended Physician Work RVU: 23.40		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		20.00	3.00	17.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		120.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>40.00</u>	99231x 0.00 99232x 1.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>69.00</u>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
63075	090	19.47	RUC Time

CPT Descriptor Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, single interspace

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
24363	090	22.47	RUC Time	1,063

CPT Descriptor 1 Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
34802	090	0.00	RUC Time	12,432

CPT Descriptor 2 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22857	090	26.93	RUC Time

CPT Descriptor Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 20.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 22856	<u>Key Reference CPT Code:</u> 63075	<u>Source of Time</u> RUC Time
Median Pre-Service Time	80.00	95.00	
Median Intra-Service Time	120.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	69.0	62.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	377.00	355.00
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	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	3.75
Urgency of medical decision making	2.85	2.88

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.94
Physical effort required	3.78	3.48
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	3.79	3.52
Outcome depends on the skill and judgment of physician	4.22	4.20
Estimated risk of malpractice suit with poor outcome	4.18	4.40

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

Pre-Service intensity/complexity	3.54	3.00
Intra-Service intensity/complexity	4.00	3.64
Post-Service intensity/complexity	3.12	3.08

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.*

Total disc arthroplasty represents a treatment option for patients requiring surgical treatment of symptomatic degenerative disc disease which has been refractory to conservative measures. Until this procedure was introduced, open surgical treatments were limited to either decompression or fusion using a variety of techniques. This technique allows for the preservation of nearly normal motion in the operated segment. Lumbar arthroplasty received FDA approval in 2004 and CPT Cat I codes were approved in 2005. Cervical arthroplasty received FDA approval last year and approval to convert the Cat III codes to Cat I codes at the recent CPT meeting.

In comparison to the key reference code 63075, the new code 22856 is a similar procedure, utilizing the exact same approach to the cervical spine. Both Procedures require the use of microdissection techniques to accomplish decompression of the spinal canal at the level of the cervical spinal cord. The new code will require more intra-time because of the additional work and time associated with the preparation of the interspace and the placement of the artificial disc. Essentially the new code 22856 includes the work of 63075 plus placing the artificial disc.

We recommend a calculated RVW of 23.90 which maintains the IWPUT of the recently reviewed base code 63075. This value is less than the survey 25th percentile but correctly between the RVWs for the key reference code 60375 and the additional reference code 22857 which is the comparable, but more time due to the anterior transabdominal approach to the lumbar spine. Our expert panel felt that the survey respondents estimated the magnitude of work of the survey code relative to the reference code plus a fusion (which would typically be done together) but did not adequately account for differences in time between the typically combined procedures and 22856. The calculated value is the sum of the RVW for 63075 plus (30 minutes additional intra-op time x IWPUT for 63075) plus (the difference in one post-op office visits 99213 vs 99212). $[19.47 + (30 \times 0.132) + 0.47 = 23.90]$.

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from standard 40 minutes.
- Positioning: Add 17 minutes (total 20 min) to account for assisting positioning of the patient in cervical lordotic traction, placing traction on the shoulders to allow for fluoroscopic visualization and positioning and confirming visualization with c-arm fluoro.
- Scrub/Dress/Wait: No change from standard 20 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0090T Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace (other than for decompression) cervical; single interspace

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

Specialty Neurosurgery How often? Sometimes

Specialty Orthopaedic Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8000

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

Please explain the rationale for this estimate. Society panel opinion. In 1999, approximately 200,000 spinal fusions were performed for a variety of diagnoses. Approximately 1/4 - 1/3 of these "could" be candidates for total disc arthroplasty, some percentage of those would be candidates for the cervical approach

Specialty Neurosurgery Frequency 3000 Percentage 37.50 %

Specialty Orthopaedic Surgery Frequency 5000 Percentage 62.50 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 23

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2006 claims submitted frequency for 0090T

Specialty Neurosurgery Frequency 9 Percentage 39.13 %

Specialty Orthopaedic Surgery Frequency 14 Percentage 60.86 %

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. A more appropriate PLI crosswalk code would be CPT Code 22318, Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; without grafting. CPT Code 22318 is more appropriate because it includes an anterior cervical approach and instrumentation.

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: 22861 Tracking Number Q3

Specialty Society Recommended RVU: **33.21**

Global Period: 090

RUC Recommended RVU: **33.21**

CPT Descriptor: Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical

(Do not report 228X3 with 22845, 22851, 228X2, 63075 when performed at the same level)

(For additional interspace revision of cervical total disc arthroplasty, report 0098T)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male presents status post anterior cervical disc arthroplasty several days ago. Follow up x-rays show migration of the implant requiring revision.

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

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

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

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

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: The results of preadmission testing are reviewed. The preoperative imaging is examined with special attention to the vascular anatomy on the cervical spine. The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The preoperative history and physical examination is updated. Preoperative orders for antibiotics and sequential compression devices are written. Select and order the appropriate antibiotic(s) and confirm timing and administration. Meet with patient and family to review planned procedure and post-operative management. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Verify correct configuration and balance of surgical microscope. Monitor/assist with positioning the patient in cervical lordotic traction. Monitor/assist with positioning of c-arm fluoroscopy and confirm appropriate fluoroscopic visualization. Indicate areas surrounding skin incision to be prepped and draped. Scrub and gown. Perform surgical "time out" with operating surgical team and anesthesia team.

Description of Intra-Service Work: A skin incision is through the old incision, and sharp and blunt dissection is used to dissect through the scar tissue of the prior operation between the carotid sheath laterally and the esophagus and trachea medially exposing the prevertebral space. The implant level is identified using fluoroscopy and the edges of the longus coli muscles are dissected and elevated from the vertebral bodies. Self-retaining retractors are inserted beneath the edge of the longus coli. The device is dissected free of the superior and inferior bone and the device is removed from the endplates. Disc space distractor pins are introduced into the C5 and C6 vertebral bodies, the distractor is applied and the space is open up with end plates parallel to each other. The implant trial is introduced into the disc space between the uncinat processes. The trial is then confirmed to be appropriately sized and located in AP and Lateral plane fluoroscopy. A drill guide is then introduced over the implant trial and if needed, new tracts are created in the inferior and superior end plates and cleaned of bone debris. The trial is removed and the final implant is inserted into the tracts previously cut and tapped into position. Fluoroscopy is used to confirm position in AP and Lateral projections,

adjustments are made as necessary. Hemostasis is achieved, the retractors are removed and the incision is closed in layers and a sterile dressing is placed.

Description of Post-Service Work:

Immediate post-service: Apply sterile dressings. Obtain final AP and lateral imaging postoperatively to document arthroplasty position. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note. Write postoperative note in the recovery room. Evaluate and document postoperative neurologic status Dictate operative report and copy referring physician(s). Patient is discharged from recovery room. Write orders for transferring to floor and discuss postoperative plan with floor nurses.

Daily hospital post-service work: Monitor and document patient progress: evaluate for swallowing or airway compromise, sepsis, bowel function, cardio respiratory function, and neurologic function. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function. Begin diet with return of bowel function. Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection. Examine lower limbs for swelling. Maintain DVT prophylaxis with SCDs and/or additional add low-dose subcutaneous anticoagulant. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films after patient upright; review images to determine arthroplasty positioning and appropriate spine alignment. Write orders for physiotherapy. Activity parameters are modified to advance the patient's ambulation and mobility. Chart patient progress notes, daily. Answer patient and family questions. Answer nursing/other staff questions.

Discharge day management: The patient is discharged when there is return of bowel function, adequate nutrition intake, adequate pain control with oral analgesics, and independent ambulation. Write prescriptions for medications needed after discharge. Home restrictions (i.e., diet, activity, bathing, driving) are discussed with the patient, family members and discharging nurse. Write orders for outpatient physiotherapy. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Office post-discharge work: Examine and talk with patient. Perform wound check.. Remove sutures/staples if placed. Order and review x-rays of the spine. Review activity and restrictions. Perform neurological exam and confirm normal strength, reflexes and sensation. Answer patient/family questions. Write medication prescriptions. Order continued physiotherapy, as necessary, monitor rehabilitation. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	John Wilson, MD, Frederick Boop, MD, Alexander Mason, MD, Charles Mick, MD, Dale Blaiser, MD				
Specialty(s):	neurosurgery, orthopaedic surgery, spine surgery				
CPT Code:	22861				
Sample Size:	200	Resp N:	13	Response: 6.5 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	1.00	1.00	6.00	10.00
Survey RVW:	24.00	35.00	36.00	40.00	62.50
Pre-Service Evaluation Time:			90.00		
Pre-Service Positioning Time:			20.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	45.00	120.00	180.00	240.00	300.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>100.00</u>	99231x 1.00 99232x 2.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>69.00</u>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	22861	Recommended Physician Work RVU: 32.71		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		20.00	3.00	17.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		180.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>80.00</u>	99231x 0.00 99232x 2.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>69.00</u>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22862	090	32.43	RUC Time

CPT Descriptor Revision including replacement of total disc arthroplasty (artificial disc) anterior approach, lumbar, single interspace

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44626	090	27.82	RUC Time	4,592

CPT Descriptor 1 Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
35646	090	32.84	RUC Time	3,354

CPT Descriptor 2 Bypass graft, with other than vein; aortobifemoral

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
63075	090	19.47	RUC Time

CPT Descriptor Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 30.7 %

TIME ESTIMATES (Median)

	CPT Code: 22861	Key Reference CPT Code: 22862	Source of Time RUC Time
Median Pre-Service Time	80.00	105.00	
Median Intra-Service Time	180.00	240.00	
Median Immediate Post-service Time	30.00	45.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	69.0	92.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	477.00	620.00
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	4.75	4.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.75
Urgency of medical decision making	4.00	4.25

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.75
Physical effort required	4.75	5.00

Psychological Stress (Mean)

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

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

Pre-Service intensity/complexity	4.75	4.75
Intra-Service intensity/complexity	5.00	5.00
Post-Service intensity/complexity	5.00	5.00

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.*

22861 is the removal and replacement of a previously implanted cervical artificial disc. The value of this code will be inextricably linked to the value of 22856 which is the code for insertion of the cervical artificial disc and 22864 which is the code for the removal of an artificial cervical disc. With this code as with 22856 and 22864, we are recommending a calculated value that is lower than the 25 percentile of our survey but is appropriately linked to the recommended value of 22856 and 22864. **We recommend a calculated RVW of 33.21.** The survey indicated 22861 had 30 minutes of additional intra time beyond 22864 and otherwise had essentially identical time and visit data. The calculated RVW is equal to 22864 plus 30 minutes x IWPOT of base code 63075

$$29.25 + (0.132 \times 30) = 33.21$$

In addition to maintaining appropriate relativity to the base code of 22856 and 22864, the recommended value also maintains relativity to the key reference code of 22862 which is also the removal and replacement of an artificial disc but in the lumbar spine. This key reference code has a wRVU of 32.43 which is similar to the survey code. 22862 has 60 minutes more intra time which is accounted for by the tediousness of dissecting through the previously operated abdominal and retroperitoneal space.

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from standard 40 minutes.
- Positioning: Add 17 minutes (total 20 min) to account for assisting positioning of the patient in cervical lordotic traction, placing traction on the shoulders to allow for fluoroscopic visualization and positioning and confirming visualization with c-arm fluoro.
- Scrub/Dress/Wait: No change from standard 20 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0096T Revision of total disc arthroplasty, anterior approach cervical; single interspace

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

Specialty neurosurgery How often? Rarely

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 80

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Less than 1% expected to require removal

Specialty neurosurgery Frequency 30 Percentage 37.50 %

Specialty orthopaedic surgery Frequency 50 Percentage 62.50 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Less than 1% expected to require removal

Specialty neurosurgery Frequency 1 Percentage 50.00 %

Specialty orthopaedic surgery Frequency 1 Percentage 50.00 %

Specialty Frequency Percentage %

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code: 22864 Tracking Number Q2

Specialty Society Recommended RVU: **29.25**

Global Period: 090

RUC Recommended RVU: **29.25**

CPT Descriptor: Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical
(Do not report 228X2 in conjunction with 228X3)
(For additional interspace removal of cervical total disc arthroplasty, report 0095T)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male with a previously implanted C5-6 total disc arthroplasty developed an infection and abscess and has demonstrated loosening of the implant requiring removal.

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

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

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

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

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

Description of Pre-Service Work: The results of preadmission testing are reviewed. The preoperative imaging is examined with special attention to the vascular anatomy on the cervical spine. The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The preoperative history and physical examination is updated. Preoperative orders for antibiotics and sequential compression devices are written. Select and order the appropriate antibiotic(s) and confirm timing and administration. Meet with patient and family to review planned procedure and post-operative management. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Verify correct configuration and balance of surgical microscope. Monitor/assist with positioning the patient in cervical lordotic traction. Monitor/assist with positioning of c-arm fluoroscopy and confirm appropriate fluoroscopic visualization. Indicate areas surrounding skin incision to be prepped and draped. Scrub and gown. Perform surgical "time out" with operating surgical team and anesthesia team.

Description of Intra-Service Work: A skin incision is made and sharp and blunt dissection is used to dissect through the scar tissue of the prior approach between the carotid sheath laterally and the esophagus and trachea medially exposing the prevertebral space. Vertebral level is identified using fluoroscopy and the edges of the longus coli muscles are dissected and elevated from the vertebral bodies. Self-retaining retractors are inserted beneath the edge of the longus coli. The device is dissected free of the superior and inferior bone and the device is removed from the endplates. Additional procedures may be performed and reported separately as appropriate. Hemostasis is achieved, the retractors are removed and the incision is closed in layers and a sterile dressing is placed.

Description of Post-Service Work:

Immediate post-service: Apply sterile dressings. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Patient is discharged from recovery room. Write orders for transferring to floor and discuss postoperative plan with floor nurses.

Daily hospital post-service work: Monitor and document patient progress: evaluate for swallowing or airway compromise, sepsis, bowel function, cardio respiratory function, and neurologic function. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function. Begin diet with return of bowel function. Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection. Examine lower limbs for swelling. Maintain DVT prophylaxis with SCDs and/or additional add low-dose subcutaneous anticoagulant. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films after patient upright; review images to determine arthroplasty positioning and appropriate spine alignment. Write orders for physiotherapy. Activity parameters are modified to advance the patient's ambulation and mobility. Chart patient progress notes, daily. Answer patient and family questions. Answer nursing/other staff questions.

Discharge day management: The patient is discharged when there is return of bowel function, adequate nutrition intake, adequate pain control with oral analgesics, and independent ambulation. Write prescriptions for medications needed after discharge. Home restrictions (i.e., diet, activity, bathing, driving) are discussed with the patient, family members and discharging nurse. Write orders for outpatient physiotherapy. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Office post-discharge work: Examine and talk with patient. Perform wound check.. Remove sutures/staples if placed. Order and review x-rays of the spine. Review activity and restrictions. Perform neurological exam and confirm normal leg strength and sensation. Answer patient/family questions. Write medication prescriptions. Order continued physiotherapy, as necessary, monitor rehabilitation. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	John Wilson, MD, Frederick Boop, MD, Alexander Mason, MD, Charles Mick, MD, Dale Blaiser, MD				
Specialty(s):	neurosurgery, orthopaedic surgery, spine surgery				
CPT Code:	22864				
Sample Size:	200	Resp N:	21	Response: 10.5 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	1.00	1.00	2.00	20.00
Survey RVW:	13.00	30.00	34.00	38.00	62.50
Pre-Service Evaluation Time:			75.00		
Pre-Service Positioning Time:			20.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	45.00	120.00	150.00	180.00	300.00
Immediate Post Service-Time:	<u>40.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>80.00</u>	99231x 0.00 99232x 2.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>69.00</u>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	22864	Recommended Physician Work RVU: 28.75		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		20.00	3.00	17.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		150.00		
Immediate Post Service-Time:	<u>40.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>80.00</u>	99231x 0.00 99232x 2.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>69.00</u>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22865	090	31.55	RUC Time

CPT Descriptor Removal of total disc arthroplasty (artificial disc), anterior approach, lumbar, single interspace

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44204	090	26.29	RUC Time	9,405

CPT Descriptor 1 Laparoscopy, surgical; colectomy, partial, with anastomosis

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44626	090	27.82	RUC Time	4,592

CPT Descriptor 2 Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
63075	090	19.47	RUC Time

CPT Descriptor Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, single interspace

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 33.3 %

TIME ESTIMATES (Median)

	CPT Code: 22864	Key Reference CPT Code: 22865	Source of Time RUC Time
Median Pre-Service Time	80.00	105.00	
Median Intra-Service Time	150.00	210.00	
Median Immediate Post-service Time	40.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	120.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	69.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	457.00	595.00	

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	4.71	4.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.71	4.83
Urgency of medical decision making	4.00	4.17

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.50
Physical effort required	4.71	4.83
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	5.00	4.83
Outcome depends on the skill and judgment of physician	5.00	4.67
Estimated risk of malpractice suit with poor outcome	5.00	4.67

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

Pre-Service intensity/complexity	4.86	4.83
Intra-Service intensity/complexity	5.00	4.83
Post-Service intensity/complexity	4.29	4.67

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.*

22864 is the removal of a previously implanted cervical artificial disc. The value of this code will be inextricably linked to the value of 22856 which is the code for insertion of the cervical artificial disc. With this code as with 22856 we are recommending a calculated value that is lower than the 25 percentile of our survey but is appropriately linked to the recommended value of 22856. **We recommend a calculated RVW of 29.25** The survey indicated 22864 had 30 minutes of additional intra time beyond 22864 and otherwise had essentially identical time and visit data except for one additional 99232HV. The calculated value is equal to (22856 recommended RVW) + (30 minutes x IWPUT of base code 63075) + (one additional 99232 HV). $[23.90 + (0.132 \times 30) + 1.39 = 29.25]$

In addition to maintaining appropriate relativity to the base code of 22856, the recommended value also maintains relativity to the key reference code of 22865 which is also the removal of an artificial disc but in the lumbar spine. This key reference code has a wRVU of 31.55 which is 2.8 greater than the survey code. 22865 has 60 minutes more intra time which is accounted for by the tediousness of dissecting through the previously operated abdominal and retroperitoneal space.

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from standard 40 minutes.
- Positioning: Add 17 minutes (total 20 min) to account for assisting positioning of the patient in cervical lordotic traction, placing traction on the shoulders to allow for fluoroscopic visualization and positioning and confirming visualization with c-arm fluoro.
- Scrub/Dress/Wait: No change from standard 20 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

	CPT		Global	WRVU	Pre	Intra	Post
3.	22554-51	Anterior cervical arthrodesis	90	8.77	95	90	177
4.	22845	Anterior spinal instrumentation	zzz	11.94		90	
5.	20931	Structural allograft for spine fusion	zzz	1.81		90	

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0093T Removal of total disc arthroplasty, anterior approach cervical; single interspace

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

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

Specialty Neurosurgery How often? Rarely

Specialty Orthopaedic Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 80

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

Please explain the rationale for this estimate. Less than 1 % expected to require removal

Specialty Neurosurgery Frequency 30 Percentage 37.50 %

Specialty Orthopaedic Surgery Frequency 50 Percentage 62.50 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Less than 1 % expected to require removal

Specialty Neurosurgery Frequency 1 Percentage 50.00 %

Specialty Orthopaedic Surgery Frequency 1 Percentage 50.00 %

Specialty Frequency Percentage %

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

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. A more appropriate PLI crosswalk code would be CPT Code 22319, Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting. CPT Code 22319 is more appropriate because it includes an anterior cervical approach and instrumentation.

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**

- 22856 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical
- 22864 Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical
- 22861 Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical

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. Additionally, the PEAC has approved 15 minutes of additional “atypical” time for complex spine codes involving multidisciplinary coordination of care prior to the procedure (see attached file from the March 2002 PEAC meeting, Tab 20).

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	H	I
1	AMA/Specialty Society Update Committee Recommendation			22856		22864		22861	
2	Meeting Date: April 2008			Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical		Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical		Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical	
3	LOCATION	Code	Staff Type	Office	Facility	Office	Facility	Office	Facility
4	GLOBAL PERIOD			090	090	090	090	090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	195	N/A	195	N/A	195
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	75	N/A	75	N/A	75
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12	N/A	12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	108	N/A	108	N/A	108
9	PRE-SERVICE								
10	Start: Following visit when decision for surgery or procedure made								
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		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
16	Other Clinical Activity coordination of care	L037D	RN/LPN/MTA		15		15		15
17	End: When patient enters office/facility for surgery/procedure								
18	SERVICE PERIOD								
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12		12		12
41	End: Patient leaves office/FACILITY								
42	POST-SERVICE Period								
43	Start: Patient leaves office/facility								
44	Conduct phone calls/call in prescriptions								
46	List Number and Level of Office Visits								
47	99211 16 minutes		16						
48	99212 27 minutes	L037D	27						
49	99213 36 minutes	L037D	36		3		3		3
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	Other								
54	Total Office Visit Time				108		108		108
55	Other Activity (please specify)								
56	End: with last office visit before end of global period								
57	MEDICAL SUPPLIES	CMS Code	Unit						
58	pack, minimum multi-specialty visit	SA048	pack		3		3		3
59	pack, post-op incision care (suture & staple)	SA053	kit		1		1		1
60									
61									
62	Equipment	CMS Code	Utilization Percentage						
63	table, power	EF031	100%		108		108		108

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2008

Buttock Fasciotomy

In June 2008, the CPT Editorial Panel created two new CPT codes for patients who are developing or having compartment syndrome involving one or more of the pelvic compartments. The most commonly recognized compartment, for this syndrome is the buttock compartment as its large muscle mass is confined by the tight inelastic fascia. The most common causes for pelvic compartment syndrome are musculoskeletal pelvic trauma, prolonged immobility with prolonged buttock pressure due to altered level of consciousness, Ehlers-Danlos syndrome, and sickle cell associated muscle infarction. If the compartment syndrome is unrecognized or untreated, it can lead to renal failure, sepsis and death. The treatment for this syndrome had previously been reported using unlisted procedure code 27299 *Unlisted procedure, pelvis or hip joint*.

27027 Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral(To report bilateral procedures, report 27027 with modifier 50)

The RUC reviewed the specialty society survey data and original recommended work value for code 27027 of 15.92 work RVUs. The RUC believed the pre-service time and post-operative visit time from the survey respondents appeared inaccurate for the service provided. The RUC believed the pre-service package number 3 – Straight forward Patient/Difficult Procedure (total 51 minutes) is appropriate for this service. However because the patient needs to be in a lateral decubitus position, the positioning time required an additional 9 minutes of time. The RUC also believed that an additional reduction in the level of post operative hospital visits was necessary and recommends one 99232 and three 99231 hospital visits. The RUC determined an additional change from the survey results in the level of post operative office visits was also necessary and the RUC recommends one 99213 and three 99212 office visits. Using a building block methodology, the **RUC recommends a work relative value for code 27027 of 12.90**. These changes and recommendations are shown in the table below. This value was further supported when the RUC reviewed reference codes 27025 *Fasciotomy, hip or thigh, any type* (work RVU 12.66) and code 22010 *Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic* (RUC reviewed April 2005, intra service time = 60 minutes, Work RVU = 12.57 090 global) and determined that code 27027 required more physician work. The RUC understands that the recommended value is slightly lower than the specialty society's 25th percentile survey results of 13.20.

27057 Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral (To report bilateral procedures, report 27057 with modifier 50)

The RUC reviewed the specialty society survey and recommended work value for code 27057 of 18.67. From the specialty society's RUC presentation the specialty and RUC believed the pre-service time and post operative visit time from the survey respondents appeared inaccurate for the service provided. The RUC determined the pre-service package number 3 – Straight forward Patient/Difficult Procedure (total 51 minutes) is appropriate for this service. However because the patient needs to be in a lateral decubitus position, the positioning time required an additional 9 minutes of time. The RUC determined that an additional reduction in the level of post operative hospital visits was necessary and recommends one 99232 and three 99231 hospital visits. The RUC determined an additional change from the survey results in the level of post operative office visits was necessary and recommends one 99213 and three 99212 office visits. After additional discussion of the intensity and complexity of 27057 compared to 27027 *Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral* the RUC believed the intra service work per unit of time (IWPUT) should be identical. Using a building block methodology, the **RUC recommends a work relative value for code 27057 of 14.77**. This value is slightly higher than the 25% percentile specialty survey results and is in proper rank order with the specialty's reference service 25025 *Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve* (work RVU = 17.77). The RUC agreed that 27057 has similar pre and post service work, similar intensities and complexities as code 27027, but has an additional 30 minutes of intra-service work.

	Specialty Original Rec	RUC Recommendation	Specialty Original Rec	RUC Recommendation
Recommended WRVU	15.92	12.90	18.67	14.77
Pre-Evaluation	60	43	60	43
Pre-Positioning	15	12	15	12
Scrub Dress Wait	15	5	15	5
Intra-Service	60	60	90	90
Immediate Post-op	30	30	30	30
99232	3	1	3	1
99231	2	3	3	3
99238	1	1	1	1
99213	2	1	2	1
99212	2	3	2	3
Total Time	456	359	506	389

Practice Expense

The RUC reviewed and agreed with the facility only practice expense recommendations the specialty had recommended except for the pre-service time for these urgent procedures. The RUC and the specialty agreed that a total of 25 minutes of pre-service time was sufficient for these services rather than the standard 60 minutes for the typical 090 day global service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●27027	J1	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral (To report bilateral procedures, report 27027 with modifier 50)	090	12.90
●27057	J2	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral (To report bilateral procedures, report 27057 with modifier 50)	090	14.77

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 27027 Tracking Number J1 Specialty Society Recommended RVU: **15.92**
 Global Period: 090 RUC Recommended RVU: **12.90**

CPT Descriptor: Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle); unilateral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 23-year-old male involved in motorcycle crash sustains fractures of the tibia and fibula, a pulmonary contusion, along with contusions and significant skin abrasions to buttocks and legs. There is a large left buttock contusion with no evidence of a pelvic fracture. Over the next six hours, the contusion and associated interstitial hemorrhage and edema expand causing increasing pain down the left leg. The patient is taken to the operating room emergently for pelvic compartment fasciotomy(ies).

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

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

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

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

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

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient is placed properly on the table and positioned with proper bolstering to aid surgical exposure of the pelvis and upper thigh.
- Indicate areas of skin to be prepped and mark surgical incisions
- The hemipelvis, flank, buttock and lower extremity are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made from on the superolateral thigh beginning at the greater trochanter and extending proximally and posteriorly into the buttock ending 4 cm below the posterior superior iliac spine. Hemostasis is achieved in the dermal and subcutaneous tissues with electrocautery. The iliotibial band is identified and incised in line with the incision. Proximally, the gluteus maximus is bluntly split in the direction of its fibers. The inferior gluteal artery is identified and protected. The gluteus medius and the tensor fascia lata muscles are identified.

The dissection is deepened to allow identification of the sciatic nerve, the piriformis, obturator internus, obturator externus, superior and inferior gemelli, and quadratus femoris muscles. Deep hematoma is identified and evacuated. The superior gluteal artery and nerve, inferior gluteal artery and nerve are identified and if injured, bleeding is controlled. The fascia overlying the gluteus medius, gluteus minimus, gluteus maximus (including gluteal aponeurosis) and tensor fascia lata muscles are released as required to provide decompression. All muscles are inspected and evaluated for viability, contractility and/or injury. Epimysial and intramuscular hemorrhage is controlled. Complete hemostasis is achieved. The wound is packed and left open

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

- Application of a dressing. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Dictate operative report.
- Write orders for transferring to surgical floor and discuss ongoing care with floor nurses.
- Orders are written for evaluation of periodic imaging and laboratory reports; review of anticoagulation laboratory values and appropriate medication adjustment, and antibiotic and pain medication adjustments
- Monitor and document patient progress.
- The circulation, sensation and motor function of the operated extremity are assessed daily
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, films, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Answer patient and family questions. Answer nursing/other staff questions.
- Physical therapy for the uses of crutches or walker is ordered
- Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy.
- Write prescriptions for medications needed post-discharge.
- Home restrictions (i.e., diet, activity, bathing) are discussed with the patient, family members and discharging nurse.
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of dressings
- Assessment of surgical wound
- Remove sutures
- Review postoperative lab studies including CBC, myoglobin and renal function
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2008				
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD; Charles Mabry, MD, FACS; Christopher Senkowski, MD, FACS				
Specialty(s):	AAOS, OTA; ACS				
CPT Code:	27027				
Sample Size:	50	Resp N:	22	Response: 44.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	1.00	1.00	2.00	10.00
Survey RVW:	10.00	13.20	17.00	18.94	30.00
Pre-Service Evaluation Time:			60.0		
Pre-Service Positioning Time:			15.0		
Pre-Service Scrub, Dress, Wait Time:			20.0		
Intra-Service Time:	30.00	60.00	60.00	68.00	100.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0 99292x 0.0			
Other Hospital time/visit(s):	<u>175.0</u>	99231x 2.0 99232x 2.0 99233x 1.0			
Discharge Day Mgmt:	<u>38.0</u>	99238x 1.0 99239x 0.00			
Office time/visit(s):	<u>85.0</u>	99211x 0.0 12x 1.0 13x 3.0 14x 0.0 15x 0.0			
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	27027				
	Specialty Recommended				
Physician Work RVU:	15.92				
Pre-Service Evaluation Time:	43.0				
Pre-Service Positioning Time:	12.0				
Pre-Service Scrub, Dress, Wait Time:	5.0				
Intra-Service Time:	60.00				
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0 99292x 0.0			
Other Hospital time/visit(s):	<u>100.0</u>	99231x 3.0 99232x 1.0 99233x 0.0			
Discharge Day Mgmt:	<u>38.0</u>	99238x 1.0 99239x 0.0			
Office time/visit(s):	<u>71.0</u>	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0			
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0			

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
25025	090	17.77	RUC Time

CPT Descriptor Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
	090			

Harvard Time

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
	090			

Harvard Time

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
27236	090	17.43	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 0.0 %

TIME ESTIMATES (Median)

	CPT Code: 27027	Key Reference CPT Code: 25025	Source of Time RUC Time
Median Pre-Service Time	60.00	60.00	
Median Intra-Service Time	60.00	125.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	120.00	
Median Discharge Day Management Time	38.0	38.00	

Median Office Visit Time	71.0	87.00
Prolonged Services Time	0.0	0.00
Median Total Time	359.00	460.00
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	3.33
--------------------------------------------------------------------------------------------------	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.33
--------------------------------------------------------------------------------------------------------------------------------	------	------

Urgency of medical decision making	4.67	4.67
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.33
--------------------------	------	------

Physical effort required	3.67	3.33
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.33	4.00
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	4.00	4.33
--------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	4.67	4.67
------------------------------------------------------	------	------

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

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

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

Post-Service intensity/complexity	3.33	3.33
-----------------------------------	------	------

Additional Rationale

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

New code 27027 describes a procedure for patients developing or having compartment syndrome involving one or more of the pelvic compartments. The most common involved compartment for this syndrome is the gluteal ("buttock") compartment as its large muscle mass is confined by the tight inelastic fascia. The most common causes for pelvic compartment syndrome are musculoskeletal pelvic trauma, prolonged immobility with prolonged buttock pressure due to altered level of consciousness (eg, acute alcohol intoxication, drug overdose, drug induced coma), Ehlers-Danlos syndrome, and sickle cell associated muscle infarction. If the compartment syndrome is unrecognized or untreated, it can lead to renal failure, sepsis and death. These sequelae are caused by muscle necrosis, acidosis, myoglobinuria, and elevations of creatinine phosphokinase, all of which contribute to renal failure. Close monitoring and treatment is essential in the patient.

The AAOS and ACS conducted a survey that resulted in 22 responses, all with experience of at least "1" in the past 12 months. The median procedure experience was also 1, which is to be expected from this long established but fairly infrequently performed procedure. The expert panel reviewing the survey data agree with the median time and visit data that include an LOS of 6 days and 4 office visits. These patients are sick post-operatively, requiring careful monitoring. The incision for decompression is extensive, deep and left open. Post-operative hospital work for 27027 is very similar to that for 11006 (Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure), a RUC surveyed code that has a 000-day global period, but requires a 99233 level visit on the day of the procedure.

In comparison to the key reference code 25025 (Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve), code 27027 is a more extensive procedure that requires more post-operative work. Although intra time for 25025 is greater than for 27027, total time for 25025 (460 min) and 27027 (483 min) are similar. The intensities for both codes are also similar (25025 IWPUT=0.060 and 27027 IWPUT = 0.062).

We are recommending the survey median RVW of 17.00 and survey median time and visit data. Another reference code that supports this value is 27236 (Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement), which has similar total time (473 min) and a similar IWPUT (0.060).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27299

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 General Surgery How often? Rarely

Specialty How often?

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

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated by Consensus Panel

Specialty AAOS Frequency 450 Percentage 90.00 %

Specialty ACS Frequency 50 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 50

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated by Consensus Panel based on typical patient

Specialty AAOS Frequency 45 Percentage 90.00 %

Specialty ACS Frequency 5 Percentage 10.00 %

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? No

If no, please select another crosswalk and provide a brief rationale. 27025

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: 27057 Tracking Number J2 Specialty Society Recommended RVU: **18.67**
Global Period: 090 RUC Recommended RVU: **14.77**

CPT Descriptor: Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle; unilateral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old female has fallen at home and been poorly mobilized for 72 hours. She presents with tenderness and discoloration over the left buttock. She is febrile with a leukocytosis. The patient is taken to the operating room emergently for pelvic compartment fasciotomy(ies) and excisional debridement of necrotic muscle in the gluteal group.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

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

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

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

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

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient is placed properly on the table and positioned with proper bolstering to aid surgical exposure of the pelvis and upper thigh.
- Indicate areas of skin to be prepped and mark surgical incisions
- The hemipelvis, flank, buttock and lower extremity are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made from on the superolateral thigh beginning at the greater trochanter and extending proximally and posteriorly into the buttock ending 4 cm below the posterior superior iliac spine. Hemostasis is achieved in the dermal and subcutaneous tissues with electrocautery. The iliotibial band is identified and incised in line with the incision. Proximally, the gluteus maximus is bluntly split in the direction of its fibers. The inferior gluteal artery is identified and protected. The gluteus medius and the tensor fascia lata muscles are

identified. The dissection is deepened to allow identification of the sciatic nerve, the piriformis, obturator internus, obturator externus, superior and inferior gemelli, and quadratus femoris muscles. Deep hematoma is identified and evacuated. The superior gluteal artery and nerve, inferior gluteal artery and nerve are identified and if injured, bleeding is controlled. The fascia overlying the gluteus medius, gluteus minimus, gluteus maximus (including gluteal aponeurosis) and tensor fascia lata muscles are released as required to provide decompression. All muscles are inspected and evaluated for viability, contractility and/or injury. All nonviable, necrotic gluteal muscles are excised. Epimysial and intramuscular hemorrhage is controlled. Complete hemostasis is achieved. The wound is packed and left open.

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

- Application of a dressing. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Dictate operative report.
- Write orders for transferring to surgical floor and discuss ongoing care with floor nurses.
- Orders are written for evaluation of periodic imaging and laboratory reports; review of anticoagulation laboratory values and appropriate medication adjustment, and antibiotic and pain medication adjustments
- Monitor and document patient progress.
- The circulation, sensation and motor function of the operated extremity are assessed daily
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, films, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Answer patient and family questions. Answer nursing/other staff questions.
- Physical therapy for the uses of crutches or walker is ordered
- Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy.
- Write prescriptions for medications needed post-discharge.
- Home restrictions (i.e., diet, activity, bathing) are discussed with the patient, family members and discharging nurse.
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of dressings
- Assessment of surgical wound
- Remove sutures
- Review postoperative lab studies including CBC, myoglobin and renal function
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2008				
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD; Charles Mabry, MD; xxx				
Specialty(s):	AAOS, OTA, ACS				
CPT Code:	27057				
Sample Size:	50	Resp N:	22	Response: 44.0 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	1.00	2.00	10.00
Survey RVW:	10.00	13.75	19.75	20.75	40.00
Pre-Service Evaluation Time:			60.0		
Pre-Service Positioning Time:			15.0		
Pre-Service Scrub, Dress, Wait Time:			20.0		
Intra-Service Time:	40.00	60.00	90.00	98.00	150.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0 99292x 0.0			
Other Hospital time/visit(s):	<u>195.0</u>	99231x 3.0 99232x 2.0 99233x 1.0			
Discharge Day Mgmt:	<u>38.0</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>85.0</u>	99211x 0.0 12x 1.0 13x 3.0 14x 0.0 15x 0.0			
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	27057				
	Specialty Recommended				
Physician Work RVU:	18.67				
Pre-Service Evaluation Time:	43.0				
Pre-Service Positioning Time:	12.0				
Pre-Service Scrub, Dress, Wait Time:	5.0				
Intra-Service Time:	90.00				
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0 99292x 0.0			
Other Hospital time/visit(s):	<u>100.0</u>	99231x 3.0 99232x 1.0 99233x 0.0			
Discharge Day Mgmt:	<u>38.0</u>	99238x 1.0 99239x 0.0			
Office time/visit(s):	<u>71.0</u>	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0			
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0			

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
25025	090	17.77	RUC Time

CPT Descriptor Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
	090			

Harvard Time

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
	090			

Harvard Time

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
27236	090	17.43	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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)

	CPT Code: 27057	Key Reference CPT Code: 25025	Source of Time RUC Time
Median Pre-Service Time	60.00	60.00	
Median Intra-Service Time	90.00	125.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	120.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	87.00	

Prolonged Services Time	0.0	0.00
Median Total Time	389.00	460.00
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	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.38
Urgency of medical decision making	4.63	4.25

Technical Skill/Physical Effort (Mean)

Technical skill required	3.13	3.25
Physical effort required	3.63	3.13

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.38	3.88
Outcome depends on the skill and judgment of physician	3.88	3.88
Estimated risk of malpractice suit with poor outcome	4.63	4.38

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

Pre-Service intensity/complexity	4.13	3.88
Intra-Service intensity/complexity	4.13	4.00
Post-Service intensity/complexity	3.38	3.38

Additional Rationale

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

New code 27057 describes a procedure for patients developing or having compartment syndrome involving one or more of the pelvic compartments, that require debridement of nonviable muscle. The most common involved compartment for this syndrome is the gluteal ("buttock") compartment as its large muscle mass is confined by the tight inelastic fascia. The most common causes for pelvic compartment syndrome are musculoskeletal pelvic trauma, prolonged immobility with prolonged buttock pressure due to altered level of consciousness (eg, acute alcohol intoxication, drug overdose, drug induced coma), EhlersDanlos syndrome, and sickle cell associated muscle infarction. If the compartment syndrome is unrecognized or untreated it can lead to renal failure, sepsis and death. These sequelae are caused by muscle necrosis, acidosis, myoglobinuria, and elevations of creatinine phosphokinase, all of which contribute to renal failure. Close monitoring and treatment is essential in the patient.

The AAOS and ACS conducted a survey with both codes 27027 and 27057 that resulted in 22 responses. For this second code, some of the respondents did not have experience in the past 12 months for 27057. However, the median procedure experience was 1. The expert panel reviewing the survey data agree with the median time and visit data that include an LOS of 7 days and 4 office visits. These patients are sick post-operatively, requiring careful monitoring. The incision for decompression is extensive, deep and left open. Post-operative hospital work for 27057 is very similar to that for 11006 (Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure), a RUC surveyed code that has a 000-day global period, but requires a 99233 level visit on the day of the procedure.

In comparison to the key reference code 25025 (Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve), code 27027 is a more extensive procedure that requires more post-operative work. Although intra time for 25025 is greater than for 27027, total time for 25025 (460 min) is less than 27057 (533 min). The intensities for both codes are similar (25025 IWPUT=0.060 and 27057 IWPUT = 0.063).

We are recommending the survey median RVW of 19.75 and survey median time and visit data. Another reference code that supports this value is 27236 (Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement), which has less total time (473 min) but a similar IWPUT (0.060).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27299

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 General Surgery How often? Rarely

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.

Please explain the rationale for this estimate. Estimated by Consensus Panel

Specialty AAOS Frequency 270 Percentage 90.00 %

Specialty ACS Frequency 30 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 30

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on current number of providers across the country

Specialty AAOS Frequency 27 Percentage 90.00 %

Specialty ACS Frequency 3 Percentage 10.00 %

Specialty Frequency Percentage %

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

Professional Liability Insurance Information (PLI)

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

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

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

CPT Code: _____
Specialty Society('s) _____

CPT Code: 27027 & 27057

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

CPT Long Descriptor:

27027: Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle); unilateral

27057: Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle; unilateral

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

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

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

A total of 25 (facility) minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA completes pre-service diagnostic and referral forms, coordinates pre-surgery services, and schedules space and equipment in facility

Intra-Service Clinical Labor Activities:

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

The standard 6 minutes has been applied for the outpatient procedures for discharge day management services from the facility.

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

Post-Service Clinical Labor Activities:

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

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			27027(I1)		27057(I2)	
	Meeting Date: February 2008 RUC Recommendation			Decompression fasciotomy(ies); pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle); unilateral alignment(s), assessment(s), and computation(s) of adjustment schedule(s)		Decompression fasciotomy(ies); pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle; unilateral	
2							
3	LOCATION	CMS Code	Staff Type	Office	Facility	Office	Facility
4	GLOBAL PERIOD			090	090	090	90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	154	N/A	154
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	25	N/A	25
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	117	N/A	117
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure made						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		15		15
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5		5
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA				
16	End: When patient enters office/facility for surgery/procedure						
17							
18	SERVICE PERIOD						
19	Start: When patient enters office/facility for surgery/procedure						
20	Pre-service services						
21	Review charts	L037D	RN/LPN/MTA				
22	Greet patient and provide gowning	L037D	RN/LPN/MTA				
23	Obtain vital signs	L037D	RN/LPN/MTA				
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA				
26	Setup scope (non facility setting only)	L037D	RN/LPN/MTA				
27	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA				
28	Sedate/apply anesthesia	L037D	RN/LPN/MTA				
29	Intra-service						
30	Assist physician in performing procedure	L037D	RN/LPN/MTA				
31	Post-Service						
32	Monitor pt following service/check tubes, monitors, drains	L037D	RN/LPN/MTA				
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA				
34	Clean Surgical Instrument Package	L037D	RN/LPN/MTA				
35	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
36	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
37	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA				
38							
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12		12
40	End: Patient leaves office/FACILITY						
41							
42	POST-SERVICE Period						
43	Start: Patient leaves office/facility						
44	Conduct phone calls/call in prescriptions						
45	List Number and Level of Office Visits						
46							
47	99211 16 minutes		16				
48	99212 27 minutes	L037D	27		3		3
49	99213 36 minutes	L037D	36		1		1
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53							
54	Total Office Visit Time				117		117
55	Other Activity (please specify)						
56	End: with last office visit before end of global period						

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			27027(I1)		27057(I2)	
2	Meeting Date: February 2008 RUC Recommendation			Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle); unilateral alignment(s), assessment(s), and computation(s) of adjustment schedule(s)		Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle; unilateral	
3	LOCATION	CMS Code	Staff Type	Office	Facility	Office	Facility
57	MEDICAL SUPPLIES	CMS Code	Unit				
58	pack, minimum multi-specialty visit	SA048	pack		5		5
59	pack, post-op incision care (suture)	SA054	kit		1		1
60	drape, sterile, three-quarter sheet	SB014	item		1		1
61							
62	underpad 2ft x 3ft (Chux)	SB044	item		1		1
63	Equipment	CMS Code	Utilization Percentage				
64	table, power	EF031	100%		135		171
65	light, exam	EQ168	100%		135		171

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Pelvic Bone Fracture

In February 2008, the CPT Editorial Panel revised four codes to clarify reporting for pelvic bone fractures as being unilateral and clarification of the nature of ring fractures. These revisions clarify that these treatments pertain to unilateral services and when performed concurrently on the left and right sides of the body, they should be reported with modifier -50.

The RUC reviewed the following pelvic bone fracture codes and agreed with the specialty society that the revisions to the code descriptors were editorial as these services were previously valued as typically unilateral with internal fixation. The RUC recommends maintaining the current work RVUs for codes 27215, 27216, 27217 and 27218. The RUC reviewed the specialty society survey physician times and determined that the pre-, intra-, immediate post-service times and the post-operative visits indicated by the survey respondents were accurate for these revised services.

27215 Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fractures(s), unilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring includes internal fixation, when performed

The RUC recommends pre-service time package 4 – facility difficult patient/difficult procedure, with an additional 12 minutes of specific positioning time for placing the patient in a lateral decubitus position, support the patient's lower extremities and position fluoroscopic equipment for adequate visualization of the pelvis. Therefore, the pre-service time is 40 minutes evaluation time, 15 minutes positioning time and 20 minutes scrub, dress wait time. The RUC recommends the survey intra-service time of 120 minutes, immediate post service time of 20 minutes, 2-99231 hospital visits, 1-99232 hospital visit, 1-99238 discharge day management, 2-99212 office visits and 1-99213 office visit. **The RUC recommends new physician times and that the work RVU for 27215 be maintained at 10.45.**

27216 Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral, (includes ipsilateral ilium, sacroiliac joint and/or sacrum)

The RUC recommends pre-service time package 4 – facility difficult patient/difficult procedure, with an additional 22 minutes specific positioning time. Therefore the pre-service time is 40 minutes evaluation time, 25 minutes positioning time and 20 minutes scrub,

dress wait time. The RUC recommends the survey intra-service time of 60 minutes, immediate post service time of 25 minutes, 3-99231 hospital visits, 1-99232 hospital visit, 1-99238 discharge day management, 1-99212 office visits and 3-99213 office visit. **The RUC recommends new physician times and that the work RVU for 27216 be maintained at 15.73.**

27217 Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral includes internal fixation when performed (includes ipsilateral pubic symphysis and/or superior/inferior rami)

The RUC recommends pre-service time package 4 – facility difficult patient/difficult procedure, with an additional 12 minutes specific positioning time. Therefore the pre-service time is 40 minutes evaluation time, 15 minutes positioning time and 20 minutes scrub, dress wait time. The RUC recommends the survey intra-service time of 120 minutes, immediate post service time of 25 minutes, 3-99231 hospital visits, 1-99232 hospital visit, 1-99238 discharge day management, 1-99212 office visits and 3-99213 office visit. **The RUC recommends new physician times and that the work RVU for 27217 be maintained at 14.65.**

27218 Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum)

The RUC recommends pre-service time package 4 – facility difficult patient/difficult procedure, with an additional 37 minutes specific positioning time. Therefore the pre-service time is 40 minutes evaluation time, 40 minutes positioning time and 20 minutes scrub, dress wait time. The RUC recommends the survey intra-service time of 150 minutes, immediate post service time of 30 minutes, 5-99231 hospital visits, 1-99232 hospital visit, 1-99238 discharge day management, 1-99212 office visits and 3-99213 office visit. **The RUC recommends new physician times and that the work RVU for 27218 be maintained at 20.93.**

The RUC noted that the survey respondents indicated higher work RVUs than the current RVUs for each of these codes. The specialty society indicated that they will address the work RVUs at the fourth Five-Year Review.

Practice Expense

The RUC recommends the standard 090-day global direct practice expenses for the facility-setting as modified by the Practice Expense Subcommittee.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲27215	R1	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fractures(s), unilateral for pelvic bone fracture(s) patterns which do not disrupt the pelvic ring with includes internal fixation, when performed (For bilateral procedure, report 27215 with modifier 50)	090	10.45 (No Change)
▲27216	R2	Percutaneous skeletal fixation of posterior pelvic ring bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral, with includes internal fixation when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum) (For bilateral procedure, report 27216 with modifier 50)	090	15.73 (No Change)
▲27217	R3	Open treatment of anterior ring pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral with includes internal fixation when performed (includes ipsilateral pubic symphysis and/or superior/inferior rami) (For bilateral procedure, report 27217 with modifier 50)	090	14.65 (No Change)
▲27218	R4	Open treatment of posterior pelvic bone ring fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral, with includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum) (For bilateral procedure, report 27218 with modifier 50)	090	20.93 (No Change)

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

CPT Code: 27215 Tracking Number R1

Specialty Society Recommended RVU: **10.45**

Global Period: 090

RUC Recommended RVU: **10.45**

CPT Descriptor: Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fractures(s), unilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring, includes internal fixation, when performed (For bilateral procedure, report 27215 with modifier 50)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 27-year-old female pedestrian is struck on her right side by a motorized vehicle and knocked to the ground. She has immediate pain over the iliac wing with ecchymosis and an obvious deformity. She complains of pain over the ilium with radiation to the anterolateral thigh, on ambulation and with respiration. Radiographs in the emergency department reveal a displaced iliac wing fracture with an intact pelvic ring. Due to the displaced fracture, dysfunction associated with activities of daily living and deformity, the patient undergoes open treatment of the fracture with internal fixation.

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

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

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

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

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

Description of Pre-Service Work:

- Write admission orders
- Review results of testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient and/or family
- Review clinical status and suitability for surgery with other healthcare providers
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning in a lateral position, held by a lateral positioning device; padding of bony prominences, with care taken to protect the axillary region as well as the downside peroneal nerve; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- Assist in positioning of fluoroscopic imaging equipment and confirm satisfactory visualization of pelvis (AP, inlet, outlet, and Judet views)
- Indicate areas of skin to be prepped and mark surgical incisions
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An extensile incision is made over the iliac crest. The muscles and fascia are incised; subperiosteal reflection from the bone is utilized to expose the injured segment(s). Care is taken to avoid injury

to the lateral femoral cutaneous nerve, sciatic nerve and the superior gluteal vessels. The fracture site(s) is cleansed of hematoma and reduction achieved using a combination of direct and indirect techniques. Provisional fixation is maintained with bone clamps and K-wires. The reduction is confirmed with image intensification. Definitive fixation is then completed using a combination of plates, screws, wires, and sutures. The reduction and position of the implants is again assessed by fluoroscopy. The wound is irrigated and closed in layers over a drain.

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

- Application of dressing.
- Assist in turning to supine position for transfer to the bed or stretcher.
- Assist in position for permanent portable radiographs which are reviewed prior to awakening from anesthesia.
- Assist in transfer from OR table to stretcher or bed.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the hospital ward – followed by daily monitoring of the wound, drains, anticoagulation, and physical therapy.
- Orders are written for evaluation of periodic imaging and laboratory reports; review of anticoagulation laboratory values and appropriate medication adjustment, and antibiotic and pain medication adjustments.
- Dictation of an operative report
- Procedure note is written in the patient chart

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The dressing is changed and the status of the wound assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is coordinated and ordered
- Write prescriptions for medications needed post-discharge.
- Follow-up visits with other providers are coordinated.
- Diagnostic tests for monitoring of anticoagulation therapy are ordered and communication of results coordinated.
- All appropriate medical records are completed, including discharge summary, discharge instructions, medication reconciliation, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD				
Specialty(s):	AAOS, OTA				
CPT Code:	27215				
Sample Size:	100	Resp N:	25	Response: 25.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	3.00	6.00	20.00
Survey RVW:	11.00	18.00	19.50	21.60	30.00
Pre-Service Evaluation Time:			75.00		
Pre-Service Positioning Time:			20.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	45.00	90.00	120.00	150.00	210.00
Immediate Post Service-Time:	<u>20.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>80.00</u>	99231x 2.00 99232x 1.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>55.00</u>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27215	Recommended Physician Work RVU: 10.45		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		120.00		
Immediate Post Service-Time:	<u>20.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>80.00</u>	99231x 2.00 99232x 1.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>55.00</u>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
27269	090	18.75	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed

***This code has the same intra-time, same hospital visits and less post-discharge work than the survey code.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 8 % of respondents: 32.0 %

TIME ESTIMATES (Median)

	CPT Code: 27215	Key Reference CPT Code: 27269	Source of Time RUC Time
Median Pre-Service Time	75.00	60.00	
Median Intra-Service Time	120.00	120.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	55.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	388.00	399.00	
Other time if appropriate			

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

The number of possible diagnosis and/or the number of management options that must be considered	3.25	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.29
Urgency of medical decision making	3.75	3.57

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	3.71
Physical effort required	3.63	3.71

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.88	3.86
Outcome depends on the skill and judgment of physician	4.25	4.43
Estimated risk of malpractice suit with poor outcome	3.38	3.29

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

Pre-Service intensity/complexity	3.43	3.13
Intra-Service intensity/complexity	3.57	3.50
Post-Service intensity/complexity	2.86	3.00

Additional Rationale

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

The nomenclature for codes 27215-27218 did not clearly indicate a unilateral procedure. A CCP was submitted as an editorial change to make the code nomenclature less ambiguous and add a parenthetical with respect to use of '-50' modifier for bilateral procedures. Rarely, bilateral injuries to the pelvis occur (for example, in the setting of multiple injuries) which involve both the left and the right sacral-iliac articulations and/or the left and right iliac, and/or left and

right ischia and/or left and right superior or inferior pubic rami. In these instances, surgical treatment may require surgery on the left and the right sides of the body, through separate skin and fascial incisions.

CMS/RUC did not consider this CCP editorial and requested a RUC survey – we presume to be certain the codes were not valued as bilateral procedures. We note that these codes have never been surveyed. The current time and visit data in the RUC and CMS database are based on specialty time allocation of a total time estimation that CMS estimated for purposes of refining practice expense RVU's.

We conducted a survey of orthopaedic trauma surgeons – surgeons that would be familiar with these procedures. We recognize that the total response is not 30, but note that almost all of the respondents have experience with these procedures, which we believe is important when reviewing infrequently performed services.

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from the standard 40 minutes
- Positioning: Add 12 minutes (total 15 min) to account for assisting positioning of the patient in a lateral position, held by a lateral positioning device; padding of bony prominences, with care taken to protect the axillary region as well as the downside peroneal nerve; assessing/adjusting position of the extremities and head; and application of thermal regulation drapes.
- Scrub/Dress/Wait: No change from standard 20 minutes.

Because these four procedures are rarely performed, the AAOS has not previously considered using resources to comment on the undervaluation of the relative work RVUs. In an effort to make the codes less ambiguous and after the required RUC survey, we find that these codes are not “relatively” valued. However, we understand that because we submitted our CCP as editorial and because we are not in a 5-year review cycle where we can request a change in the value, **we are recommending maintaining the current values and accepting the recommended time and visit data – until the next 5-year-review, when we may be allowed to present compelling evidence that the codes are misvalued. It is clear by comparison of time and visits to the references that these codes are not overvalued.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27215

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

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Specialty How often?

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

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

Please explain the rationale for this estimate. national frequency not available - The incidence of these injuries depends on the frequency of high energy trauma, especially motor vehicular crashes and falls from heights (e.g. industrial injuries). Most patients with these injuries are treated at Level I and Level II Trauma Centers as certified by the ACS. These injuries occur in patients younger than 40 years of age most frequently.

Specialty	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? 68

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2006 data

Specialty orthopaedic surgery	Frequency 60	Percentage 88.23 %
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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. 27215 (use current 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: 27216 Tracking Number R2

Specialty Society Recommended RVU: **15.73**

Global Period: 090

RUC Recommended RVU: **15.73**

CPT Descriptor: Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)
(For bilateral procedure, report 27216 with modifier 50)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old male is involved in a motor vehicle crash and is transported to the emergency department. He complains of posterior left hip and buttock pain. He is unable to sit upright or stand due to pain. Radiographs reveal a dislocation of the left sacroiliac joint. The patient is taken to the operating room for repair using percutaneous skeletal fixation.

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

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

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

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

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

Description of Pre-Service Work:

- Review results of testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Write admission orders
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient and/or family
- Review clinical status and suitability for surgery with other healthcare providers
- Verify that all required instruments and supplies are available
- Perform, direct and supervise patient positioning in supine position, utilizing skeletal traction and a specialized fracture table.
- Padding of bony prominences, with care taken to protect the perineal region as well as the opposite side sciatic nerve; application of thermal regulation drapes
- Assess position of the upper extremities and head, adjust as needed
- Assist in positioning of fluoroscopic imaging equipment and confirm satisfactory visualization of the pelvis (AP, inlet, outlet, and Judet views)
- Reduce the SI dislocation using a combination of skeletal traction, limb positioning, and external supports; confirm satisfactory reduction with fluoroscopic imaging.
- Indicate areas of skin to be prepped and mark surgical incisions
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A small incision is made in the gluteal region based upon image guidance and pre-operative planning. The muscles and fascia are incised. A guide pin is inserted through the ilium, across the SI joint, and

into the sacrum. This is monitored using multiplanar images (AP, lateral inlet, and outlet views) to avoid injury to the lumbosacral nerve roots. Once appropriate position is confirmed a cannulated screw is inserted. Depending upon the stability of the fracture, the quality of the bone, the morphology of the pelvis, and the size of the patient additional screws are inserted using separate incisions and similar techniques. The reduction and position of the implants are confirmed with fluoroscopy. The wounds are irrigated and closed in layers

Description of Post-Service Work:

Post-service work: in facility

- Application of dressing.
- Skeletal traction is released and the traction pin is removed. Assist in relocation to the supine position for transfer to the bed or stretcher, including adjustment and or modification of the fracture table.
- Assist in position for permanent portable radiographs which are reviewed prior to awakening from anesthesia.
- Assist in transfer from OR table to stretcher or bed.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the hospital ward – followed by daily monitoring of the wound, drains, anticoagulation, and physical therapy.
- Orders are written for evaluation of periodic imaging and laboratory reports; review of anticoagulation laboratory values and appropriate medication adjustment, and antibiotic and pain medication adjustments.
- Dictation of an operative report
- Procedure note is written in the patient chart

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The dressing is changed and the status of the wound assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is coordinated and ordered
- Write prescriptions for medications needed post-discharge.
- Follow-up visits with other providers are coordinated.
- Diagnostic tests for monitoring of anticoagulation therapy are ordered and communication of results coordinated.
- All appropriate medical records are completed, including discharge summary, discharge instructions, medication reconciliation, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	R. Dale Blasier, Md; William Creevy, MD				
Specialty(s):	AAOs, OTA				
CPT Code:	27216				
Sample Size:	100	Resp N:	18	Response: 18.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	13.00	24.00	50.00
Survey RVW:	10.00	18.13	20.00	24.25	40.00
Pre-Service Evaluation Time:			68.00		
Pre-Service Positioning Time:			25.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	30.00	46.00	60.00	60.00	240.00
Immediate Post Service-Time:	<u>25.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>100.00</u>	99231x 3.00 99232x 1.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27216	Recommended Physician Work RVU: 15.73		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		25.00	3.00	22.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	<u>25.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>100.00</u>	99231x 3.00 99232x 1.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
27236	090	17.43	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
24430	090	15.07	RUC Time

CPT Descriptor Repair of nonunion or malunion, humerus; without graft (eg, compression technique)

**This code has 40 min more intra-time, but 2 day less hospital and less total time.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 27.7 %

TIME ESTIMATES (Median)

	CPT Code: 27216	Key Reference CPT Code: 27236	Source of Time RUC Time
Median Pre-Service Time	85.00	90.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	25.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	393.00	473.00	
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	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	2.60
Urgency of medical decision making	3.80	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	2.80
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.80	3.20
Outcome depends on the skill and judgment of physician	5.00	2.80
Estimated risk of malpractice suit with poor outcome	4.60	2.40

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

Pre-Service intensity/complexity	4.00	2.80
Intra-Service intensity/complexity	4.40	3.00
Post-Service intensity/complexity	3.40	2.40

Additional Rationale

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

The nomenclature for codes 27215-27218 did not clearly indicate a unilateral procedure. A CCP was submitted as an editorial change to make the code nomenclature less ambiguous and add a parenthetical with respect to use of '-50' modifier for bilateral procedures. Rarely, bilateral injuries to the pelvis occur (for example, in the setting of multiple injuries) which involve both the left and the right sacral-iliac articulations and/or the left and right iliac, and/or left and

right ischia and/or left and right superior or inferior pubic rami. In these instances, surgical treatment may require surgery on the left and the right sides of the body, through separate skin and fascial incisions.

CMS/RUC did not consider this CCP editorial and requested a RUC survey – we presume to be certain the codes were not valued as bilateral procedures. We note that these codes have never been surveyed. The current time and visit data in the RUC and CMS database are based on specialty time allocation of a total time estimation that CMS estimated for purposes of refining practice expense RVU's.

We conducted a survey of orthopaedic trauma surgeons – surgeons that would be familiar with these procedures. We recognize that the total response is not 30, but note that almost all of the respondents have experience with these procedures, which we believe is important when reviewing infrequently performed services.

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from standard 40 minutes
- Positioning: Add 22 minutes (total 25 min) to account for assisting positioning of the patient in traction and for both sides of the frame, as well as being in a lateral position. There is also padding of bony prominences, with care taken to protect the axillary region as well as the downside peroneal nerve; assessing/adjusting position of the extremities and head; and application of thermal regulation drapes.
- Scrub/Dress/Wait: No change from standard 20 minutes.

Because these four procedures are rarely performed, the AAOS has not previously considered using resources to comment on the undervaluation of the relative work RVUs. In an effort to make the codes less ambiguous and after the required RUC survey, we find that these codes are not “relatively” valued. However, we understand that because we submitted our CCP as editorial and because we are not in a 5-year review cycle where we can request a change in the value, **we are recommending maintaining the current values and accepting the recommended time and visit data – until the next 5-year-review, when we may be allowed to present compelling evidence that the codes are misvalued. It is clear by comparison of time and visits to the references that these codes are not overvalued.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27216

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

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Specialty How often?

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

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

Please explain the rationale for this estimate. national frequency not available - The incidence of these injuries depends on the frequency of high energy trauma, especially motor vehicular crashes and falls from heights (e.g. industrial injuries). Most patients with these injuries are treated at Level I and Level II Trauma Centers as certified by the ACS. These injuries occur in patients younger than 40 years of age most frequently.

Specialty	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? 281

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2006 data

Specialty orthopaedic surgery	Frequency 255	Percentage 90.74 %
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Specialty	Frequency 0	Percentage 0.00 %
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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. 27216 (use current 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: 27217 Tracking Number R3

Specialty Society Recommended RVU: **14.65**

Global Period: 090

RUC Recommended RVU: **14.65**

CPT Descriptor: 27217 Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral, includes internal fixation when performed (includes ipsilateral pubic symphysis and/or superior/inferior rami) (For bilateral procedure, report 27217 with modifier 50)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34-year-old male is involved in a motorcycle crash and complains of pain in his right hip and groin. He has pain with weight bearing and hip motion. Radiographs in the emergency department demonstrate disruption of the pelvic ring anteriorly with an oblique parasymphysial fracture exiting through the inferior pubic symphysis. The patient is taken to the operating room where he undergoes open treatment of the fracture-symphyseal injury with internal fixation.

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

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

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

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

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

Description of Pre-Service Work:

- Review results of testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Write admission orders
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient and/or family
- Review clinical status and suitability for surgery with other healthcare providers
- Verify that all required instruments and supplies are available
- Perform, direct and supervise patient positioning in a modified supine position, utilizing skeletal traction and a specialized fracture table.
- Padding of bony prominences, with care taken to protect the perineal region as well as the opposite side sciatic nerve; application of thermal regulation drapes
- Assess position of the upper extremities and head, adjust as needed
- Assist in positioning of fluoroscopic imaging equipment and confirm satisfactory visualization of the pelvis (AP, inlet, outlet, and Judet views)
- Initial reduction of fracture and symphyseal dislocation using a combination of skeletal traction, limb positioning, and external supports.
- Insert and / or confirm adequate function of foley catheter.
- Indicate areas of skin to be prepped and mark surgical incisions
- Perform surgical "time out" with operating surgical team
- Scrub and gown

Description of Intra-Service Work: A curved transverse low anterior incision is made to the rectus fascia which is then divided vertically and minimally elevated from the pubic rami. The bladder and urethra are identified and assessed for injury. The pelvic hematoma is evacuated and hemostasis obtained. The extent of the bony and ligamentous injury is identified. The fracture and symphysis are re-positioned using a combination of direct manipulation and bone clamps; this is checked with fluoroscopy. Provisional fixation with K-wires is achieved and the alignment checked again with fluoroscopy. Definitive fixation is completed with plates and screws, under image intensification. The wound is irrigated and closed over a drain.

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

- Application of dressing.
- Skeletal traction is released and the traction pin is removed. Assist in relocation to the supine position for transfer to the bed or stretcher, including adjustment and or modification of the fracture table.
- Assist in position for permanent portable radiographs which are reviewed prior to awakening from anesthesia.
- Assist in transfer from OR table to stretcher or bed.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the hospital ward – followed by daily monitoring of the wound, drains, anticoagulation, and physical therapy.
- Orders are written for evaluation of periodic imaging and laboratory reports; review of anticoagulation laboratory values and appropriate medication adjustment, and antibiotic and pain medication adjustments.
- Dictation of an operative report
- Procedure note is written in the patient chart

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The dressing is changed and the status of the wound assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is coordinated and ordered
- Write prescriptions for medications needed post-discharge.
- Follow-up visits with other providers are coordinated.
- Diagnostic tests for monitoring of anticoagulation therapy are ordered and communication of results coordinated.
- All appropriate medical records are completed, including discharge summary, discharge instructions, medication reconciliation, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD				
Specialty(s):	AAOS, OTA				
CPT Code:	27217				
Sample Size:	100	Resp N:	18	Response: 18.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	6.00	14.00	20.00	30.00
Survey RVW:	15.00	20.00	21.50	25.75	50.00
Pre-Service Evaluation Time:			65.00		
Pre-Service Positioning Time:			23.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	60.00	90.00	120.00	120.00	150.00
Immediate Post Service-Time:	<u>25.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>100.00</u>	99231x 3.00 99232x 1.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27217	Recommended Physician Work RVU: 14.65		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		120.00		
Immediate Post Service-Time:	<u>25.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>100.00</u>	99231x 3.00 99232x 1.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
27236	090	17.43	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 22.2 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 27217	<u>Key Reference CPT Code:</u> 27236	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	90.00	
Median Intra-Service Time	120.00	90.00	
Median Immediate Post-service Time	25.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	443.00	473.00	
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	4.25	3.25
Urgency of medical decision making	4.00	3.25

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	3.75
Physical effort required	4.25	3.75

Psychological Stress (Mean)

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

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

Pre-Service intensity/complexity	3.75	3.50
Intra-Service intensity/complexity	4.00	3.50
Post-Service intensity/complexity	3.50	3.50

Additional Rationale

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

The nomenclature for codes 27215-27218 did not clearly indicate a unilateral procedure. A CCP was submitted as an editorial change to make the code nomenclature less ambiguous and add a parenthetical with respect to use of '-50' modifier for bilateral procedures. Rarely, bilateral injuries to the pelvis occur (for example, in the setting of multiple injuries) which involve both the left and the right sacral-iliac articulations and/or the left and right iliac, and/or left and

right ischia and/or left and right superior or inferior pubic rami. In these instances, surgical treatment may require surgery on the left and the right sides of the body, through separate skin and fascial incisions.

CMS/RUC did not consider this CCP editorial and requested a RUC survey – we presume to be certain the codes were not valued as bilateral procedures. We note that these codes have never been surveyed. The current time and visit data in the RUC and CMS database is based on specialty time allocation of a total time estimation that CMS estimated for purposes of refining practice expense RVU's.

We conducted a survey of orthopaedic trauma surgeons – surgeons that would be familiar with these procedures. We recognize that the total response is not 30, but note that almost all of the respondents have experience with these procedures, which we believe is important when reviewing infrequently performed services.

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from standard 40 minutes
- Positioning: Add 12 minutes (total 15 min) to account for assisting positioning of the patient in a lateral position, held by a lateral positioning device; padding of bony prominences, with care taken to protect the axillary region as well as the downside peroneal nerve; assessing/adjusting position of the extremities and head; and application of thermal regulation drapes.
- Scrub/Dress/Wait: No change from standard 20 minutes.

Because these four procedures are rarely performed, the AAOS has not previously considered using resources to comment on the undervaluation of the relative work RVUs. In an effort to make the codes less ambiguous and after the required RUC survey, we find that these codes are not “relatively” valued. However, we understand that because we submitted our CCP as editorial and because we are not in a 5-year review cycle where we can request a change in the value, **we are recommending maintaining the current values and accepting the recommended time and visit data – until the next 5-year-review, when we may be allowed to present compelling evidence that the codes are misvalued. It is clear by comparison of time and visits to the references that these codes are not overvalued.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27217

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

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Specialty How often?

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

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

Please explain the rationale for this estimate. national frequency not available - The incidence of these injuries depends on the frequency of high energy trauma, especially motor vehicular crashes and falls from heights (e.g. industrial injuries). Most patients with these injuries are treated at Level I and Level II Trauma Centers as certified by the ACS. These injuries occur in patients younger than 40 years of age most frequently.

Specialty	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? 224

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2006 data

Specialty orthopaedic surgery	Frequency 215	Percentage 95.98 %
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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. 27217 (use current 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: 27218 Tracking Number R4

Specialty Society Recommended RVU: **20.93**

Global Period: 090

RUC Recommended RVU: **20.93**

CPT Descriptor: Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral, includes internal fixation when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum) (For bilateral procedure, report 27218 with modifier 50)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 28-year-old male is involved in a motor vehicle crash. He is brought to the emergency department complaining of buttock, hip and flank pain. He has pain on movement, with respiration and is unable to sit or stand. Radiographs reveal a break in the posterior pelvic ring with a displaced fracture of the left posterior ilium exiting anteriorly through the sacroiliac joint. The patient is taken to the operating room and undergoes open treatment of the left fracture-dislocation with internal fixation.

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

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

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

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

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

Description of Pre-Service Work:

- Review results of testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Write admission orders
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient and/or family
- Review clinical status and suitability for surgery with other healthcare providers
- Verify that all required instruments and supplies are available
- Insert and / or confirm adequate function of foley catheter
- After induction of general anesthesia, perform, direct, and supervise the transfer to the prone position, utilizing skeletal traction and a specialized pelvic fracture table.
- Padding of bony prominences, with care taken to protect the perineal region as well as the peroneal nerve; application of thermal regulation drapes
- Direct position of the opposite lower extremity, upper extremities and head, adjust as needed
- Assist in positioning of fluoroscopic imaging equipment and confirm satisfactory visualization of the pelvis (AP, inlet, outlet, and Judet views)
- Initial reduction of the ilium and SI joint dislocation using a combination of skeletal traction, limb positioning, and external supports.
- Indicate areas of skin to be prepped and mark surgical incisions
- Perform surgical "time out" with operating surgical team
- Scrub and gown

Description of Intra-Service Work: A vertically oriented posterior incision is made just lateral to the SI joint and carried to the gluteal fascia which is then incised and carefully reflected. Care is taken to avoid injury to the sciatic nerve. The pelvic hematoma is evacuated and hemostasis obtained. The extent of the bony and ligamentous injury is identified. The fractured ilium and SI joint are re-positioned using a combination of direct manipulation and bone clamps; this is checked with fluoroscopy. Provisional fixation with K-wires is achieved and the alignment checked again with fluoroscopy. Definitive fixation is completed with standard plates and screws for the iliac fracture. Cannulated screws are inserted over a guidewire from the ilium across the SI joint, and into the sacrum under image intensification to stabilize the SI joint dislocation. The position of these screws is carefully monitored to avoid injury to the lumbosacral nerve roots. Once satisfactory fixation is completed, the wound is irrigated and closed over a drain.

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

- Application of dressing.
- Skeletal traction is released and the traction pin is removed. Assist in relocation to the supine position for transfer to the bed or stretcher, including adjustment and or modification of the fracture table.
- Assist in position for permanent portable radiographs which are reviewed prior to awakening from anesthesia.
- Assist in transfer from fracture table to stretcher or bed.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the hospital ward – followed by daily monitoring of the wound, drains, anticoagulation, and physical therapy.
- Orders are written for evaluation of periodic imaging and laboratory reports; review of anticoagulation laboratory values and appropriate medication adjustment, and antibiotic and pain medication adjustments.
- Dictation of an operative report
- Procedure note is written in the patient chart

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The dressing is changed and the status of the wound assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is coordinated and ordered
- Write prescriptions for medications needed post-discharge.
- Follow-up visits with other providers are coordinated.
- Diagnostic tests for monitoring of anticoagulation therapy are ordered and communication of results coordinated.
- All appropriate medical records are completed, including discharge summary, discharge instructions, medication reconciliation, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD				
Specialty(s):	AAOS, OTA				
CPT Code:	27218				
Sample Size:	100	Resp N:	18	Response: 18.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	5.00	10.00	20.00
Survey RVW:	16.00	24.25	27.00	30.00	60.00
Pre-Service Evaluation Time:			73.00		
Pre-Service Positioning Time:			30.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	90.00	120.00	150.00	180.00	240.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>140.00</u>	99231x 5.00 99232x 1.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27218	Recommended Physician Work RVU: 20.93		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		40.00	3.00	37.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		150.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>140.00</u>	99231x 5.00 99232x 1.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
27227	090	25.21	RUC Time

CPT Descriptor Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 55.5 %

TIME ESTIMATES (Median)

	CPT Code: 27218	Key Reference CPT Code: 27227	Source of Time RUC Time
Median Pre-Service Time	100.00	90.00	
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	140.0	120.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	543.00	550.00	
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	4.50	4.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	4.44
Urgency of medical decision making	4.10	4.11

Technical Skill/Physical Effort (Mean)

Technical skill required	4.90	4.89
Physical effort required	4.80	4.89

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.90	4.89
Outcome depends on the skill and judgment of physician	4.90	4.89
Estimated risk of malpractice suit with poor outcome	4.80	4.78

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

Pre-Service intensity/complexity	4.60	4.56
Intra-Service intensity/complexity	5.00	4.89
Post-Service intensity/complexity	4.00	4.11

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 nomenclature for codes 27215-27218 did not clearly indicate a unilateral procedure. A CCP was submitted as an editorial change to make the code nomenclature less ambiguous and add a parenthetical with respect to use of '-50' modifier for bilateral procedures. Rarely, bilateral injuries to the pelvis occur (for example, in the setting of multiple injuries) which involve both the left and the right sacral-iliac articulations and/or the left and right iliac, and/or left and

right ischia and/or left and right superior or inferior pubic rami. In these instances, surgical treatment may require surgery on the left and the right sides of the body, through separate skin and fascial incisions.

CMS/RUC did not consider this CCP editorial and requested a RUC survey – we presume to be certain the codes were not valued as bilateral procedures. We note that these codes have never been surveyed. The current time and visit data in the RUC and CMS database are based on specialty time allocation of a total time estimation that CMS estimated for purposes of refining practice expense RVU's.

We conducted a survey of orthopaedic trauma surgeons – surgeons that would be familiar with these procedures. We recognize that the total response is not 30, but note that almost all of the respondents have experience with these procedures, which we believe is important when reviewing infrequently performed services..

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from standard 40 minutes
- Positioning: Add 37 minutes (total 40 min) to account for assisting positioning of the patient who is in traction and in a prone position, held by a positioning device. There is also padding of bony prominences, with care taken to protect the axillary region as well as the downside peroneal nerve; assessing/adjusting position of the extremities and head; and application of thermal regulation drapes.
- Scrub/Dress/Wait: No change from standard 20 minutes.

Because these four procedures are rarely performed, the AAOS has not previously considered using resources to comment on the undervaluation of the relative work RVUs. In an effort to make the codes less ambiguous and after the required RUC survey, we find that these codes are not “relatively” valued. However, we understand that because we submitted our CCP as editorial and because we are not in a 5-year review cycle where we can request a change in the value, **we are recommending maintaining the current values and accepting the recommended time and visit data – until the next 5-year-review, when we may be allowed to present compelling evidence that the codes are misvalued. It is clear by comparison of time and visits to the references that these codes are not overvalued.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27218

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

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Specialty How often?

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

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

Please explain the rationale for this estimate. national frequency not available - The incidence of these injuries depends on the frequency of high energy trauma, especially motor vehicular crashes and falls from heights (e.g. industrial injuries). Most patients with these injuries are treated at Level I and Level II Trauma Centers as certified by the ACS. These injuries occur in patients younger than 40 years of age most frequently.

Specialty	Frequency	Percentage	%
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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? 123

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2006 data

Specialty orthopaedic surgery	Frequency 118	Percentage 95.93 %
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Specialty	Frequency 0	Percentage 0.00 %
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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. 27218 (use current code)

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

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

CPT Long Descriptor:

27215: Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fractures(s), unilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring, includes internal fixation, when performed

27216: Percutaneous skeletal fixation of posterior pelvic ring fracture and/or dislocation (includes ilium, sacroiliac joint and/or sacrum)

27217: Open treatment of anterior ring fracture and/or dislocation with internal fixation (includes pubic symphysis and/or rami)

27218: Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum)

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

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

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

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

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

Post-Service Clinical Labor Activities:

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

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			27215 (R1)		27216 (R2)	
2	Meeting Date: April 2008			Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fractures(s), unilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring, includes internal fixation, when performed		Percutaneous skeletal fixation of posterior pelvic ring fracture and/or dislocation (includes ilium, sacroiliac joint and/or sacrum)	
3	LOCATION	Code	Staff Type	Office	Facility	Office	Facility
4	GLOBAL PERIOD			090	090	090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	135	N/A	180
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	33	N/A	33
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	90	N/A	135
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure made						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA				
17	End: When patient enters office/facility for surgery/procedure						
18	SERVICE PERIOD						
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12		12
41	End: Patient leaves office/FACILITY						
42	POST-SERVICE Period						
43	Start: Patient leaves office/facility						
44	Conduct phone calls/call in prescriptions						
46	List Number and Level of Office Visits						
47	99211 16 minutes		16				
48	99212 27 minutes	L037D	27		2		1
49	99213 36 minutes	L037D	36		1		3
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
54	Total Office Visit Time				90		135
55	Other Activity (please specify)						
56	End: with last office visit before end of global period						
57	MEDICAL SUPPLIES	CMS Code	Unit				
58	pack, minimum multi-specialty visit	SA048	pack		3		4
59							
60							
61	Equipment	CMS Code	Utilization Percentage				
62	table, power	EF031	100%		90		135
63	light, exam	EQ168	100%		90		135

	A	B	C	H	I	J	K
1	AMA/Specialty Society RVS Update Committee Recommendation			27217 (R3)		27218 (R4)	
2	Meeting Date: April 2008			Open treatment of anterior ring fracture and/or dislocation with internal fixation (includes pubic symphysis and/or rami)		Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum)	
3	LOCATION	Code	Staff Type	Office	Facility	Office	Facility
4	GLOBAL PERIOD			090	090	090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	180	N/A	180
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	33	N/A	33
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	135	N/A	135
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure made						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA				
17	End: When patient enters office/facility for surgery/procedure						
18	SERVICE PERIOD						
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12		12
41	End: Patient leaves office/FACILITY						
42	POST-SERVICE Period						
43	Start: Patient leaves office/facility						
44	Conduct phone calls/call in prescriptions						
46	List Number and Level of Office Visits						
47	99211 16 minutes		16				
48	99212 27 minutes	L037D	27		1		1
49	99213 36 minutes	L037D	36		3		3
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
54	Total Office Visit Time				135		135
55	Other Activity (please specify)						
56	End: with last office visit before end of global period						
57	MEDICAL SUPPLIES			CMS Code	Unit		
58	pack, minimum multi-specialty visit	SA048	pack		4		4
59							
60							
61	Equipment			CMS Code	Utilization Percentage		
62	table, power	EF031	100%		135		135
63	light, exam	EQ168	100%		135		135

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Hepatorenal Bypass

The CPT Editorial Panel met in February 2008 and created new CPT code 35535 *Bypass graft, with vein; hepatorenal* to provide more specificity to bypass graft, with vein procedures. Currently there are codes for extra-anatomic bypass with vein for the splenic artery to the left renal artery and by direct splenic artery transposition onto the left renal artery, however a mirror image procedure for the right side had not been addressed. This new service code identifies a similar bypass with vein but this bypass originates on the hepatic artery and ends on the right renal artery. Unlike aorto-renal revascularization, this alternative bypass is performed in patients who have significant cardiac disease and in whom manipulation of the aorta is understood to be inappropriate or excessively morbid.

Hepatorenal bypass with vein conduit is a highly complex renal salvage operation typically performed on patients whose clinical status places them at unacceptably high risk for aortic cross-clamp placement, and therefore not candidates for direct aorto-renal bypass. The typical patient is one with an aorta heavily laden with atherosclerotic plaque that is likely to suffer embolization of shattered plaque if a large vascular clamp were applied to the aorta. Another clinical indication is the patient with advanced coronary artery disease and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF or cardiac death.

A random survey of 100 vascular surgeons indicated CPT code 35535 is a highly complex, intense, and time consuming procedure. The specialty society's survey results indicated a median relative work value of 35.00, however, due to the time, intensity, and complexity of the procedure the specialty recommended its 75th percentile survey RVU of 38.00. The RUC reviewed the specialty society's key reference service 35536 *Bypass graft, with vein; splenorenal* (work RVU = 33.60, intra-service work time = 240) in relation to this new code, and agreed that new service 35535 involved more physician work and effort. The RUC also reviewed codes 35531 *Bypass graft, with vein; aortoceliac or aortomesenteric* (work RVU = 38.98, intra-service time = 240 minutes, RUC MPC listed) and 35560 *Bypass graft, with vein; aortorenal* (work RVU = 33.90, intra-service time = 200) in relation to this new code. The RUC understood that hepatorenal bypass surgery scores near the top of all intensity and complexity measures and therefore, benchmarked the new code off of code 35536 and 35531.

Both 35536 and 35535 involve operations performed on patients with multiple advanced medical comorbidities typically including hyperlipidemia, coronary artery disease, diffuse atherosclerosis and severe hypertension. The survey code, hepato-renal bypass graft, is a

more complex surgical procedure, requiring dangerous dissection in the portal triad just inferior to the liver with risk of injury to neighboring pancreas, common bile duct, portal vein and other vital structures. Arterial blood flow to the liver is interrupted while the proximal anastomosis is being performed and this results in post-operative hepatic dysfunction with LFT elevation, interruption of protein synthetic activity and the potential for post-operative coagulopathy. The intra-service duration of 35535 hepato-renal bypass is also substantially longer than spleno-renal bypass. This is reflected by the additional 60 minutes of intra-service time compared to the reference service. The specialty and RUC recommend a relative work value of 38.00 which is 4.40 RVUs more than the reference service and equates the service to the specialty society's 75th percentile survey result. This increment of 4.40 RVUs is justified by understanding that 60 minutes of intra-service time at an IWPUT of 0.09 would actually result in an intra-service increment of 5.40 RVUs. Thus, the recommended 4.40 increment is a conservative adjustment for this additional intra-service time.

The RUC also acknowledged the closely related clinical service on the MPC list is CPT 35531, an intra-abdominal visceral revascularization using vein conduit. The relative work value of 35531 is slightly higher than the recommended work value for the 35535 hepatorenal bypass. However, code 35531 has 15 minutes more pre-service time than what the RUC recommends for 35535. The two services have identical intra-service time of 240 minutes. The intra-service work per unit of time (IWPUT) of the MPC reference and 35535 are nearly identical (0.087 and 0.090). Code 35531 has one more hospital visit than 35535, thereby accounting for the 0.98 higher RVW of this MPC reference service. Overall, the RUC concurred that the comparison with this MPC reference service serves to justify an RVW of 38.00 for 35535, hepato-renal bypass.

Code 35560 is another good comparison service from a clinical perspective because it accomplishes the same end-point, revascularization of a severely ischemic kidney. The major clinical differences are two-fold, first the 35560 patient is sufficiently healthy (or at least "less-sick") such that his/her aorta may undergo aortic cross-clamp placement. Second the aorto-renal bypass is 200 minutes in duration, 40 minutes less than the hepato-renal bypass. This reflects the additional time required to safely dissect out the common hepatic / proper hepatic / gastroduodenal artery region required for the hepato-renal bypass graft. This additional 40 minutes of intense intra-service time multiplied by the IWPUT may be considered to reflect $40 \times 0.090 = 3.60$ additional intra-service work RVUs. Adding the 3.60 intra-service RVUs to the reference service 33.90 RVW results in 37.50, within 2% of the value the RUC recommends for the new service.

The RUC agreed with the specialty society's rationale for choosing its 75th percentile survey results based on comparisons with three clinically-related RUC-surveyed vascular surgical services. **The RUC recommends a work relative value of 38.00 for code 35535.**

Practice Expense

The RUC recommends the specialty societies' recommended inputs for these facility only procedures as they are standard 090 day global inputs.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
35501		Bypass graft, with vein; common carotid-ipsilateral internal carotid	090	28.99 (No Change)
●35535	S1	hepatorenal <u>(Do not report 35535 in conjunction with 35221, 35251, 35281, 35500, 35536, 35560, 35631, 35636)</u>	090	38.00

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

CPT Code: 35535 Tracking Number S1

Specialty Society Recommended RVU: **38.00**

Global Period: 090

RUC Recommended RVU: **38.00**

CPT Descriptor: Bypass graft, with vein; hepatorenal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey. A 70-year-old female smoker with hypercholesterolemia and significant coronary artery disease has chronic renal insufficiency and severe hypertension refractory to maximum doses of 3 medications. She underwent stent placement in the right renal artery origin two years ago. Duplex ultrasound confirms a recurrent stenosis, and arteriography reveals near occlusion of the right renal artery felt unsuitable for repeat percutaneous intervention. Her infrarenal aorta contains diffuse atherosclerotic plaque, and she is deemed high risk for aortic crossclamping. A hepatorenal bypass is performed using vein conduit.

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

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

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

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

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

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assess for appropriateness of DVT prophylaxis; if yes, assure appropriate selection, timing, and administration
- Assess need for beta-blockers, order as required.
- Review medical history and radiology reports
- Review radiographic images including angiograms, CTscans, MRAs, duplex vein mapping
- Review results of other preoperative testing (blood tests, EKG, CXR)
- Review reports of consultants providing preoperative assessment and clearance as indicated
- Meet with patient and family to review planned procedure and postoperative management
- Reexamine patient to ensure that physical findings have not changed and dictate history and physical
- Obtain final informed consent
- Review hospital consent, mark patient
- Discuss perioperative medical management with anesthesiologist
- Review planned procedure with OR staff including vein harvest site
- Verify that all required instruments and supplies are available
- Change into scrub clothes
- Monitor/assist with positioning of the patient
- Ensure that radiographic images are available in the OR
- Mark planned incisions including both abdominal and vein harvest sites
- Monitor/assist with prepping and draping
- Scrub and gown
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform laparotomy & complete routine abdominal exploration
- Dissect soft tissue inferior to liver to find common hepatic artery
- Clear soft tissue from common hepatic artery, gastroduodenal and proper hepatic artery origins
- Expose adequate lengths of these three arteries to achieve proximal and distal control
- Incise soft tissue over right kidney and find right renal artery
- Clear soft tissue from renal artery of sufficient length for proximal and distal control
- Incise skin of thigh and calf for saphenous vein harvest
- Dissect soft tissue to find saphenous vein
- Clear soft tissue from surface of saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from thigh
- Test saphenous vein conduit for leaks & Repair leaks with 7-0 vascular suture
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on common hepatic, proper hepatic & gastroduodenal arteries
- Perform longitudinal arteriotomy at proximal anastomosis site
- Anastomose vein conduit to hepatic artery with vascular suture
- Remove clamp, test for leaks & apply additional sutures as needed to control hemorrhage
- Apply proximal and distal clamps to right renal artery & perform arteriotomy at anastomosis site
- Cut vein conduit to appropriate length & anastomose end of vein conduit to right renal artery
- Flush system to remove air and debris
- Remove clamps & apply additional sutures as needed to achieve hemostasis
- Palpate distal pulses to check for restitution of blood flow
- Listen with Doppler to assure normal flow pattern throughout the reconstruction
- Reverse anticoagulant with protamine
- Irrigate abdomen & perform final hemostasis check
- Irrigate with sterile saline, close fascia, subcutaneous tissue & skin of abdominal incision
- Irrigate and close saphenous harvest site

Description of Post-Service Work:

- Apply sterile dressings. Monitor patient during reversal of anesthesia.
- Monitor transport of patient from OR to recovery room.
- Discuss postoperative recovery care with anesthesia and nursing staff.
- Write postoperative orders.
- Discuss procedure and outcome with family in waiting area.
- Write postoperative note.
- Dictate operative note and copy to referring physician
- Write orders for transferring to surgical floor and discuss ongoing care with floor nurses.
- Examine patient, check wound and patient progress - Monitor closely for urinary output
- Correctly assign procedural CPT codes
- Write daily orders for postoperative medications, diet, and patient activity
- Check wounds, change dressings, and monitor patient progress. Chart notes.
- Review patient management with nursing staff
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Monitor incision for signs of infection or hematoma
- Assess for any signs of bypass graft failure including flank pain, severe hypertension, oliguria
- Answer patient and family questions
- Answer nursing staff questions
- Discuss patient progress with referring physician
- Assure adequate level of pain control
- Assess daily to determine if discharge criteria are met, discuss with hospital utilization review nurse
- Chart discharge instructions

- Write prescriptions for medications and supplies needed post-discharge
- Review post-discharge wound care and activity limitations with patient and family
- Dictate discharge summary
- Perform medication reconciliation

Postoperative Work – In Office for duration of 90-day global period:

- Examine patient, remove sutures/staples
- Monitor vein harvest site
- Answer patient and family questions
- Review renal function reports
- Order and assess bypass graft patency studies as indicated
- Assess for adequacy of pain control
- Discuss advancing daily activities with patient
- Discuss long term scar management with patient
- Discuss renal function reports with patient and need for any additional testing or consultation
- Arrange for any indicated additional testing and review results
- Arrange for any indicated consultation, prepare documents for transmission to appropriate consultants
- Discuss progress with referring physician(s) and consultants (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Gary Seabrook MD, David Han MD, Robert Zwolak MD				
Specialty(s):	Society for Vascular Surgery				
CPT Code:	35535				
Sample Size:	100	Resp N:	35	Response: 35.0 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	1.00	2.00	3.00
Survey RVW:	32.00	33.75	35.00	38.00	41.00
Pre-Service Evaluation Time:			70.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	180.00	210.00	240.00	240.00	300.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>140.00</u>	99291x 2.00 99292x 0.00			
Other Hospital time/visit(s):	<u>120.00</u>	99231x 2.00 99232x 2.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>62.00</u>	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	35535	Recommended Physician Work RVU: 38.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		240.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>70.00</u>	99291x 1.00 99292x 0.00		
Other Hospital time/visit(s):	<u>175.00</u>	99231x 2.00 99232x 2.00 99233x 1.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>62.00</u>	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
35536	090	33.60	RUC Time

CPT Descriptor Bypass graft, with vein; splenorenal**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
35531	090	38.98	RUC Time	170

CPT Descriptor 1 Bypass graft, with vein; aortoceliac or aortomesenteric

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
35560	090	33.90	RUC Time

CPT Descriptor Bypass graft, with vein; aortorenal**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 60.0 %

TIME ESTIMATES (Median)

	CPT Code: 35535	Key Reference CPT Code: 35536	Source of Time RUC Time
Median Pre-Service Time	75.00	70.00	
Median Intra-Service Time	240.00	180.00	
Median Immediate Post-service Time	30.00	25.00	
Median Critical Care Time	70.0	0.00	
Median Other Hospital Visit Time	175.0	175.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	690.00	550.00	
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	4.29	4.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.24	4.14
Urgency of medical decision making	3.81	3.86

Technical Skill/Physical Effort (Mean)

Technical skill required	4.62	4.48
Physical effort required	4.19	4.14

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.48	4.33
Outcome depends on the skill and judgment of physician	4.52	4.48
Estimated risk of malpractice suit with poor outcome	3.57	3.52

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

Pre-Service intensity/complexity	4.14	4.10
Intra-Service intensity/complexity	4.52	4.43
Post-Service intensity/complexity	3.81	3.81

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.*

Clinical Background: Hepato-renal bypass with vein conduit is a highly complex renal salvage operation typically performed on patients whose clinical status places them at unacceptably high risk for aortic cross-clamp placement, and therefore not candidates for direct aorto-renal bypass. The typical scenario is a patient with an aorta heavily laden with atherosclerotic plaque (such as our clinical vignette) that is likely to suffer embolization of shattered plaque if a large vascular clamp were applied to the aorta. Another clinical indication is the patient with advanced coronary artery disease

and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF, and cardiac death.

Recommended RVW 38.00: We recommend the 75th percentile survey value because it is fully justified based on the long duration of the surgical procedure, the need for post-operative critical care, a 7-day hospitalization, the IWPUT analysis, the intensity and complexity measures, plus favorable work comparisons with three RUC-surveyed services of similar magnitude, one of which is also an MPC list procedure.

IWPUT: The IWPUT of this service, with the recommended visit pattern and a recommended RVW of 38.00, is 0.090. This is a typical value for a complex intra-abdominal arterial reconstruction.

Intensity and Complexity Measures: Hepato-renal bypass scores near the top of all intensity and complexity measures. Patients who require this vascular reconstruction are elderly and always have many associated medical co-morbidities. If the proximal anastomosis is technically faulty the right kidney may die or the liver may become overtly ischemic. If the distal anastomosis is faulty, the kidney won't survive. This operation carries a significant peri-operative mortality rate of 5-10%, and this in itself should serve to bolster intensity and complexity at the top of the chart. There are very few procedures among the 8,000 Category I CPT codes that carry this degree of morbidity and mortality.

Pre-Time: This is a very complex patient about to undergo an extremely complex operation. Pre-times of the three comparison procedures we discuss in this proposal are 70 minutes (RUC approved in 2000), 90 minutes (RUC approved in 2000), and 90 minutes (RUC approved in 2000). This patient requires positioning and surgical preparation of two separate surgical sites. The first is the abdomen and lower chest area where the abdominal or abdomino-retroperitoneal incision will be made. Typically extra support devices are placed under the right costophrenic angle to elevate the right kidney. This requires special attention to padding to avoid skin injury. The second surgical area is the vein harvest site, usually on one of the lower extremities. For this, the hip and knee must be flexed, the hip outwardly rotated, and the knee and ankle sufficiently padded and supported to prevent injury during this long operation. This extra positioning work readily justifies the additional 12 minutes requested herein. In fact, this is a very conservative estimate of the additional positioning time required.

Critical Care Visits: Thirty-four of 35 survey respondents (97%) identified the requirement for critical care in this service. In fact, the majority of survey respondents stated that two or more critical care services were typical for this patient. A consistent observation made by our expert consensus panel is that while surgeons perform critical care on these patients and enter it accurately in the visit columns of the RUC surveys, they always tend to under-estimate the associated physician work during the magnitude estimation process of recommending a final RVW. Thus, while the majority of respondents noted two or more critical care services, the median survey RVW contains only enough post-operative RVUs for one 99291, and we are left with a mismatch of visits and RVUs. In this particular case, our expert consensus panel reviewed the survey data, the recommended visit patterns, and overall clinical situation, and we recommend reducing the critical care 99291 services from the most commonly cited frequency of two, down to one. The second high intensity visit has been entered as a 99233 instead of 99291. The critical care provided by the surgeon typically occurs during the first 24 hours following surgery and involves high complexity decision making to assess, manipulate, and support vital circulatory system functions in the setting of massive intra-abdominal third spacing and transient hepatic failure due to inflow artery occlusion during creation of the proximal anastomosis of the bypass graft, and to prevent shock in patients with underlying coronary artery disease. The work includes interpretation of cardiac output measurements, chest x-rays, pulse oximetry, and blood gases. Performance of gastric intubation and vascular access performed during the course of critical care service is included therein. Special consideration is directed to control of blood pressure that may still be extremely high, as in the pre-operative status of this patient, or conversely, if a single critical renal artery stenosis has just been bypassed, the patient's blood pressure may be suddenly very low due to loss of the positive feedback renin-angiotensin-aldosterone hormonal drive.

Comparison with Key Reference Service 35536, Bypass graft with vein; splenorenal: The key reference service has a RUC-approved RVW of 33.60. Both operations are performed on patients with multiple advanced medical comorbidities typically including hyperlipidemia, coronary artery disease, diffuse atherosclerosis and severe hypertension. The survey code, hepato-renal bypass graft, is a more complex surgical procedure, requiring dangerous

dissection in the portal triad just inferior to the liver with risk of injury to neighboring pancreas, common bile duct, portal vein and other vital structures. Arterial blood flow to the liver is interrupted while the proximal anastomosis is being performed, and this results in post-operative hepatic dysfunction with LFT elevation, interruption of protein synthetic activity and the potential for post-operative coagulopathy. The intra-service duration of 35535 hepato-renal bypass is also substantially longer than spleno-renal bypass. This is reflected by the additional 60 minutes of intra-service time compared to the reference service. The recommended RVW of 38.00 is 4.40 RVUs more than the reference service. This increment of 4.40 RVUs is justified by recalling that 60 minutes of intra-service time at an IWPUT of 0.09 would actually result in an intra-service increment of 5.40 RVUs. Thus, the recommended 4.40 increment is a conservative adjustment for this additional intra-service time. In conclusion, the recommended RVW of 38.00 is appropriate based on comparison to the RUC-surveyed key reference service.

Comparison with MPC Service 35531, Bypass graft, with vein; aortoceliac or aortomesenteric: The most closely related clinical service on the MPC list is CPT 35531, an intra-abdominal visceral revascularization using vein conduit. The RVW of 35531 is 38.98, slightly higher than our recommended RVW of 38.00 for the 35535 hepato-renal bypass. 35531 has 15 minutes more pre-service time than what we are recommending for 35535. The two services have identical intra-service time of 240 minutes. The IWPUTs of the MPC reference and the proposed new service are nearly identical (0.087 and 0.090). 35531 has one more hospital visit than 35535, thereby accounting for the 0.98 higher RVW of this MPC reference service. Overall, comparison with this MPC reference service serves to justify an RVW of 38.00 for 35535, hepato-renal bypass.

Comparison with 35560 Bypass graft with vein; aorto-renal: This is another good comparison service from a clinical perspective because it accomplishes the same end-point, revascularization of a severely ischemic kidney. 35560 has a RUC-surveyed RVW of 33.90. The major clinical differences are two-fold, first the 35560 patient is sufficiently healthy (or at least “less-sick”) such that his/her aorta may undergo aortic cross-clamp placement. Second the aorto-renal bypass is 200 minutes in duration, 40 minutes less than the hepato-renal bypass. This reflects the additional time required to safely dissect out the common hepatic / proper hepatic / gastroduodenal artery region required for the hepato-renal bypass graft. This additional 40 minutes of intense intra-service time multiplied by the IWPUT may be considered to reflect $40 \times 0.090 = 3.60$ additional intra-service work RVUs. Adding the 3.60 intra-service RVUs to the reference service 33.90 RVW results in 37.50, within 2% of the value we recommend for the new service.

In conclusion, based on comparisons with three clinically-related, RUC-surveyed vascular surgical services, in addition to the IWPUT analysis, we believe an RVW of 38.00 is appropriate and fully justified for the 90-day global service of hepato-renal bypass graft using vein conduit.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 Unlisted procedure, vascular surgery

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

Specialty vascular surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 200

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

Please explain the rationale for this estimate. expert panel opinion

Specialty vascular surgery Frequency 195 Percentage 97.50 %

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? 199

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel opinion

Specialty vascular surgery Frequency 195 Percentage 97.98 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Long Descriptor:

35535 Bypass graft, with vein; hepatorenal

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 surgeons representing vascular surgery reviewed the practice expense details for the survey codes relative to other facility-only 90-day global services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: No changes were made to the standard pre-service 090 day global practice expense clinical labor times. A total of 60 minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA completes pre-service diagnostic and referral forms, coordinates pre-surgery services, schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

The standard 12 minutes has been applied for these inpatient procedures for discharge day management related services.

Post-Service Clinical Labor Activities:

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

Supplies and Equipment:

Post-surgical supplies and equipment necessary for post-discharge surgical care have been indicated.

	A	B	C	D	E
1	AMA/Specialty Society RVS RUC Recommendation			35535	
2	Meeting Date: April 2008			Bypass graft, with vein; hepatorenal	
3	LOCATION	Code	Staff Type	Office	Facility
4	GLOBAL PERIOD			090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	171
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	99
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7
17	End: When patient enters office/facility for surgery/procedure				
18	SERVICE PERIOD				
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12
41	End: Patient leaves office/FACILITY				
42	POST-SERVICE Period				
43	Start: Patient leaves office/facility				
44	Conduct phone calls/call in prescriptions				
46	<i>List Number and Level of Office Visits</i>				
47	99211 16 minutes		16		
48	99212 27 minutes	L037D	27		1
49	99213 36 minutes	L037D	36		2
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
54	<i>Total Office Visit Time</i>				99
55	Other Activity (please specify)				
56	End: with last office visit before end of global period				
57	MEDICAL SUPPLIES	CMS Code	Unit		
58	pack, minimum multi-specialty visit	SA048	pack		3
59	pack, post-op incision care (suture)	SA054	kit		1
60					
61					
62	Equipment	CMS Code	Utilization Percentage		
63	table, power	EF031	100%		99
64	light, exam	EQ168	100%		99

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Tibial-Tibial Bypass with Vein

Lower extremity bypass with autogenous conduit has been performed for limb salvage for over twenty years. The lower extremity bypass graft CPT codes are typically described based on inflow artery, outflow artery, and the conduit used. The CPT codes describing lower extremity revascularization with vein as conduit have been systematically described in the CPT manual for the majority of inflow and outflow combinations except tibial artery to tibial artery. The CPT Editorial Panel met in February 2008 and created code 35570 *Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial* to provide more specificity and to complete the family of lower extremity vein bypass codes.

35570 Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial

The RUC reviewed the survey results from 39 vascular surgeons regarding new code 35570 and agreed the data was robust and reflected the time, complexity, and intensity of the service provided. In comparison, the RUC reviewed the specialty's key reference code 35671 *Bypass graft, with other than vein; popliteal-tibial or -peroneal artery* (work RVU = 20.64, intra-service time = 130), 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU = 27.82, intra-service time = 150), and 35523 *Bypass graft, with vein; brachial-ulnar or -radial* (work RVU = 24.00, intra-service time = 180).

In comparison to the specialty's key reference service, both operations are performed on patients with peripheral arterial disease (PAD), but the reference service, because it requires larger size input, and because it uses synthetic conduit, requires much less operating room time than a tibial-tibial bypass graft using vein conduit. Specifically, 35570 has additional 105 minutes of intra-service time (240 minutes vs. 135 minutes) compared to the key reference service. That 105 minutes of additional intra-service time at an intra-service work per unit of time of 0.063 represents an intra-service increment of 6.62 RVUs. In addition, the 35570 patient has an ischemic ulcer, and the tibial-tibial arterial bypass graft patient has a longer and more intensive post-operative course. Inpatient post operative work totals 9.64 RVUs compared to 5.49 for 35671, an incremental difference of 4.15 RVUs. Thus, if one begins with the 20.64 RVW of the key reference, and adds 6.62 RVUs for intra-time, plus 4.15 RVUs of additional post-service time, the cumulative RVW for 35570 would be 31.41. [20.64+6.62+4.15 = 31.41].

The RUC found that CPT code 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU = 27.28) is the closest 90-day global service (by relative work value ranking) on the RUC's Multi-Specialty Points of Comparison (MPC) list compared to the recommended RVW of new code 35570. 35570 requires much more intra-service time (240 minutes) than this MPC reference service (150 minutes). Additionally even using a conservative intra-service for arterial reconstructions, this increment would add 90 minutes x 0.063 = 5.67 RVUs to the value of the reference to estimate the value of the new service. 44626 has a two-day longer length of stay and a slightly different in-hospital visit profile with a total of 11.64 post-operative in-hospital work RVUs. This is 2.00 RVUs more than 35570, which has 9.64. In contrast, 44626 has one less office visit and 1.31 fewer office visit RVUs compared to 35570. Using these data, the RUC computed a value for 35570 from the MPC service 44626 by starting with the RVW of 44626 and making adjustments for intra and post-service. The calculation is $27.82 + 5.67 - 2.00 + 1.31 = 32.80$. However, the RUC and specialty society agreed that the survey median RVU of 29.00 appropriately valued this service in light of the reference services.

Further supporting an RVU recommendation of 29.00 and in comparison to 35523, the RUC concurred that 35523 has a slightly less intense in-hospital and office visit pattern because the upper extremity has fewer wound healing problems and requires a slightly shorter hospital stay. The hospital and office visit pattern are slightly greater magnitude on the leg wherein the foot ulcer is more likely to be infected and requiring attention with antibiotics, etc. Total post-service work for the new code 35570 is 12.40 compared to 7.76 for 35523, an incremental difference of 4.64 in favor of the new service.

The RUC believed that tibial-tibial bypass carries very high intensity and complexity values. Patients who require this vascular reconstruction are elderly and always have many associated medical co-morbidities. After review of the specialty survey results, comparing similar and related codes, and gaining a clear picture of the service, the RUC agreed with the specialty society's survey median work RVU of 29.00 for new service 35570. **The RUC recommends a relative work value of 29.00 for code 35570.**

Practice Expense:

The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
35501		Bypass graft, with vein; common carotid-ipsilateral internal carotid	090	28.99 (No Change)
●35570	T1	tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial (Do not report 35570 in conjunction with 35256, 35286)	090	29.00

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

CPT Code: 35570 Tracking Number T1

Specialty Society Recommended RVU: **29.00**

Global Period: 090

RUC Recommended RVU: **29.00**

CPT Descriptor: Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/ peroneal trunk-tibial

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year old cigarette-smoking hypertensive diabetic woman with coronary artery disease develops ischemic ulceration of the great toe. Diagnostic evaluation reveals minimal occlusive disease from the aorta to the proximal tibial arteries, but she has occlusion of all three tibial vessels soon after their origins. The distal anterior tibial artery reconstitutes. A proximal to distal anterior tibial artery bypass graft is performed using reversed vein conduit.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

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

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

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assess for appropriateness of DVT prophylaxis; if yes, assure appropriate selection, timing, and administration
- Assess need for beta-blockers, order as required.
- Review medical history and radiology reports
- Review radiographic images including angiograms, CTscans, MRAs, duplex vein mapping
- Review results of other preoperative testing (blood tests, EKG, CXR)
- Review reports of consultants providing preoperative assessment and clearance as indicated
- Meet with patient and family to review planned procedure and postoperative management
- Reexamine patient to ensure that physical findings have not changed and dictate history and physical
- Obtain final informed consent
- Review hospital consent, mark patient
- Discuss perioperative medical management with anesthesiologist
- Review planned procedure with OR staff including vein harvest site
- Verify that all required instruments and supplies are available
- Change into scrub clothes
- Monitor/assist with positioning of the patient
- Ensure that radiographic images are available in the OR
- Mark planned incisions including proximal & distal anastomoses and vein harvest sites
- Monitor/assist with prepping and draping
- Scrub and gown
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work:

Every patient requires individualized assessment for surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps. Vascular surgeons typically wear magnifying operating "loupes" for distal bypass grafts, but there is no additional coding for doing so.

Proximal Arterial Dissection:

- o Incise skin overlying proximal tibial artery
- o Dissect through soft tissue in calf to expose & incise fascia
- o Separate muscle bundles to expose proximal tibial artery, avoiding injury to multiple nearby nerves & veins
- o Clear soft tissue from 5-6 cm of proximal tibial artery
- o Gently pass soft rubber loop around this vessel
- o Assess quality of inflow by testing pulsatility and/or examining with handheld Doppler

Distal Dissection:

- o Incise skin overlying target distal tibial artery
- o Dissect through soft tissue, avoid injury to surrounding structures
- o Incise appropriate muscle compartment fascia
- o Develop dissection plane towards tibial artery target
- o Apply mechanical retractors as needed to allow dissection to continue into deep compartments
- o Identify appropriate neurovascular bundle
- o Carefully tease tibial veins and nerves away from target artery
- o Expose 5-6 cm of target tibial artery, avoiding injury to small branches o
- o Achieve hemostasis after unavoidable incidental division of small artery branches and larger veins
- o Perform visual and palpation exam of target artery to determine if soft enough to allow suture placement
- o If acceptable target, move on to next step. If not, extend dissection or move to another artery
- o Pass soft rubber loops around exposed target artery for control
- o Depending on distal target site, create tunnel / pathway for bypass conduit
- o Ensure tunnel has no sharp turns or fascial planes that would compress or kink bypass

Vein Harvest

- o Incise skin over segment of donor vein to be harvested, (typically ipsilateral greater saphenous vein)
- o Dissect through soft tissue to expose vein along entire length of vein required for bypass
- o Dissect, ligate and divide all side-branches of donor vein, avoiding injury to saphenous nerve
- o Completely dissect soft tissue from around entire length of donor vein
- o Ligate and divide proximal and distal ends of vein once assured that sufficient length has been harvested
- o Move vein from limb to back table for preparation
- o Gently flush blood from saphenous conduit using heparinized saline
- o Occlude end of vein and distend with pressurized saline looking for untied branches and other sources of leak
- o Repair leaks with 7-0 vascular suture using great caution not to reduce caliber of flow channel
- o Decide if vein will be reversed, thereby not requiring valve lysis, vs antegrade use
- o If antegrade use, lyse valves using a range of valvulotome devices
- o Retest for leaks and repair as needed with 7-0 vascular suture using great caution not to reduce caliber

Proximal Anastomosis:

- o Anticoagulate patient with IV heparin
- o Insert mechanical retractors in proximal calf to allow sufficient space to perform anastomosis
- o Apply vascular clamps to inflow artery
- o Carefully perform longitudinal arteriotomy
- o Bring vein conduit onto table, determine which end will be inflow site
- o Bevel proximal end of vein to match arteriotomy
- o Perform 90% of anastomosis (vein conduit to tibial artery) with fine vascular suture
- o Open clamps briefly to flush system, and therefore remove air & debris
- o Complete anastomosis, remove arterial clamps
- o Apply additional sutures as needed to control hemorrhage
- o Pass vein conduit through appropriate plane to distal tibial target artery with care to avoid twists/kinks

Distal Anastomosis:

- o Stretch vein conduit to full length
- o Open vascular clamp momentarily to test quality of blood flow through vein conduit
- o Insert mechanical retraction device to allow sufficient space to sew distal anastomosis
- o Apply proximal and distal vascular clamps to target vessel with care to avoid nerves, veins, etc
- o Carefully perform distal tibial arteriotomy
- o Cut and bevel vein conduit to exactly match length and size of arteriotomy
- o Perform 90% of vein to tibial anastomosis with very fine vascular suture
- o Open clamps briefly to flush out air & debris
- o Complete anastomosis
- o Remove vascular clamps
- o Apply additional sutures as required to achieve hemostasis
- o Listen with Doppler and palpate distal pulses to assure bypass patency
- o Perform other completion maneuvers as required to ensure technical adequacy
- o This may include inserting angiocatheter into bypass for completion study
- o Revise bypass as required to achieve technically adequate endpoint and good blood flow
- o Irrigate all incisions and tunnels copiously
- o Reverse heparin
- o Achieve wound hemostasis as needed with cautery, sutures, ties
- o Close all incisions in multiple layers
- o Recheck pulses to assure patency prior to application of sterile dressings

Description of Post-Service Work:

- Apply sterile dressings. Monitor patient during reversal of anesthesia.
- Monitor and assist transport of patient from OR to recovery room.
- Discuss postoperative recovery care with anesthesia and nursing staff.
- Write postoperative orders and note.
- Discuss procedure and outcome with family in waiting area.
- Frequently perform neurovascular checks to ensure patency of new bypass graft.
- Dictate operative note and copy to referring physician
- Write orders for transferring to surgical floor and discuss ongoing care with floor nurses.
- Examine patient, check wounds and patient progress - Monitor closely for bypass patency
- Correctly assign procedural CPT codes
- Write daily orders for postoperative medications, diet, and patient activity
- Perform daily evaluation of foot ulcer
- Prescribe appropriate local topical wound care and IV abx as needed for foot ulcer
- Check surgical wounds, change dressings, and monitor patient progress daily. Chart notes daily.
- Review patient management with nursing staff daily
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Monitor incision for signs of infection or hematoma
- Assess for any signs of bypass graft failure including foot pain, sensorimotor deficit, ulcer enlargement
- Answer patient and family questions
- Answer nursing staff questions
- Discuss patient progress with referring physician
- Assure adequate level of pain control
- Assess daily to determine if discharge criteria are met, discuss with hospital utilization review nurse
- Chart discharge instructions
- Write prescriptions for medications and supplies needed post-discharge
- Review post-discharge wound care and activity limitations with patient and family
- Dictate discharge summary
- Perform medication reconciliation

Postoperative Work – In Office for duration of 90-day global period:

- Examine patient, remove sutures/staples
- Monitor vein harvest site
- Answer patient and family questions

- Assess for adequacy of pain control
- Order and assess bypass graft patency studies as indicated
- Assess foot ulcer at every visit
- Prescribe local wound care, topical antibiotic, oral antibiotics as required for foot ulcer care
- Discuss advancing daily activities with patient
- Discuss long term scar management with patient
- Discuss vascular function reports with patient and need for any additional testing or consultation
- Arrange for any indicated additional testing and review results
- Arrange for any indicated consultation, prepare documents for transmission to appropriate consultants
- Discuss progress with referring physician(s) and consultants (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Gary Seabrook MD, David Han MD, Robert Zwolak MD				
Specialty(s):	Society for Vascular Surgery				
CPT Code:	35570				
Sample Size:	100	Resp N:	39	Response: 39.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	2.00	3.00	6.00
Survey RVW:	21.00	24.85	29.00	35.00	45.00
Pre-Service Evaluation Time:			60.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	120.00	180.00	240.00	300.00	360.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>70.00</u>	99291x 1.00 99292x 0.00			
Other Hospital time/visit(s):	<u>160.00</u>	99231x 2.00 99232x 3.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>69.00</u>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	35570	Recommended Physician Work RVU: 29.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		240.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>215.00</u>	99231x 2.00 99232x 3.00 99233x 1.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>69.00</u>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
35671	090	20.64	RUC Time

CPT Descriptor Bypass graft, with other than vein; popliteal-tibial or -peroneal artery**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44626	090	27.82	RUC Time	4,592

CPT Descriptor 1 Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
35523	090	24.00	RUC Time

CPT Descriptor Bypass graft, with vein; brachial-ulnar or -radial**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 43.5 %

TIME ESTIMATES (Median)

	CPT Code: 35570	Key Reference CPT Code: 35671	Source of Time RUC Time
Median Pre-Service Time	75.00	70.00	
Median Intra-Service Time	240.00	135.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	215.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	69.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	667.00	435.00	
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	4.12	4.06
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	3.94	3.94

Technical Skill/Physical Effort (Mean)

Technical skill required	4.88	4.47
Physical effort required	4.12	3.71
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.29	4.24
Outcome depends on the skill and judgment of physician	4.71	4.59
Estimated risk of malpractice suit with poor outcome	3.53	3.47

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

Pre-Service intensity/complexity	4.06	4.00
Intra-Service intensity/complexity	4.65	4.41
Post-Service intensity/complexity	3.82	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.*

Clinical Background: Tibial-tibial bypass graft using vein conduit is a complex limb salvage operation typically performed on patients who will go on to leg amputation if they do not undergo surgical revascularization. This is not an operation performed for intermittent claudication. Only the end-stage peripheral arterial disease (PAD) patient is offered this operation. The typical patient has diffuse advanced atherosclerosis with many medical comorbidities including decades of smoking, hyperlipidemia, coronary artery blockages and all the ravages of widespread vascular disease. The

typical patient also has an ischemic foot ulcer that requires additional attention and treatment by the surgeon in a simultaneous attempt to avoid toe or forefoot amputation due to infection.

Recommended RVW 29.00: We recommend the median survey value because it is fully justified based the associated pre, intra, and post-service physician work as documented in the RUC survey, in addition to an IWPOT analysis, the associated intensity and complexity measures, and favorable physician work comparisons with three RUC-surveyed services of similar magnitude, one of which is an MPC list procedure.

IWPOT 0.063: The IWPOT of this service, with the recommended visit pattern and the median survey RVW of 29.00 is very low at 0.063. This indicates the service may be undervalued at the recommended RVW. This is not a typical value for a complex major distal arterial reconstruction performed for limb salvage. Our consensus panel believes that the entire family of lower extremity arterial revascularizations using vein conduit is undervalued.

Intensity and Complexity Measures: Tibial-tibial bypass carries very high intensity and complexity values. Patients who require this vascular reconstruction are elderly and always have many associated medical co-morbidities. If the patient does not undergo successful bypass surgery, he/she will almost certainly require leg amputation from terminal limb ischemia. This operation carries a significant 30-day mortality of approximately 5%, and there are very few procedures among the 8,000 Category I CPT codes that carry this degree of morbidity and mortality. The peri-operative mortality and significant morbidity for the survivors serves as overt testimony to the intensity and complexity of this procedure.

Pre-Time: This is a complex patient about to undergo a long and difficult operation. Pre-times of the three comparison procedures we discuss in this proposal are 70 (RUC approved in 2000), 60 (RUC approved in 2000), and 75 (RUC approved in 2008). Therefore, the pre-time requested herein falls within the range of RUC approved values approved over the last 8 years. This patient requires special positioning time because of operation on an extremity in addition to extra time required for prepping and draping an ulcerated (and therefore infected/colonized by definition) foot into the wound. In some operating rooms there is an effort to cover and exclude the ulcerated area from the sterile adjacent limb by using a sterile iodinated sticky-drape. In others, the effort is to apply extra surgical scrub efforts at the ulcerated area and prep it into the field. Needless to say, this always requires additional time. The second surgical area is the vein harvest site, which may or may not be on the same lower extremity. In addition, the hip and knee must be flexed, the hip rotated outwards, and the knee and ankle sufficiently padded and supported to prevent injury during this long operation. This extra positioning work readily justifies the additional 12 minutes requested herein. In fact, this is a very conservative estimate of the additional positioning time required.

Critical Care Visits (none): Twenty-one of 39 survey respondents (54%) identified the requirement for critical care in this service, ranging from 1 to 3 visits. The other 46% did not include critical care. A consistent observation made by our expert consensus panel is that while surgeons perform critical care on these patients and enter it accurately by visit in the RUC surveys, they always tend to under-estimate the associated physician work during the magnitude estimation process of recommending a final RVW. Thus, while the majority indicated that they perform critical care services, the median survey RVW does not contain sufficient post-operative RVUs for a 99291 visit, and we are left with a mismatch of visits and RVUs. In this particular case, our expert consensus panel reviewed the survey data and clinical situation, and we decided that with the dilemma is best solved in this procedure by eliminating the 99291 critical care service. We therefore elected to down-shift the survey-based hospital 99291 critical care service to a 99233 hospital visit.

Office Visits: Reviewers may notice that the pattern of three 99213 office visits is slightly greater than the reference service. This is because the typical patient requiring this operation has an ischemic foot ulcer that requires significant clinical attention, easily justifying three level 3 office visits.

Comparison with Key Reference Service 35671, Bypass graft, with other than vein; popliteal-tibial or -peroneal artery: Seventeen respondents chose 35671 as the key reference service, likely because it is also a lower extremity bypass graft, but there is a wide clinical and physician work disparity between 35671 and 35570. The key reference service has a RUC-approved RVW of 20.64. Both operations are performed on patients with peripheral arterial disease

(PAD), but the reference service, because it has a more proximal larger size input, and because uses synthetic conduit, requires much less OR time than a tibial-tibial bypass graft using vein conduit. Specifically, 35570 has additional 105 minutes of intra-service time (240 minutes vs. 135 minutes) compared to the key reference service. That 105 minutes of additional intra-service time at an IWPUT of 0.063 represents an intra-service increment of 6.62 RVUs. In addition, the 35570 patient has an ischemic ulcer, and the tibial-tibial arterial bypass graft patient has a longer and more intensive post-operative course. In-hospital post-op work is 9.64 RVUs compared to 5.49 for 35671, an increment of 4.15 RVUs. Thus, if one begins with the 20.64 RVW of the key reference, and adds 6.62 RVUs for intra-time, plus 4.15 RVUs if additional post-service time, the cumulative RVW for 35570, based on the key reference, would be $20.64 + 6.62 + 4.15 = 31.41$.

In conclusion, this comparison with the key reference service leads to the conclusion that 35570 could be valued as high as 31.41. This readily justifies our recommended RVW of 29.00 for the new code.

Comparison with MPC Service 44626, Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure). CPT 44626 is a service performed by some vascular surgeons. With an RVW of 27.82, CPT 44626 is the closest 90-day global service (by RVW ranking) on the MPC list to the recommended RVW of our new code 35570. 35570 has much more intra-service time (240 minutes) than the MPC reference service (150 minutes), and even using a conservative IWPUT for arterial reconstructions, this increment would add $90 \text{ minutes} \times 0.063 = 5.67$ RVUs to the value of the reference to estimate the value of the new service. 44626 has a two-day longer length of stay and a slightly different in-hospital visit profile with a total of 11.64 post-operative in-hospital work RVUs. This is 2.00 RVUs more than 35570, which has 9.64. In contrast, 44626 has one less office visit and 1.31 fewer office visit RVUs compared to 35570. Using these data we can build a value for 35570 from the MPC service 44626 by starting with the RVW of 44626 and making adjustments for intra and post-service. The calculation is $27.82 + 5.67 - 2.00 + 1.31 = 32.80$. Therefore, building from 44626, the appropriate RVW for 35570 would be 32.80. Based on the survey data we feel we can recommend only 29.00 RVUs for 35570.

Comparison with clinically relevant RUC-surveyed code 35523, Bypass graft, with vein; brachial-ulnar or – radial: This upper extremity bypass code was evaluated by the RUC in April 2008. It has an RVW of 24.00, pre-time of 75 minutes (same as we are recommending for 35570), intra-time of 180 minutes (60 minutes less than 35570) because the tibial arteries are deeper and more diseased in the leg than the brachial and radial arteries in the arm, and because the dissection of two diseased and very small diameter tibial arteries is more work than exposing a brachial artery and one small diameter vessel (the radial or ulnar). 35523 has a slightly less intense in-hospital and office-visit pattern because the upper extremity has fewer wound healing problems and requires a slightly shorter hospital stay. The hospital and office visit pattern are slightly greater magnitude on the leg wherein the foot ulcer is more likely to be infected and requiring attention with antibiotics, etc. Total post-service work for the new code 35570 is 12.40 compared to 7.76 for 35523, and increment of 4.64 in favor of the new service. Starting with the reference service RVW of 24.00, then adding the incremental 60 minutes of intra-service time ($60 \times 0.063 = 3.78$) and the post-service work increment (4.64) one arrives at $24.00 + 3.78 + 4.64 = 32.42$ for the new service, readily justifying our 29.00 recommendation.

Comparison with RUC-surveyed lower extremity bypass grafts using vein conduit, ordered in ascending RVW order, demonstrates appropriate placement at recommended RVW of 29.00:

35558 fem-fem	RVW: 23.00, 180 min intra time, medium size vessels are slightly less complex work
35571 pop-tib	RVW: 25.39, 180 min intra time, one medium, one very small vessel
35556 fem-pop	RVW: 26.62, 251 min intra time, two medium vessels therefore slightly less complex
35570 tib-tib	RVW: 29.00, 240 min intra time, two very small vessels, more complex work
35566 fem-tib	RVW: 32.22, 306 min intra time, one medium, one very small vessel, full leg length

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 Unlisted procedure, vascular surgery

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

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

Specialty vascular surgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 200

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

Please explain the rationale for this estimate. expert panel opinion

Specialty vascular surgery Frequency 195 Percentage 97.50 %

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? 199

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel opinion

Specialty vascular surgery Frequency 195 Percentage 97.98 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Long Descriptor:

35570 Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/ peroneal trunk-tibial

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 surgeons representing vascular surgery reviewed the practice expense details for the survey codes relative to other facility-only 90-day global services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

The standard 12 minutes has been applied for these inpatient procedures for discharge day management related services.

Post-Service Clinical Labor Activities:

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

Supplies and Equipment:

Post-surgical supplies and equipment necessary for post-discharge surgical care have been indicated.

	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation			35570	
2	Meeting Date: April 2008			Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/ peroneal trunk-tibial	
3	LOCATION	Code	Staff Type	Office	Facility
4	GLOBAL PERIOD			090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	180
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	108
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7
17	End: When patient enters office/facility for surgery/procedure				
18	SERVICE PERIOD				
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12
41	End: Patient leaves office/FACILITY				
42	POST-SERVICE Period				
43	Start: Patient leaves office/facility				
44	Conduct phone calls/call in prescriptions				
46	<i>List Number and Level of Office Visits</i>				
47	99211 16 minutes		16		
48	99212 27 minutes		27		
49	99213 36 minutes	L037D	36		3
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
54	Total Office Visit Time				108
55	Other Activity (please specify)				
56	End: with last office visit before end of global period				
57	MEDICAL SUPPLIES	CMS Code	Unit		
58	pack, minimum multi-specialty visit	SA048	pack		3
59	pack, post-op incision care (suture)	SA054	kit		1
60					
61					
62	Equipment	CMS Code	Utilization Percentage		
63	table, power	EF031	100%		108
64	light, exam	EQ168	100%		108

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Ilio-celiac Bypass, Ilio-mesenteric Bypass and Ilio-renal Bypass

The CPT Editorial Panel met in February 2008 and created three new procedure codes that would allow for more specific reporting of vascular bypass operations. Prior to this meeting, procedure codes to report extra-anatomic bypass grafts to route blood around stenotic or occluded mesenteric arteries had not been created, only aortic based procedures using either vein or other than vein for revascularization of the superior mesenteric artery or celiac artery existed. One alternative inflow source is constructed from the iliac artery, is well established, and available for both mesenteric bypasses. Three new procedure codes were created to allow for this specific reporting of this bypass operation.

35632 Bypass graft, with other than vein; ilio-celiac

The specialty society indicated that ilio-celiac bypass with synthetic conduit is a highly complex visceral salvage operation typically performed on patients whose clinical status places them at unacceptably high risk for aortic cross-clamp placement and who are therefore not candidates for direct aorto-celiac bypass. One typical indication is the patient with an aorta aneurysm that might rupture if a large vascular clamp were applied. Other clinical presentations include patients with diffuse aortic atherosclerotic plaque creating a risk for embolization, or patients with advanced coronary artery disease and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF or cardiac death. All typical patients who undergo this operation were agreed to be significantly malnourished and at increased risk for post-operative infection and wound healing problems.

The RUC reviewed the specialty society's survey results from 33 vascular surgeons who concurred that the key reference service code 35631 *Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU = 35.90) was almost identical in its physician time, intensity, and complexity measures. The specialty and the RUC agreed that both operations had similar risks to the patient and stress placed upon the physician. The new code, ilio-celiac bypass, has 15 more minutes of intra-service time (240 vs. 225), due to the distant dissection of the common iliac artery and all the considerations and work associated with tunneling a longer graft from the pelvis to the upper abdomen, avoiding kinks, creating unusual and dangerous tunnels (e.g. retro-pancreatic), etc. With the established complexity of the intra-service portion of this operation, the 15 minute increment reflecting approximately 1.23 additional RVUs for the

new service compared to the reference, and an intensive care visit not present in the reference code, the RUC agreed that the specialty society's recommended work value for code 356X1 of 36.00. The RUC also reviewed physician services 33512 *Coronary artery bypass, vein only; three coronary venous grafts* (work RVU = 43.87) and 43621 *Gastrectomy, total; with Roux-en-Y reconstruction* (work RVU = 39.40) in relation to 35632 for physician time, intra-service work per unit of time, and complexity. The RUC agreed that the specialty society's median survey results as recommended by the specialty provided for the proper rank order between these services and amongst other vascular surgical operations. **The RUC recommends a relative work value for CPT code 35632 of 36.00.**

35633 Bypass graft, with other than vein; ilio-mesenteric

The specialty society indicated that ilio-SMA bypass with synthetic conduit is a highly complex visceral salvage operation typically performed on malnourished patients whose clinical status indicates an unacceptably high risk for aortic cross-clamp placement, thereby excluding them from direct aorto-SMA bypass. One typical clinical indication is the patient with an aorta aneurysm that might rupture if a large vascular clamp were applied. Other clinical settings include patients with diffuse aortic atherosclerotic plaque creating a risk for diffuse embolization if a clamp were placed, or patients with advanced coronary artery disease and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF, and cardiac death. All typical patients who undergo this operation are significantly malnourished and therefore at increased risk for post-operative infection and wound healing problems.

The RUC reviewed the specialty society's survey results from 33 vascular surgeons who concurred the key reference service code 35631 *Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU = 35.90) was almost identical in its physician time, intensity, and complexity measures. The specialty and the RUC agreed that both operations had similar risks to the patient and stress placed upon the physician. In addition, both operations are performed on malnourished patients with multiple advanced medical comorbidities typically including hyperlipidemia, coronary artery disease, and diffuse atherosclerosis. Both procedures require complex and dangerous dissection in a vascular space rarely approached by surgeons. There is also risk associated with the possibility of injury to neighboring bowels, pancreas, common bile duct, portal vein and other vital structures. Both procedures carry major risk of hemorrhage, transient post-operative hepatic dysfunction with all the associated sequelae, and in this case there is risk for bowel infarction. The specialty indicated that vascular surgeons often perform 35633 ilio-mesenteric bypass on patients who are even more ill than those who undergo 35631 based on cardiac co-morbidities or the presence of intra-aortic pathology that make it too dangerous to approach the aorta directly, as in 35631.

The RUC and the specialty agreed that new code, ilio-mesenteric bypass, has 15 more minutes of intra-service time (240 vs. 225), due to 1) the dissection of the common iliac artery in the pelvis, 2) the longer graft that must be placed, and 3) all the considerations of graft tunneling, kink avoidance, etc. associated with that longer graft. The intensity of the dissection is the same in both cases, while the

intensity of the iliac dissection is slightly less than the intensity of the aortic dissection in 35631. Thus, there is 15 minutes of additional intra-service time, but the overall intra-service intensity is slightly less. It is the hospital visit pattern that makes the primary difference in work values. 35633 includes two intensive care visits that are not present in the reference code. The in hospital post service work RVUs are therefore 14.58 compared to 7.58 in the reference. With the office visit patterns are identical, and beginning with the work value of 35.90 from the reference service, and adding 7.58 RVUs to reflect the additional inpatient post operative care, the RUC estimated the physician work of the new code at 35.90 plus 7.58, or 43.48 RVUs. However, the RUC and the specialty agreed that this work RVU of 43.48 would establish a rank order anomaly with code 33512 *Coronary artery bypass, vein only; three coronary venous grafts* (work RVU = 43.87) and 43621 *Gastrectomy, total; with Roux-en-Y reconstruction* (work RVU = 39.40). Therefore, the RUC and the specialty agreed that the proper valuation and rank order for code 35633 was the 75th percentile specialty survey value of 38.98. **The RUC recommends a relative work value for code 35633 of 38.98.**

35634 Bypass graft, with other than vein; ilio-renal

The specialty society indicated that ilio-renal bypass with synthetic conduit is a highly complex renal salvage operation typically performed on patients with severe hypertension and at least some degree of renal insufficiency whose clinical condition includes an unacceptably high risk for aortic cross-clamp placement, thereby excluding them from direct aorto-renal bypass surgery. One typical indication is the patient with an aorta aneurysm that might rupture if a large vascular clamp were applied. Other clinical settings include patients with diffuse aortic atherosclerotic plaque creating a risk for diffuse embolization if a clamp were placed, or patients with advanced coronary artery disease and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF, and cardiac death. Virtually all patients who undergo this operation are elderly and have multiple significant medical co-morbidities such as a long history of tobacco abuse, coronary artery disease, COPD, hypertension, and hyperlipidemia.

The RUC reviewed the specialty society's survey results from 33 vascular surgeons who concurred the key reference service code 35631 *Bypas graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU = 35.90) was almost identical in its physician time, intensity, and complexity measures to code 35634. The specialty and the RUC agreed that both operations had similar risks to the patient and stress placed upon the physician. In addition, both operations are performed on patients with multiple advanced medical comorbidities typically including coronary artery disease, hypertension, hyperlipidemia, diffuse atherosclerosis plus all the ravages brought about by decades of tobacco abuse. Both procedures require complex and dangerous arterial dissection. There is risk of injury to neighboring bowels and kidneys. Both procedures carry major risk of hemorrhage and transient post-operative renal dysfunction with all the associated sequelae. In addition to these similarities, vascular surgeons oftentimes perform 35634 ilio-renal bypass on patients who are even more ill than those who undergo 35631 based on cardiac co-morbidities or the presence of aortic pathology.

The RUC and specialty agreed that new code 35634, ilio-renal bypass, has 5 more minutes of intra-service time (230 vs. 225), due to the dissection of the common iliac artery in the pelvis, the longer graft that must be placed, and all the considerations of graft tunneling, kink avoidance, etc. The intensity of the renal dissection is the same in both cases, while the intensity of the iliac dissection is slightly less than that of the aortic dissection in 35631. Thus, there is 5 minutes of additional intra-service time, but the overall intra-service intensity is slightly less for 35634. Although the post operative work is more extensive for 356X3 than for 35631, the RUC and the specialty society agreed in comparison to code 43621 *Gastrectomy, total; with Roux-en-Y reconstruction* (work RVU = 39.40), the physician work of 35634 is slightly less. The RUC agreed with the specialty society's rank order determination and recommendation of 35.20 for code 35634. **The RUC recommends a relative work value of 35.20 for CPT code 35634.**

Practice Expense:

The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
35601		Bypass graft, with other than vein; common carotid-ipsilateral internal carotid	090	26.99 (No Change)
●35632	U1	ilio-celiac (Do not report code 35632 in conjunction with 35221, 35251, 35281, 35531, 35631)	090	36.00
●35633	U2	ilio-mesenteric (Do not report code 35633 in conjunction with 35221, 35251, 35281, 35531, 35631)	090	38.98

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●35634	U3	ilio-renal (Do not report code 35634 in conjunction with 35221, 35251, 35281, 35560, 35536, 35631)	090	35.20

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

CPT Code: 35632 Tracking Number U1

Specialty Society Recommended RVU: **36.00**

Global Period: 090

RUC Recommended RVU: **36.00**

CPT Descriptor: Bypass graft, with other than vein; ilio-celiac

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old female smoker with hypercholesterolemia and significant coronary artery disease has severe post-prandial abdominal pain and a 40 pound weight loss over the last few months due to food-fear. Upper endoscopy reveals ischemic gastric ulcers. Arteriography reveals occlusion of the celiac artery origin. Her superior mesenteric artery is patent, but there are no collaterals feeding the celiac system. Her aorta is aneurysmal, and cannot be clamped safely for a proximal anastomosis. Her common iliac arteries contain plaque but are adequate to serve as inflow. An ilio-celiac bypass is performed using synthetic conduit.

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

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

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

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

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

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assess for appropriateness of DVT prophylaxis; if yes, assure appropriate selection, timing, and administration
- Assess need for beta-blockers, order as required.
- Review medical history and radiology reports
- Review radiographic images including angiograms, CTscans, MRAs, duplex vein mapping
- Review results of other preoperative testing (blood tests, EKG, CXR)
- Review reports of consultants providing preoperative assessment and clearance as indicated
- Meet with patient and family to review planned procedure and postoperative management
- Reexamine patient to ensure that physical findings have not changed and dictate history and physical
- Obtain final informed consent
- Review hospital consent, mark patient
- Discuss perioperative medical management with anesthesiologist
- Review planned procedure with OR staff
- Verify that all required instruments and supplies are available
- Change into scrub clothes
- Monitor/assist with positioning of the patient
- Ensure that radiographic images are available in the OR
- Mark planned abdominal incision site
- Monitor/assist with prepping and draping
- Scrub and gown
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform long midline laparotomy & routine abdominal exploration
- Mobilize small bowel to expose distal infrarenal aorta and one common iliac artery
- Incise retroperitoneum and clear soft tissue from these arteries
- Expose adequate length of common iliac artery to achieve proximal and distal control with enough space to sew mosis
- Retract liver upwards and incise soft tissue overlying celiac axis
- Ever so gently dissect out celiac, common hepatic, splenic and left gastric arteries and pass soft loops for control
- Determine exact pathway of proposed graft from common iliac to celiac
- Create appropriate tunnels for graft, possibly including retro-pancreatic, or trans-mesenteric
- Pass Teflon tie through tunnels to preserve exact location
- Choose appropriate diameter synthetic conduit
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on inflow common iliac artery
- Incise inflow iliac longitudinally at proximal anastomosis site
- Bevel end of conduit appropriately and anastomose synthetic conduit to inflow iliac with vascular suture
- Remove clamps and test for leaks
- Apply additional sutures as needed to control hemorrhage
- Insonate common iliac with Doppler to ensure flow beyond anastomosis has been restored
- Pass conduit through pre-made tunnels taking care to avoid kinks
- Examine geometry of graft-to-ceeliac proposed anastomosis to determine optimal lie of graft
- Apply proximal and distal clamps to celiac beyond occlusion, as well as splenic, hepatic and gastric arteries
- Incise celiac artery longitudinally at distal anastomosis site
- Cut synthetic conduit to appropriate length and bevel the end to optimize geometry
- Anastomose end of synthetic conduit to celiac artery
- Flush system to remove air and debris
- Remove clamps & apply additional sutures as needed to achieve hemostasis
- Palpate pulses in celiac, common hepatic and splenic vessels to assess restitution of blood flow
- Listen with Doppler to these vessels and to liver assure normal flow has been restored
- Reverse anticoagulant with protamine
- Irrigate abdomen & final check for hemostasis
- Close abdominal incision
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

- Apply sterile dressings. Monitor patient during reversal of anesthesia.
- Monitor transport of patient from OR to recovery room.
- Discuss postoperative recovery care with anesthesia and nursing staff.
- Write postoperative orders.
- Discuss procedure and outcome with family in waiting area.
- Write postoperative note.
- Dictate operative note and copy to referring physician
- Correctly assign procedural CPT codes
- When appropriate, write orders for transferring to surgical floor and discuss ongoing care with floor nurses.
- Examine patient frequently, check wound and patient progress - Monitor closely for urinary output
- Write daily orders for postoperative medications, diet, and patient activity
- Check wounds, change dressings, and monitor patient progress. Chart notes.
- Review patient management with nursing staff
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Monitor incision for signs of infection or hematoma. Watch for resumption of GI function
- Assess for any signs of bypass graft failure including abdominal pain, liver dysfunction, oliguria
- Answer patient and family questions
- Answer nursing staff questions

- Discuss patient progress with referring physician
- Assure adequate level of pain control
- Assess daily to determine if discharge criteria are met, discuss with hospital utilization review nurse
- Chart discharge instructions
- Write prescriptions for medications and supplies needed post-discharge
- Review post-discharge wound care and activity limitations with patient and family
- Dictate discharge summary
- Perform medication reconciliation

Postoperative Work – In Office for duration of 90-day global period:

- Examine patient, remove sutures/staples
- Answer patient and family questions
- Review nutritional studies, ability to eat, signs/symptoms of gastric ulcer healing
- Order and assess bypass graft patency studies as indicated
- Assess for adequacy of pain control
- Discuss advancing daily activities with patient
- Discuss long term scar management with patient
- Discuss GI and Liver function reports with patient and need for any additional testing or consultation
- Arrange for any indicated additional testing and review results
- Arrange for any indicated consultation, prepare documents for transmission to appropriate consultants
- Discuss progress with referring physician(s) and consultants (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s)	Gary Seabrook MD, David Han MD, Robert Zwolak MD				
Specialty(s)	vascular surgery				
CPT Code:	35632				
Sample Size:	100	Resp N:	33	Response: 33.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	1.00	1.00	6.00
Survey RVW:	31.00	35.00	36.00	39.00	55.00
Pre-Service Evaluation Time:			70.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	180.00	220.00	240.00	270.00	360.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>140.00</u>	99291x 2.00 99292x 0.00			
Other Hospital time/visit(s):	<u>120.00</u>	99231x 2.00 99232x 2.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>62.00</u>	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	35632	Recommended Physician Work RVU: 36.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		240.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>70.00</u>	99291x 1.00 99292x 0.00		
Other Hospital time/visit(s):	<u>175.00</u>	99231x 2.00 99232x 2.00 99233x 1.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>62.00</u>	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
35631	090	35.90	RUC Time

CPT Descriptor Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
35631	090	35.90	RUC Time	1,041

CPT Descriptor 1 Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33512	090	43.87	RUC Time	5,949

CPT Descriptor 2 Coronary artery bypass, vein only; three coronary venous grafts

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
43621	090	39.40	RUC Time

CPT Descriptor Gastrectomy, total; with Roux-en-Y reconstruction**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 75.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 35632	<u>Key Reference CPT Code:</u> 35631	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	110.00	
Median Intra-Service Time	240.00	225.00	
Median Immediate Post-service Time	30.00	38.00	
Median Critical Care Time	70.0	0.00	
Median Other Hospital Visit Time	175.0	175.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	690.00	648.00	
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	4.48	4.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.44	4.40
Urgency of medical decision making	4.08	4.08

Technical Skill/Physical Effort (Mean)

Technical skill required	4.84	4.72
Physical effort required	4.36	4.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.80	4.80
Outcome depends on the skill and judgment of physician	4.80	4.80
Estimated risk of malpractice suit with poor outcome	3.96	4.00

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

Pre-Service intensity/complexity	4.52	4.48
Intra-Service intensity/complexity	4.76	4.68
Post-Service intensity/complexity	4.24	4.24

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.*

Clinical Background: Ilio-celiac bypass with synthetic conduit is a highly complex visceral salvage operation typically performed on patients whose clinical status places them at unacceptably high risk for aortic cross-clamp placement, and who are therefore not candidates for direct aorto-celiac bypass. One typical indication is the patient with an aorta aneurysm (such as our clinical vignette) that might rupture if a large vascular clamp were applied. Other clinical presentations include patients with diffuse aortic atherosclerotic plaque creating a risk for embolization, or patients with

advanced coronary artery disease and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF, and cardiac death. All typical patients who undergo this operation are significantly malnourished and at increased risk for post-operative infection and wound healing problems.

Recommended RVW 36.00: We recommend the median survey value because it is fully justified based on IWPUT analysis, intensity and complexity measures, and favorable work comparisons with three RUC-surveyed services of similar magnitude, two of which are MPC list procedures.

IWPUT 0.082: The IWPUT of this service, with the recommended visit pattern and a recommended RVW of 36.00, is 0.082. This is actually a low IWPUT for a complex intra-abdominal arterial reconstruction and serves to verify the conservative nature of this RVW recommendation.

Intensity and Complexity Measures: Ilio-celiac bypass scores near the top of all intensity and complexity measures. Patients who require this vascular reconstruction are elderly, always have many associated medical co-morbidities, and are significantly malnourished. If the proximal or distal anastomosis is technically faulty the graft may thrombose and the liver and stomach may become overtly ischemic leading to major morbidity and/or mortality. In fact, this operation carries a 30-day mortality of 5-10%, and there very few procedures among the 8,000 Category I CPT codes that are this dangerous.

Pre-Time: This is a very sick patient about to undergo an extremely complex operation. Pre-time of the key reference service is 110 minutes, approved by the RUC in 2000. This patient requires position and surgical preparation such that both the common iliac artery deep in the pelvis and the right side of the chest may be accessed. The anesthesia team usually places extra large-bore IV catheters, arterial pressure monitoring lines and more often than not, a central venous catheter. This extra positioning and preparation work readily justifies the additional 12 minutes requested herein. In fact, this is a very conservative estimate of the additional positioning time required, especially compared to that of the key reference service (110 minutes) approved by the RUC 8 years ago in August 2000. We believe the request for 75 minutes actually underestimates the true pre-service time involved in safely preparing the patient for this operation.

Critical Care Visits: Thirty-one of 33 survey respondents (94%) identified the requirement for critical care in this service. In fact, the majority of survey respondents stated that two or more critical care services were typical for this patient. A consistent observation made by our expert consensus panel is that while surgeons perform critical care on these patients and enter it accurately by visit in the RUC surveys, they always tend to under-estimate the associated physician work in the magnitude estimation process. Thus, while the majority indicated they perform two or more critical care services, the median survey RVW does not contain sufficient post-operative RVUs for two 99291 services, and we are left with a mismatch of RVUs and visits. In this particular case, our expert consensus panel reviewed the data and clinical situation, and we recommend reducing the critical care visits from the survey data frequency of two, to one 99291 and one 99233. The critical care provided by the surgeon typically occurs during the first 24 hours following surgery and involves high complexity decision making to assess, manipulate, and support vital circulatory system functions in the setting of massive intra-abdominal third spacing and hopefully transient hepatic failure due to inflow arterial occlusion during creation of the celiac anastomosis, and to prevent shock in patients with underlying coronary artery disease and chronic malnutrition. The work includes interpretation of cardiac output measurements, chest x-rays, pulse oximetry, and blood gases. Performance of gastric intubation and vascular access performed during the course of critical care service is included therein. Special consideration is directed to avoidance of iatrogenic infection in this chronically malnourished patient.

Comparison with Key Reference Service: 35631, Bypass graft with other than vein; aortoceliac, aortomesenteric, aortorenal: The key reference service has a RUC-approved RVW of 35.90. Both operations are performed on malnourished patients with multiple advanced medical comorbidities typically including hyperlipidemia, coronary artery disease, and diffuse atherosclerosis. Both procedures require complex and dangerous dissection in a space rarely approached by surgeons within the dense tissue surrounding the celiac axis. There is risk of injury to neighboring

stomach, pancreas, common bile duct, portal vein and other vital structures. Both procedures carry major risk of hemorrhage, transient post-operative hepatic dysfunction with LFT elevation, interruption of protein synthetic activity and the potential for post-operative coagulopathy. In fact, vascular surgeons oftentimes perform 35632 ilio-celiac bypass on patients who are even more ill than those who undergo 35631 because the patients have formidable cardiac comorbidities or the presence of thick irregular intra-aortic pathology.

Point-by-point comparison of the service elements yields the following information. The new code, ilio-celiac bypass, has 15 more minutes of intra-service time (240 vs. 225), due to the more distant dissection of the common iliac artery and all the considerations and work associated with tunneling a longer graft from the pelvis to the upper abdomen, avoiding kinks, creating unusual and dangerous tunnels (e.g. retro-pancreatic), etc. With the established complexity of the intra-service portion of this operation the 15 minute increment reflects approximately 1.23 additional RVUs for the new service compared to the reference. In addition, the visit pattern includes an intensive care visit not present in the reference. The remainder of the in-hospital and office visit pattern are similar. Thus, beginning with the RVW of 35.90 for the reference service, adding 1.23 RVUs to reflect the additional intra-service time, plus the increment for one critical care visit, this comparison to the key reference service justifies an RVW well in excess of 36.00 survey median value that we recommend.

Comparison with MPC Reference Service 35631, Bypass graft with other than vein; aorto-celiac, aorto-mesenteric, aorto-renal: The most similar service on the MPC in terms of clinical analogy and RVW is the one just reported as the key reference service, chosen by 76% of the survey respondents. The MPC reference has an RVW of 35.90, and we are recommending an RVW of 36.00 for this service, based primarily on an additional 15 minutes of intra-service time in the new code.

Comparison with MPC Reference Service 33512, Coronary artery bypass, vein only; three coronary venous grafts: Three vessel coronary bypass graft is a well known service on the MPC list with an RVW of 43.87. It is an operation performed by some vascular surgeons. The typical patient undergoing coronary bypass is extremely similar to the typical peripheral arterial disease patient, such as the one cited here with chronic mesenteric ischemia. 33512 carries a 9-day hospital length of stay compared to 7 days for 35632. Overall, 33512 has 20.07 RVUs of post-service work compared to 15.02 for c, a difference of 5.05 RVUs in favor of 33512. Comparison of intra-service work is challenging. Both

coronary bypass and ilio-celiac bypass are operations with major intensity. The most intense portions of 33512 are probably greater than the most intense portions of ilio-celiac bypass, but both have intervals where the patient's life hangs in the balance and depends on the surgeon's skill. Both operations require significant surgical dissection to reach the target vessels (median sternotomy for 33512 and extensive pelvic arterial and peri-celiac dissection for 35632). 35632 therefore has 27 more intra-service minutes than 33512 (240 vs. 213 minutes), but at slightly lower intensity. If we can assume physician work equipoise for the intra-service portions of these two operations, we can estimate the value of 35632 by subtracting the post-work increment 5.05 from the RVW of 33512, therefore 43.87 minus 5.05 equals 38.82. This means that even if there is a fairly significant intra-service intensity difference favoring 33512, the recommended RVW of 36.00 for 35632 is reasonably justified.

Comparison with CPT 43621 Gastrectomy, total; with Roux-en-Y reconstruction:

43621 is a complex general surgery procedure performed in the upper abdomen. Some vascular surgeons perform this operation. It has a time and visit pattern extremely close to that of 35632, which we are currently valuing. 43621 has a RUC-approved RVW of 39.40 (August 2005).

Element	43621	35632
Pre-time	60 min	75 min
Intra-time	240 min	240 min
Intra-intensity	high	equal or higher
IWPUT	0.080	0.082
Immed Post	30 min	30 min
99291	1	1
99233	2	1

99232	3	2
99231	3	2
99238	1	1
99213	2	2
99212	1	1
RVW	39.40	36.00 recommended

Conclusion: These two services have very similar time and visit elements. Intra-service work is probably at work equipoise or slightly in favor of 35632. Post-service is 3-days longer for 43621 but visit pattern is similar. Total post-service work is 19.17 for 43621 and 15.02 for 35632, a difference of 4.15 RVUs. Starting with the RVW of 39.40 for 43621, and subtracting 4.15 RVUs for the difference in post-service work, one arrives at an estimated 35.25 RVUs for 35632, a value almost exactly the 36.00 that we recommend for this service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 Unlisted procedure, vascular surgery

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

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

Specialty vascular surgery How often? Rarely

Specialty How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 200

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

Please explain the rationale for this estimate. expert panel opinion

Specialty vascular surgery	Frequency 195	Percentage 97.50 %
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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? 199

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel opinion

Specialty vascular surgery	Frequency 195	Percentage 97.98 %
----------------------------	---------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code: 35633 Tracking Number U2

Specialty Society Recommended RVU: **38.98**

Global Period: 090

RUC Recommended RVU: **38.98**

CPT Descriptor: Bypass graft, with other than vein; ilio-mesenteric

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old female smoker with hypercholesterolemia and significant coronary artery disease has severe post-prandial abdominal pain and a 40 pound weight loss due to food-fear. She has had previous gastric surgery. Arteriography reveals near occlusion of the celiac artery and a long segment superior mesenteric artery occlusion. Her infrarenal aorta harbors a small aortic aneurysm and cannot be used for inflow. Her common iliac arteries are diseased but acceptable inflow sources. An ilio-superior mesenteric artery bypass is performed using synthetic conduit.

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

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

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

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

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assess for appropriateness of DVT prophylaxis; if yes, assure appropriate selection, timing, and administration
- Assess need for beta-blockers, order as required.
- Review medical history and radiology reports
- Review radiographic images including angiograms, CTscans, MRAs, duplex vein mapping
- Review results of other preoperative testing (blood tests, EKG, CXR)
- Review reports of consultants providing preoperative assessment and clearance as indicated
- Meet with patient and family to review planned procedure and postoperative management
- Reexamine patient to ensure that physical findings have not changed and dictate history and physical
- Obtain final informed consent
- Review hospital consent, mark patient
- Discuss perioperative medical management with anesthesiologist
- Review planned procedure with OR staff
- Verify that all required instruments and supplies are available
- Change into scrub clothes
- Monitor/assist with positioning of the patient
- Ensure that radiographic images are available in the OR
- Mark planned abdominal incision site
- Monitor/assist with prepping and draping
- Scrub and gown
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform long midline laparotomy & routine abdominal exploration
- Mobilize small bowel to expose distal infrarenal aorta and one common iliac artery
- Incise retroperitoneum and clear soft tissue from these arteries
- Expose adequate length of common iliac artery to achieve proximal and distal control with enough space to sew mosis
- Retract transverse mesocolon upwards and incise soft tissue overlying superior mesenteric artery (SMA)
- Ever so gently dissect out SMA and proximal branches and pass soft loops for control
- Determine exact pathway of proposed graft from common iliac to SMA
- Create appropriate tunnels for graft, options including trans-mesenteric approach or retroperitoneal
- Pass Teflon tie through tunnels to preserve exact location
- Choose appropriate diameter synthetic conduit
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on inflow common iliac artery
- Perform arteriotomy of inflow iliac longitudinally at proximal anastomosis site
- Bevel end of conduit appropriately and anastomose synthetic conduit to inflow iliac with vascular suture
- Remove clamps and test for leaks
- Apply additional sutures as needed to achieve hemostasis
- Insonate common iliac with handheld Doppler to ensure flow beyond anastomosis has been restored
- Pass conduit through pre-made tunnels taking care to avoid kinks
- Examine geometry of graft-to-SMA proposed anastomosis to determine optimal lie of graft
- Apply proximal and distal clamps to SMA beyond occlusion, as well as to adjacent branch arteries
- Perform longitudinal arteriotomy of SMA at distal anastomosis site
- Cut synthetic conduit to appropriate length and bevel the end to optimize geometry
- Anastomose end of synthetic conduit to SMA
- Flush system to remove air and debris
- Remove clamps & apply additional sutures as needed to achieve hemostasis
- Palpate pulse in SMA to assess restitution of blood flow
- Listen with Doppler to SMA and branches to assure normal flow has been restored
- Revise graft as needed to optimize blood flow, then reverse anticoagulant with protamine
- Irrigate abdomen & final check for hemostasis
- Close abdominal incision
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

- Apply sterile dressings. Monitor patient during reversal of anesthesia.
- Monitor transport of patient from OR to recovery room.
- Discuss postoperative recovery care with anesthesia and nursing staff.
- Write postoperative orders.
- Discuss procedure and outcome with family in waiting area.
- Write postoperative note.
- Dictate operative note and copy to referring physician
- Correctly assign procedural CPT codes
- When appropriate, write orders for transferring to surgical floor and discuss ongoing care with floor nurses.
- Examine patient frequently, check wound and patient progress - Monitor closely for urinary output
- Write daily orders for postoperative medications, diet, and patient activity
- Check wounds, change dressings, and monitor patient progress. Chart notes.
- Review patient management with nursing staff
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Monitor incision for signs of infection or hematoma. Watch for resumption of GI function
- Assess for any signs of bypass graft failure including abdominal pain, liver dysfunction, oliguria
- Answer patient and family questions
- Answer nursing staff questions

- Discuss patient progress with referring physician
- Assure adequate level of pain control
- Assess daily to determine if discharge criteria are met, discuss with hospital utilization review nurse
- Chart discharge instructions
- Write prescriptions for medications and supplies needed post-discharge
- Review post-discharge wound care and activity limitations with patient and family
- Dictate discharge summary
- Perform medication reconciliation

Postoperative Work – In Office for duration of 90-day global period:

- Examine patient, remove sutures/staples
- Answer patient and family questions
- Review nutritional studies, ability to eat, signs/symptoms of positive nutritional balance
- Order and assess bypass graft patency studies as indicated
- Assess for adequacy of pain control
- Discuss advancing daily activities with patient
- Discuss long term scar management with patient
- Discuss GI and Liver function reports with patient and need for any additional testing or consultation
- Arrange for any indicated additional testing and review results
- Arrange for any indicated consultation, prepare documents for transmission to appropriate consultants
- Discuss progress with referring physician(s) and consultants (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Gary Seabrook MD, David Han MD, Robert Zwolak MD				
Specialty(s):	vascular surgery				
CPT Code:	35633				
Sample Size:	100	Resp N:	33	Response: 33.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	1.00	2.00	6.00
Survey RVW:	31.00	35.00	36.00	38.98	55.00
Pre-Service Evaluation Time:			70.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	180.00	210.00	240.00	240.00	300.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>140.00</u>	99291x 2.00 99292x 0.00			
Other Hospital time/visit(s):	<u>120.00</u>	99231x 2.00 99232x 2.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>62.00</u>	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	35633	Recommended Physician Work RVU: 38.98		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		240.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>140.00</u>	99291x 2.00 99292x 0.00		
Other Hospital time/visit(s):	<u>120.00</u>	99231x 2.00 99232x 2.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>62.00</u>	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
35631	090	35.90	RUC Time

CPT Descriptor Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
35631	090	35.90	RUC Time	1,041

CPT Descriptor 1 Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33512	090	43.87	RUC Time	5,949

CPT Descriptor 2 Coronary artery bypass, vein only; three coronary venous grafts

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
43621	090	39.40	RUC Time

CPT Descriptor Gastrectomy, total; with Roux-en-Y reconstruction**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 75.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 35633	<u>Key Reference CPT Code:</u> 35631	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	110.00	
Median Intra-Service Time	240.00	225.00	
Median Immediate Post-service Time	30.00	38.00	
Median Critical Care Time	140.0	0.00	
Median Other Hospital Visit Time	120.0	175.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	705.00	648.00	
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	4.48	4.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	4.40
Urgency of medical decision making	4.08	4.08

Technical Skill/Physical Effort (Mean)

Technical skill required	4.76	4.76
Physical effort required	4.36	4.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.84	4.84
Outcome depends on the skill and judgment of physician	4.80	4.80
Estimated risk of malpractice suit with poor outcome	4.00	4.04

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

Pre-Service intensity/complexity	4.48	4.48
Intra-Service intensity/complexity	4.68	4.72
Post-Service intensity/complexity	4.24	4.28

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.*

Clinical Background: Ilio-SMA bypass with synthetic conduit is a highly complex visceral salvage operation typically performed on malnourished patients whose clinical status indicates an unacceptably high risk for aortic cross-clamp placement, thereby excluding them from direct aorto-SMA bypass. One typical clinical indication is the patient with an aorta aneurysm (such as our clinical vignette) that might rupture if a large vascular clamp were applied. Other clinical settings include patients with diffuse aortic atherosclerotic plaque creating a risk for diffuse embolization if a clamp were

placed, or patients with advanced coronary artery disease and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF, and cardiac death. All typical patients who undergo this operation are significantly malnourished and therefore at increased risk for post-operative infection and wound healing problems.

Recommended RVW 38.98: We recommend the 75th percentile survey value because it is fully justified based on IWPOT analysis, intensity and complexity measures, and favorable work comparisons with three RUC-surveyed services of similar magnitude, two of which are MPC list procedures.

IWPOT 0.084: The IWPOT of this service, with the recommended visit pattern and a recommended RVW of 38.98, is 0.084. This is a typical, or even low, value for a complex intra-abdominal arterial reconstruction.

Intensity and Complexity Measures: Ilio-mesenteric bypass scores near the top of all intensity and complexity measures. Patients who require this vascular reconstruction are elderly, always have many associated medical comorbidities, and are significantly malnourished. If the proximal or distal anastomosis is technically faulty the graft may thrombose and the bowel will become overtly ischemic and progress to gangrene of successful salvage is not undertaken. This operation carries a 30-day mortality of 5-10%, and there very few procedures among the 8,000 Category I CPT codes with this degree of morbidity and mortality. Safe to say this procedure numbers among the 2-3% most morbid procedures in CPT, thereby justifying the very high intensity and complexity measures.

Pre-Time: This is a very sick patient about to undergo an extremely complex operation. Pre-time of the key reference service is 110 minutes, approved by the RUC in 2000. This patient requires positioning and surgical preparation such that both the common iliac arteries deep in the pelvis and the right side of the chest may be accessed. The anesthesia team usually places extra large-bore IV catheters, arterial pressure monitoring lines and more often than not, a central venous catheter or a transesophageal echo. This extra positioning and preparation work readily justifies the additional 12 minutes requested herein. In fact, this is a very conservative estimate of the additional positioning time required, especially compared to that of the key reference service (110 minutes) approved by the RUC 8 years ago in August 2000. We believe the request for 75 minutes actually underestimates the true pre-service time involved in safely preparing the patient for this operation.

Critical Care Visits (2): Thirty-one of 33 survey respondents (94%) identified the requirement for critical care in this service. In fact, the majority of survey respondents (17/33) stated that two or more critical care services were typical for this very sick patient. A consistent observation made by our expert consensus panel is that while surgeons perform critical care on these patients and enter it accurately by visit in the RUC surveys, they always tend to under-estimate the associated physician work in the magnitude estimation process. Thus, while the majority indicated they perform two or more critical care services, the median survey RVW does not contain sufficient post-operative RVUs for two 99291 services, and we are left with a mismatch of RVUs and visits. In this particular case, our expert consensus panel reviewed the data and clinical situation. Following revascularization of the SMA there is typically an enormous fluid requirement as the bowels are overtly ischemic during the time that the anastomosis is being performed. There is major post-operative third-spacing and the need for minute-to-minute management of fluid boluses and blood products. Patients typically require administration vasopressor drips following this operation. We therefore recommend two critical care visits for this code because we believe that true critical care service is provided by the surgeon during the first 48 hours following surgery. The visit sequence has been depicted accurately by the survey respondents. Since we believe the visit pattern to be accurate, we are recommending the 75th percentile survey value to accurately account for two critical care services. To summarize, the critical care provided by the surgeon typically occurs during the first 48 hours following surgery and involves high complexity decision making to assess, manipulate, and support vital circulatory system functions in the setting of massive intra-abdominal third spacing and transient whole-bowel ischemia due to SMA occlusion during creation of the bypass graft anastomosis. This work is done to prevent shock in patients with underlying coronary artery disease. The work includes interpretation of cardiac output measurements, chest x-rays, pulse oximetry, and blood gases. Performance of gastric intubation and vascular access performed during the course of critical care service is included therein. Special consideration is directed to double-product control in a patient with significant underlying coronary artery disease.

Comparison with Key Reference Service : 35631, Bypass graft with other than vein; aortoceliac, aortomesenteric, aortorenal: The key reference service has a RUC-approved RVW of 35.90. Both operations are performed on malnourished patients with multiple advanced medical comorbidities typically including hyperlipidemia, coronary artery disease, and diffuse atherosclerosis. Both procedures require complex and dangerous dissection in a vascular space rarely approached by surgeons. There is risk of injury to neighboring bowels, pancreas, common bile duct, portal vein and other vital structures. Both procedures carry major risk of hemorrhage, transient post-operative hepatic dysfunction with all the associated sequelae, and in this case there is risk for bowel infarction. Vascular surgeons oftentimes perform 35633 ilio-mesenteric bypass on patients who are even more ill than those who undergo 35631 based on cardiac comorbidities or the presence of intra-aortic pathology that make it too dangerous to approach the aorta directly, as in 35631.

By point-by-point comparison of service elements, these two procedures are quite similar. The new code, ilio-mesenteric bypass, has 15 more minutes of intra-service time (240 vs. 225), due to 1) the dissection of the common iliac artery in the pelvis, 2) the longer graft that must be placed, and 3) all the considerations of graft tunneling, kink avoidance, etc. associated with that longer graft. The intensity of the SMA dissection is the same in both cases, while the intensity of the iliac dissection is slightly less than the intensity of the aortic dissection in 35631. Thus, there is 15 minutes of additional intra-service time, but the overall intra-service intensity is slightly less. These two minor differences therefore cancel each other out, achieving physician work equipoise for the intra-service portion of this comparison. It is the hospital visit pattern that makes the primary difference in RVWs. Based on the clinical discussion above, 35633 includes two intensive care visits that are not present in the reference. The in-hospital post service RVUs are therefore 14.58 compared to 7.58 in the reference. The office visit patterns are identical. Thus, beginning with the RVW of 35.90 for the reference service, and adding 7.58 RVUs to reflect the additional in-hospital post-op care, we estimate the physician work of the new code at 35.90 plus 7.58, or 43.48 RVUs. In conclusion, this comparison of the new code with its key reference indicates that an RVW as high as 43.48 can be justified. Therefore, the comparison readily justifies the recommended RVW of 38.98.

Comparison with MPC Reference Service 35631, Bypass graft with other than vein; aorto-celiac, aorto-mesenteric, aorto-renal:

The most similar service on the MPC in terms of clinical analogy and RVW is also the service that most survey respondents chose most often as the reference service. In the comparison provided immediately above, this MPC reference readily justifies an RVW of 38.98 for 35633.

Comparison with MPC Reference Service 33512, Coronary artery bypass, vein only; three coronary venous grafts:

Three vessel coronary bypass graft is a well known service on the MPC list with an RVW of 43.87. It is an operation performed by some vascular surgeons who are also trained in CT surgery. The typical patient undergoing coronary bypass is extremely similar to the typical peripheral arterial disease patient, such as the one cited here with chronic mesenteric ischemia. 33512 carries a 9-day hospital length of stay compared to 7 days for 35633. Overall, 33512 has 20.07 RVUs of post-service work compared to 17.52 for 35633, a difference of 2.52 RVUs in favor of 33512.

Comparison of intra-service work is challenging. Both coronary bypass and ilio-SMA bypass are operations with major intensity. The most intense portions of 33512 are probably greater than the most intense portions of ilio-SMA bypass, but both have intervals where the patient's life hangs in the balance and depends on the surgeon's skill. Both operations require significant surgical dissection to reach the target vessels (median sternotomy for 33512 and extensive pelvic arterial and peri-SMA dissection for 35633). 35633 has 27 more intra-service minutes than 33512 (240 vs. 213 minutes), but at slightly lower intensity. If we can assume physician work equipoise for the intra-service portions of these two operations, we can estimate the value of 35633 by subtracting the post-work increment 2.52 from the RVW of 33512, therefore 43.87 minus 2.52 equals 41.35. This means that even if there is a fairly significant intra-service intensity difference favoring 33512, the recommended RVW of 38.98 for 35633 is reasonably justified.

Comparison with CPT 43621 Gastrectomy, total; with Roux-en-Y reconstruction:

43621 is a complex general surgery procedure performed in the upper abdomen. It has a time and visit pattern extremely close to that of 35633, which we are currently valuing. 43621 has a RUC-approved RVW of 39.40 (August 2005).

Element	43621	35633
Pre-time	60 min	75 min
Intra-time	240 min	240 min
Intra-intensity	high	equal or higher
Immed Post	30 min	30 min
99291	1	2
99233	2	0
99232	3	2
99231	3	2
99238	1	1
99213	2	2
99212	1	1

Conclusion: These two services have very similar time and visit elements. Intra-service is probably at work equipoise or slightly in favor of 35633. Post-service is 3-days longer for 43621 but visit pattern is more intense for 35633 due to hemodynamic fluid shifts. Total post-service work is 19.17 for 43621 and 17.52 for 35633, a difference of 1.65 RVUs. Starting with the RVW of 39.40 for 43621, and subtracting 1.65 RVUs for the difference in post-service work, one arrives at an estimated 37.75 RVUs for 35633, a value within 3% of the 38.98 that we recommend for 35633.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 Unlisted procedure, vascular surgery

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

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

Specialty vascular surgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 200

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

Please explain the rationale for this estimate. expert panel opinion

Specialty vascular surgery Frequency 195 Percentage 97.50 %

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? 199

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel opinion

Specialty vascular surgery Frequency 195 Percentage 97.98 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code: 35634 Tracking Number U3

Specialty Society Recommended RVU: **35.20**

Global Period: 090

RUC Recommended RVU: **35.20**

- CPT Descriptor: Bypass graft, with other than vein; iliorenal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old female smoker with hypercholesterolemia and coronary artery disease has chronic renal insufficiency and severe hypertension refractory to maximum doses of 3 medications. She underwent renal stent placement three years ago, but her hypertension has now recurred. Duplex ultrasound confirms recurrent renal artery stenosis. Arteriogram reveals near occlusion of the artery felt unlikely to respond to repeat percutaneous intervention. She has a small infrarenal aortic aneurysm that precludes aortorenal bypass. An iliorenal bypass graft is performed using prosthetic conduit.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

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

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

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

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

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assess for appropriateness of DVT prophylaxis; if yes, assure appropriate selection, timing, and administration
- Assess need for beta-blockers, order as required.
- Review medical history and radiology reports
- Review radiographic images including angiograms, CTscans, MRAs, duplex vein mapping
- Review results of other preoperative testing (blood tests, EKG, CXR)
- Review reports of consultants providing preoperative assessment and clearance as indicated
- Meet with patient and family to review planned procedure and postoperative management
- Reexamine patient to ensure that physical findings have not changed and dictate history and physical
- Obtain final informed consent
- Review hospital consent, mark patient
- Discuss perioperative medical management with anesthesiologist
- Review planned procedure with OR staff
- Verify that all required instruments and supplies are available
- Change into scrub clothes
- Monitor/assist with positioning of the patient
- Ensure that radiographic images are available in the OR
- Mark planned abdominal incision site
- Monitor/assist with prepping and draping
- Scrub and gown
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Perform long midline laparotomy & routine abdominal exploration
- Mobilize small bowel to expose distal infrarenal aorta and one common iliac artery
- Incise retroperitoneum and clear soft tissue from these arteries
- Expose adequate length of common iliac artery to achieve proximal and distal control with enough space to sew mosis
- Incise Gerota's fascia overlying kidney that is to be revascularized
- Gently dissect out renal artery, avoiding injury to vena cava & associated structures, pass soft loops around artery for
- Determine exact pathway of proposed graft from common iliac to renal artery
- Create appropriate tunnels for graft, options including trans-abdominal approach or retroperitoneal
- Pass Teflon tie through tunnels to preserve exact location
- Choose appropriate diameter synthetic conduit
- Request administration of renal protective agents by anesthesia
- Administer systemic anticoagulant and wait for circulation
- Place proximal and distal clamps on inflow common iliac artery
- Perform longitudinal arteriotomy of inflow iliac artery at proximal anastomosis site
- Bevel end of conduit appropriately and anastomose synthetic conduit to inflow iliac with vascular suture
- Remove clamps and test for leaks
- Apply additional sutures as needed to achieve hemostasis
- Insonate common iliac with handheld Doppler to ensure flow beyond anastomosis has been restored
- Pass conduit through pre-made tunnels taking care to avoid kinks
- Examine geometry of graft-to-renal artery anastomosis to determine optimal lie of graft
- Apply proximal and distal clamps to renal artery, as well as to adjacent branch arteries
- Perform longitudinal arteriotomy of renal artery at distal anastomosis site
- Cut synthetic conduit to appropriate length and bevel the end to optimize geometry
- Anastomose end of synthetic conduit to renal artery
- Flush system to remove air and debris
- Remove clamps & apply additional sutures as needed to achieve hemostasis
- Palpate pulse in renal artery to assess restitution of blood flow
- Listen with Doppler to renal and branches to assure normal flow has been restored
- Revise graft as needed to optimize blood flow, then reverse anticoagulant with protamine
- Irrigate abdomen & final check for hemostasis
- Close abdominal incision
- Irrigate subcutaneous tissue & Close skin

Description of Post-Service Work:

- Apply sterile dressings. Monitor patient during reversal of anesthesia.
- Monitor transport of patient from OR to recovery room.
- Discuss postoperative recovery care with anesthesia and nursing staff.
- Write postoperative orders.
- Discuss procedure and outcome with family in waiting area.
- Write postoperative note.
- Dictate operative note and copy to referring physician
- Correctly assign procedural CPT codes .
- When appropriate, write orders for transferring to surgical floor and discuss ongoing care with floor nurses.
- Examine patient frequently, check wound and patient progress - Monitor closely for urinary output
- Write daily orders for postoperative medications, diet, and patient activity
- Check wounds, change dressings, and monitor patient progress. Chart notes.
- Review patient management with nursing staff
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Monitor incision for signs of infection or hematoma.
- Assess for any signs of bypass graft failure including flank pain, creatinine elevation, oliguria
- Answer patient and family questions

- Answer nursing staff questions
- Discuss patient progress with referring physician
- Assure adequate level of pain control
- Assess daily to determine if discharge criteria are met, discuss with hospital utilization review nurse
- Chart discharge instructions
- Write prescriptions for medications and supplies needed post-discharge
- Review post-discharge wound care and activity limitations with patient and family
- Dictate discharge summary
- Perform medication reconciliation

Postoperative Work – In Office for duration of 90-day global period:

- Examine patient, remove sutures/staples
- Answer patient and family questions
- Review nutritional studies, ability to eat, signs/symptoms of positive nutritional balance
- Order and assess bypass graft patency studies as indicated
- Assess for adequacy of pain control
- Discuss advancing daily activities with patient
- Discuss long term scar management with patient
- Discuss renal function reports with patient and need for any additional testing or consultation
- Arrange for any indicated additional testing and review results
- Arrange for any indicated consultation, prepare documents for transmission to appropriate consultants
- Discuss progress with referring physician(s) and consultants (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Gary Seabrook MD, David Han MD, Robert Zwolak MD				
Specialty(s):	vascular surgery				
CPT Code:	35634				
Sample Size:	100	Resp N:	33	Response: 33.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	1.00	1.00	6.00
Survey RVW:	31.00	35.00	36.00	38.00	53.00
Pre-Service Evaluation Time:			70.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	180.00	200.00	230.00	240.00	345.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>140.00</u>	99291x 2.00 99292x 0.00			
Other Hospital time/visit(s):	<u>120.00</u>	99231x 2.00 99232x 2.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>62.00</u>	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	35634	Recommended Physician Work RVU: 35.20		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		230.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>70.00</u>	99291x 1.00 99292x 0.00		
Other Hospital time/visit(s):	<u>175.00</u>	99231x 2.00 99232x 2.00 99233x 1.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>62.00</u>	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
35631	090	35.90	RUC Time

CPT Descriptor Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
35631	090	35.90	RUC Time	1,041

CPT Descriptor 1 Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33512	090	43.87	RUC Time	5,949

CPT Descriptor 2 Coronary artery bypass, vein only; three coronary venous grafts

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
43621	090	39.40	RUC Time

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

Number of respondents who choose Key Reference Code: 21 % of respondents: 63.6 %

TIME ESTIMATES (Median)

	CPT Code: 35634	Key Reference CPT Code: 35631	Source of Time RUC Time
Median Pre-Service Time	75.00	110.00	
Median Intra-Service Time	230.00	225.00	
Median Immediate Post-service Time	30.00	38.00	
Median Critical Care Time	70.0	0.00	
Median Other Hospital Visit Time	175.0	175.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	680.00	648.00	
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	4.62	4.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.52	4.52
Urgency of medical decision making	3.95	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.71	4.67
Physical effort required	4.57	4.62

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.62	4.62
Outcome depends on the skill and judgment of physician	4.76	4.71
Estimated risk of malpractice suit with poor outcome	4.05	4.05

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

Pre-Service intensity/complexity	4.57	4.57
Intra-Service intensity/complexity	4.57	4.57
Post-Service intensity/complexity	4.33	4.38

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.*

Clinical Background: Ilio-renal bypass with synthetic conduit is a highly complex renal salvage operation typically performed on patients with severe hypertension and at least some degree of renal insufficiency whose clinical condition includes an unacceptably high risk for aortic cross-clamp placement, thereby excluding them from direct aorto-renal bypass surgery. One typical indication is the patient with an aorta aneurysm (as in the clinical vignette) that might rupture if a large vascular clamp were applied. Other clinical settings include patients with diffuse aortic atherosclerotic

plaque creating a risk for diffuse embolization if a clamp were placed, or patients with advanced coronary artery disease and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF, and cardiac death. Virtually all patients who undergo this operation are elderly and have multiple significant medical co-morbidities such as a long history of tobacco abuse, coronary artery disease, COPD, hypertension, and hyperlipidemia.

Recommended RVW of 35.20: The median survey value of this service is 36.00. It has 10 minutes less intra-service time than the procedure being surveyed simultaneously (35632) but is otherwise similar in terms of work and complexity measures. We therefore recommend reducing the RVW by an amount that suitably reflects this increment (10 minutes x IWPUT of 0.08 = 0.80 RVUs). We recommend 36.00 minus 0.80 = 35.20 RVUs. This RVW is fully justified based on IWPUT analysis, intensity and complexity measures, and favorable work comparisons with three RUC-surveyed services of similar magnitude, two of which are MPC list procedures.

IWPUT 0.082: The IWPUT of this service, with the recommended visit pattern and a recommended RVW of 35.20 is 0.082. This is a typical value for a complex intra-abdominal arterial reconstruction.

Intensity and Complexity Measures: Ilio-renal bypass graft scores near the top of all intensity and complexity measures. As noted above, patients who require this vascular reconstruction are elderly, and always have many associated medical co-morbidities. If the proximal or distal anastomosis is technically faulty the graft may thrombose and the kidney will die. This operation carries a 30-day mortality in the 5% range, and there very few procedures among the 8,000 Category I CPT codes with this mortality risk. This procedure must certain number among the 2-3% most morbid procedures in CPT, thereby justifying the very high intensity and complexity values.

Pre-Time: This is a very sick patient about to undergo an extremely complex operation. Pre-time of the key reference service is 110 minutes, approved by the RUC in 2000. This patient requires positioning and surgical preparation such that both the common iliac arteries deep in the pelvis and the right side of the chest may be accessed. The anesthesia team usually places extra large-bore IV catheters, arterial pressure monitoring lines and more often than not, a central venous catheter or a transesophageal echo. This extra positioning and preparation work readily justifies the additional 12 minutes requested herein. In fact, this is a very conservative estimate of the additional positioning time required, especially compared to that of the key reference service (110 minutes) approved by the RUC 8 years ago in August 2000. We believe the request for 75 minutes of pre-time actually underestimates the true pre-service time involved in safely preparing the patient for this operation.

Critical Care Visits: Thirty-one of 33 survey respondents (94%) identified the requirement for critical care in this service. In fact, the majority of respondents indicated that they perform more than one critical care service in caring for the typical patient after ilio-renal bypass surgery. A consistent observation made by our expert consensus panel is that while surgeons perform critical care on these patients and enter it accurately by visit on the RUC surveys, they always tend to under-estimate the associated physician work during the magnitude estimation process. Thus, while the majority indicated they perform more than one critical care service, the median survey RVW does not contain sufficient post-operative RVUs to reflect this work, and we are left with a mismatch between visits and RVUs. In this particular case, our expert consensus panel reviewed the data and clinical situation. Following revascularization of the renal there is major third-spacing that mandates minute-to-minute management of fluid boluses and brood products. Blood pressure instability is additionally treated with strong vasopressors that require constant adjustment. For the typical ilio-renal bypass graft patient, most of this critical care occurs during the first 24-hours and settles out thereafter, and we therefore recommend one, but not two, critical care services.

To summarize, the critical care provided by the surgeon during this procedure involves high complexity decision making to assess, manipulate, and support vital circulatory system functions in the setting of massive intra-abdominal third spacing to prevent shock in patients with underlying coronary artery disease. The work includes interpretation of cardiac output measurements, chest x-rays, pulse oximetry, and blood gases. Performance of gastric intubation and vascular access performed during the course of critical care service is included therein. Special consideration is directed to control of blood pressure that may still be extremely high, as in the pre-operative status of this patient, or conversely, if a

single critical renal artery stenosis has just been successfully bypassed, the patient's blood pressure may be extremely low due to sudden loss of the renin-angiotensin-aldosterone hormonal drive.

Comparison with Key Reference Service : 35631, Bypass graft with other than vein; aortoceliac, aortomesenteric, aortorenal: The key reference service has a RUC-approved RVW of 35.90. Both operations are performed on patients with multiple advanced medical comorbidities typically including coronary artery disease, hypertension, hyperlipidemia, diffuse atherosclerosis plus all the ravages brought about by decades of tobacco abuse. Both procedures require complex and dangerous arterial dissection. There is risk of injury to neighboring bowels and kidneys. Both procedures carry major risk of hemorrhage and transient post-operative renal dysfunction with all the associated sequelae. In addition to these similarities, vascular surgeons oftentimes perform 3563X3 ilio-renal bypass on patients who are even more ill than those who undergo 35631 based on cardiac co-morbidities or the presence of aortic pathology such as our vignette patient.

With direct point-by-point comparison of service elements, these two procedures are quite similar. The new code, ilio-renal bypass, has 5 more minutes of intra-service time (230 vs. 225), due to the dissection of the common iliac artery in the pelvis, the longer graft that must be placed, and all the considerations of graft tunneling, kink avoidance, etc. The intensity of the renal dissection is the same in both cases, while the intensity of the iliac dissection is slightly less than that of the aortic dissection in 35631. Thus, there is 5 minutes of additional intra-service time, but the overall intra-service intensity is slightly less for 35634. These two minor differences therefore cancel each other out, achieving physician work equipoise for the intra-service portion of this comparison. It is the hospital visit pattern that makes the primary difference in RVWs. Based on the clinical discussion above, 35634 includes one intensive care visit that is not present in the reference. The in-hospital post service RVUs are therefore 12.75 compared to 8.43 in the reference, a difference of 4.32 RVUs in favor of the new service. The office visit patterns are identical. Thus, beginning with the RVW of 35.90 for the reference service, and adding 4.32 RVUs to reflect the additional in-hospital post-op care, we could estimate the physician work of the new code at 35.90 plus 4.32, or 40.22 RVUs. In conclusion, this comparison of the new code with its key reference indicates that an RVW as high as 40.22 can be justified. Therefore, the comparison readily justifies the recommended RVW of 35.20.

Comparison with MPC Reference Service 35631, Bypass graft with other than vein; aorto-celiac, aorto-mesenteric, aorto-renal:

The most similar service on the MPC in terms of clinical analogy and RVW is also the service that most survey respondents chose most often as the reference service. In the comparison provided immediately above, this MPC reference readily justifies an RVW of 35.20 for 35634.

Comparison with MPC Reference Service 33512, Coronary artery bypass, vein only; three coronary venous grafts:

Three vessel coronary bypass graft is a well known service on the MPC list with an RVW of 43.87. It is an operation performed by some vascular surgeons who are also trained in CT surgery. The typical patient undergoing coronary bypass is extremely similar to the typical peripheral arterial disease patient, such as the one cited here with severe renal artery occlusive disease. 33512 has a 9-day hospital length of stay compared to 7 days for 35634. Overall, 33512 has 20.07 RVUs of post-service work compared to 15.02 for 35634, a difference of 5.05 RVUs in favor of 33512.

Comparison of intra-service work is challenging. Both coronary bypass and ilio-renal bypass are operations with major intensity. The most intense portions of 33512 are probably greater than the most intense portions of ilio-renal bypass, but both have intervals where the patient's life hangs in the balance and depends on the surgeon's skill. Both operations require significant surgical dissection to reach the target vessels (median sternotomy for 33512 and extensive pelvic arterial and peri-renal dissection for 35634). 35634 has 17 more intra-service minutes than 33512 (230 vs. 213 minutes), but at slightly lower intensity. If we can assume physician work equipoise for the intra-service portions of these two operations, we can estimate the value of 35634 by subtracting the post-work increment 5.05 from the RVW of 33512,

therefore 43.87 minus 5.05 equals 38.82. This means that even if there is a fairly significant intra-service intensity difference favoring 33512, the recommended RVW of 35.20 for 35634 is well justified by this comparison.

Comparison with CPT 43621 Gastrectomy, total; with Roux-en-Y reconstruction:

43621 is a complex general surgery procedure performed in the upper abdomen. It has a time and visit pattern extremely close to that of 35634, which we are currently valuing. 43621 has a RUC-approved RVW of 39.40 (August 2005 mtg).

Element	43621	35634
Pre-time	60 min	75 min
Intra-time	240 min	230 min
Intra-intensity	high	equal or higher
Immed Post	30 min	30 min
99291	1	1
99233	2	1
99232	3	2
99231	3	2
99238	1	1
99213	2	2
99212	1	1
RVW	39.40	35.20 recommended

Conclusion: These two services have very similar time and visit elements. Intra-service work achieves clinical equipoise or slightly favors 35634. Post-service visit pattern is similar, but 43621 has three more inpatient days. Total post-service work is 19.17 for 43621 and 15.02 for 35634, a difference of 4.15 RVUs. Starting with the RVW of 39.40 for 43621, and subtracting 4.15 RVUs for the difference in post-service work, one arrives at an estimated 35.25 RVUs for 35634, a value almost exactly the 35.20 that we recommend for 35634.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 Unlisted procedure, vascular surgery

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

Specialty vascular surgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. expert panel opinion

Specialty vascular surgery Frequency 195 Percentage 97.50 %

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? 199

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel opinion

Specialty vascular surgery Frequency 195 Percentage 97.98 %

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
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs**

CPT Long Descriptor:

- 35632** Bypass graft, with other than vein; ilio-celiac
- 35633** Bypass graft, with other than vein; ilio-mesenteric
- 35634** Bypass graft, with other than vein; iliorenal

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 surgeons representing vascular surgery reviewed the practice expense details for the survey codes relative to other facility-only 90-day global services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

The standard 12 minutes has been applied for these inpatient procedures for discharge day management related services.

Post-Service Clinical Labor Activities:

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

Supplies and Equipment:

Post-surgical supplies and equipment necessary for post-discharge surgical care have been indicated.

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation			35632		35633		35634	
2	Meeting Date: April 2008			Bypass graft, with other than vein; ilio-celiac		Bypass graft, with other than vein; ilio-mesenteric		Bypass graft, with other than vein; ilio-renal	
3	LOCATION	Code	Staff Type	Office	Facility	Office	Facility	Office	Facility
4	GLOBAL PERIOD			090	090	090	090	090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	171	N/A	171	N/A	171
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60	N/A	60	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12	N/A	12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	99	N/A	99	N/A	99
9	PRE-SERVICE								
10	Start: Following visit when decision for surgery or procedure made								
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		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	End: When patient enters office/facility for surgery/procedure								
18	SERVICE PERIOD								
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12		12		12
41	End: Patient leaves office/FACILITY								
42	POST-SERVICE Period								
43	Start: Patient leaves office/facility								
44	Conduct phone calls/call in prescriptions								
46	<i>List Number and Level of Office Visits</i>								
47	99211 16 minutes		16						
48	99212 27 minutes	L037D	27		1		1		1
49	99213 36 minutes	L037D	36		2		2		2
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	Other								
54	<i>Total Office Visit Time</i>			99		99		99	
55	Other Activity (please specify)								
56	End: with last office visit before end of global period								
57	MEDICAL SUPPLIES	CMS Code	Unit						
58	pack, minimum multi-specialty visit	SA048	pack		3		3		3
59	pack, post-op incision care (suture)	SA054	kit		1		1		1
60									
61									
62	Equipment	CMS Code	Utilization Percentage						
63	table, power	EF031	100%		99		99		99
64	light, exam	EQ168	100%		99		99		99

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

September 2007

Tongue Suspension

With the increasing recognition of sleep disordered breathing/obstructive sleep apnea syndrome due to retro-lingual airway narrowing, tongue base suspension has become a commonly used method for surgical management. Tongue base suspension is designed to create a larger retrolingual airway and help prevent airway obstruction at this site during sleep.

The RUC reviewed 41512 *Tongue base suspension, permanent suture technique*. The specialty presented data for 54 otolaryngologists. The RUC determined that the survey 25th percentile as recommended by the specialty overstated the amount of work associated with this procedure.

The committee agreed with the specialty society that the surveyed code has the same intra-service intensity as compared to the reference code, 21685 *Hyoid myotomy and suspension* (Work RVU=14.89, IWPUR = 0.047). Therefore, the committee used a building block approach to evaluate the surveyed code. The committee used the specialty society recommended times and associated work RVUs as well as the reference service's IWPUR to compute a recommended value as described below:

Time	Intensity	Work RVU
30 minutes of Pre-Service Evaluation and Positioning Time	0.0224	0.67
15 minutes of Pre-Service Scrub, Dress & Wait Time	0.0081	0.12
60 minutes of Intra-Service Time	0.047	2.82
30 minutes of Post-Service Time	0.0224	0.67
0.5 – 99238	1.28	0.64
2.0 – 99212	0.45	0.90
1.0 – 99213	0.92	0.92
Total RVUs		6.75

The RUC agrees that 6.75 work RVUs is an appropriate value for this procedure as compared to other reference codes which have similar times and intensities including 30520 *Septoplasty or submucous resection, with or without cartilage scoring, contouring or*

replacement with graft (Work RVU=6.85) which has a pre-service time of 38.5 minutes, an intra-service time of 60 minutes and a post-service time of 15 minutes and 49325 *Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed* (Work RVU=6.77) which has a pre-servie time of 40 minutes, an intra-servie time of 60 minutes and a post-servie time of 20 minutes. Because of these reference services as well as further support from the building block methodology employed by the RUC, the RUC believes that 41512 is appropriately valued at 6.75 Work RVUs. **The RUC recommends 6.75 Work RVU for 41512.**

Practice Expense:

The RUC reviewed the proposed practice expense inputs for 41512 and modified them to reflect the appropriate number and level of office visits and include several pieces of equipment necessary to perform the procedure.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
●41512	D1	Tongue base suspension, permanent suture technique (For suture of tongue to lip for micrognathia use 41510)	090	N/A	6.75

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

CPT Code: 41512 Tracking Number
Global Period: 090

Specialty Society Recommended RVU: **8.65**
RUC Recommended RVU: **6.75**

CPT Descriptor: Tongue base suspension, permanent suture technique
(For suture of tongue to lip for micrognathia use 41510)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old, hypertensive male with a BMI of 35 kg/m² is diagnosed with severe obstructive sleep apnea by polysomnography. He exhibits an apnea-hypopnea index (AHI) of 52/hour and concomitant severe oxygen desaturation. He has failed both CPAP and BiPAP due to non-compliance. Prior nasal surgery and uvulopalatopharyngoplasty also failed to produce subjective or objective improvement of his sleep apnea. Examination shows macroglossia and fiberoptic laryngoscopy demonstrates retrolingual airway narrowing and collapse.

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:

- *Write preadmission orders for preoperative medications
- *Review medical history, pathology and radiology reports
- *Review radiographic images of the head and neck and surveillance for distant metastases
- *Review results of preadmission testing (lab, EKG)
- *Meet with patient and family to review planned procedure and post-operative management
- *Reexamine patient to make sure that physical findings have not changed and update H&P
- *Obtain informed consent
- *Review airway and medical management with anesthesiologist
- *Verify that all required instruments and supplies are available
- *Change into scrub clothes
- *Monitor/assist with positioning of patient - with placement of a transverse shoulder roll to provide neck extension.
- *Review radiographic images on view box.
- *Supervise anesthesia monitoring equipment set up to be certain it will not interfere with draping
- *Scrub and gown
- *Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: After general anesthesia with naso-tracheal intubation, appropriate landmarks are marked to maintain orientation and determine the position of the neurovascular bundles. The planned incision site is injected with a local anesthetic with epinephrine.

An incision is either made in the floor of mouth or the submental area in order to access the posterior cortex of the anterior mandible. Other than the minor differences associated with the intraoral versus external submental approach to the mandible, the procedure is virtually identical regardless of access incision.

If performed through the floor of mouth, an incision is made a few millimeters posterior to Wharton's ducts, along the lingual frenulum. Blunt dissection is performed in the midline, to gain access to the posterior cortex of the mandible. Periosteum is elevated from the mandible just superior to the genioglossus tubercle and inferior to the dental roots. A drill system is used to attach a screw or metal plate to the cortex of the mandible. A suture (or sutures) is (are) attached to the screw or plate. One end of the permanent suture is then passed with a suture passer, from the floor of mouth incision, through tongue muscle, into the posterior aspect of the base of tongue. The suspension suture may attach to the

base of tongue tissue by means of suture triangulation or other means. The suture/sutures are tightened and the base of tongue is suspended anteriorly. Anterior tongue movement is verified. Bleeding is controlled and the mucosal incision is closed.

When the procedure is performed from the submental area, the incision is made through skin, subcutaneous tissue, and platysma muscle. Periosteum is elevated off the mandibular cortex and the screw or plate is attached to the mandibular cortex just inferior to the genioglossus tubercle. The suspension sutures are placed in an identical fashion. At the end of the procedure, the incision is copiously irrigated, hemostasis obtained, closed with sutures and then dressed with a sterile dressing.

Description of Post-Service Work: POST-SERVICE HOSPITAL WORK:

*Apply sterile dressings. Monitor patient during reversal of anesthesia. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Review immediate postoperative care with hospital staff. Write postoperative orders. Discuss procedure and outcome with family in waiting area. Exam the patient to insure proper hypoglossal nerve function. Write postoperative note. Dictate operative report and copy the referring physician.

*Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection or pharyngocutaneous fistula

*Remove staples or sutures, when appropriate

*Monitor overall status of patient including written entries in patient chart and discussions with nursing staff and other allied health personnel

*Review results of pathology report and convey information to patient and family when available and discuss the need for additional treatment, if appropriate

*Assure adequate level of pain control

*Monitor for signs of depression

*Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy

*Write prescriptions for medications and supplies needed post-discharge.

*Home restrictions (ie, diet, activity, bathing) 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, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		09/2007				
Presenter(s):	Peter Weber, MD; MD; Samuel Mickelson, MD					
Specialty(s):	American Academy of Otolaryngology - Head and Neck Surgery					
CPT Code:	41512					
Sample Size:	280	Resp N:	54	Response: 19.2 %		
Sample Type:	Panel					
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate		0.00	1.00	3.00	9.00	40.00
Survey RVW:		0.00	8.65	14.44	16.12	175.00
Pre-Service Evaluation Time:				10.0		
Pre-Service Positioning Time:				10.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		2.00	45.00	60.00	78.75	120.00
Immediate Post Service-Time:		27.50				

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	<u>20.0</u>	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	<u>38.0</u>	99238x 1.00 99239x 0.00
Office time/visit(s):	<u>39.0</u>	99211x 0.0 12x 1.0 13x 1.0 14x 0.0 15x 0.0 - -
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 41512		
		<u>Specialty Recommended</u>
Physician Work RVU:		8.65
Pre-Service Evaluation Time:		15.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	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:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	55.0	99211x 0.0 12x 2.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
21685	090	14.89	RUC Time

CPT Descriptor Hyoid myotomy and suspension

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 31.4 %

TIME ESTIMATES (Median)

	CPT Code: 41512	Key Reference CPT Code: 21685	Source of Time RUC Time
Median Pre-Service Time	45.00	0.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	40.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	55.0	212.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	209.00	380.00	
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	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	3.70
Urgency of medical decision making	2.82	2.76

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	3.64
Physical effort required	3.76	3.52

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.88	3.47
Outcome depends on the skill and judgment of physician	4.00	3.58
Estimated risk of malpractice suit with poor outcome	3.64	3.29

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

Pre-Service intensity/complexity	3.94	3.64
Intra-Service intensity/complexity	3.58	3.41
Post-Service intensity/complexity	3.58	3.58

Additional Rationale

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

After a thorough analysis of the data, calculation of the IWPOT, and comparison to other services of similar work and intensity, we concluded that the 25th percentile is most appropriate and more accurately reflects the work involved in this service.

For the post-operative visits, it is more likely that the physician will see the patient for post-discharge office visits, rather than for in-hospital visits.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT unlisted code 41599 (Unlisted procedure, tongue, floor of mouth)

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

Specialty Otolaryngology - Head & Neck Sugery

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The prevalence of obstructive sleep apnea syndrome is 4% of adult males and 2% of adult females in the U.S. Currently, 250,000 patients are diagnosed yearly with obstructive sleep apnea. Approximately 20,000 present each year for surgical intervention to correct the underlying obstructive anatomy, of which a relatively small number (10%) would undergo this procedure.

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

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

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. based on Medicare claims data

Specialty	Frequency 0	Percentage 0.00 %
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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. 30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft as this reference code better estimates the liability associated with 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
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs**

CPT Long Descriptor: Tongue base suspension, permanent suture technique (For suture of tongue to lip for micrognathia use 41510)

Sample Size: 280 _____ Response Rate: (%): 19.2 _____ Global Period: 090 _____

Geographic Practice Setting %: Rural 3.7 _____ Suburban 59.35 _____ Urban 35.18 _____

Type of Practice %: 12.96 _____ Solo Practice
46.29 _____ Single Specialty Group
14.81 _____ Multispecialty Group
25.94 _____ Medical School Faculty Practice Plan

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

An expert panel of physicians familiar with practice expense methodology and the procedure in question reached consensus on the scope of work for clinical labor, and the supplies and equipment utilized in the procedure.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Completes pre-service diagnostic & referral form. Coordinates pre-surgery services, reviews test or exam results. Schedules the space & equipment for use in the facility.

During office visit before the surgery, reviews the test results. Provides pre-surgery patient education; obtains patient's consent. Conducts follow-up phone calls and gives prescription orders to patient.

Intra-Service Clinical Labor Activities:

Provides nursing support to physician during surgery, readying supplies and equipment.

Post-Service Clinical Labor Activities:

Assists with the monitoring of the patient during reversal of anesthesia. Assists with the transport of the patient from operating room to recovery room. Discusses and reviews the postoperative recovery care with the physician. Manages the completion of diagnostic forms, lab requisitions. Coordinates post-op follow up visits and prescriptions.

With the patient, reiterates home restrictions from physician (ie, diet, activity, bathing), and goes over self-care instructions.

	A	B	C	D	E	F
1				41512		
2	Meeting Date: September 2007 Practice Expense Subcommittee TAB 8			Tongue base suspension, permanent suture technique (For suture of tongue to lip for micrognathia use 41510)		
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	
4	GLOBAL PERIOD			90	90	
5	TOTAL CLINICAL LABOR TIME			0.0	156.0	
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	60.0	
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	6.0	
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	90.0	
9	PRE-SERVICE					
10	Start: Following visit when decision for surgery or procedure made					
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		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		0	
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		20	
16	Other Clinical Activity (please specify)				7	
17	End: When patient enters office/facility for surgery/procedure					
18	SERVICE PERIOD					
19	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure					
20	Review charts					
21	Greet patient and provide gowning	L037D	RN/LPN/MTA			
22	Obtain vital signs	L037D	RN/LPN/MTA			
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			
27	Sedate/apply anesthesia					
28	Intra-service					
29	Assist physician in performing procedure	L037D	RN/LPN/MTA			
30	Post-Service					
31	drains					
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			
33	Clean Scope					
34	Clean Surgical Instrument Package	L037D	RN/LPN/MTA			
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, 99239 –15 minutes				6	
39	Other Clinical Activity (please specify)					
40	End: Patient leaves office					

	A	B	C	D	E	F
1				41512		
	Meeting Date: September 2007 Practice Expense Subcommittee TAB 8			Tongue base suspension, permanent suture technique (For suture of tongue to lip for micrognathia use 41510)		
2						
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	
41	POST-SERVICE Period					
42	Start: Patient leaves office/facility					
43	Conduct phone calls/call in prescriptions					
	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			
44	List Number and Level of Office Visits					
46	99211 16 minutes		16			
47	99212 27 minutes		27		2	
48	99213 36 minutes		36		1	
49	99214 53 minutes		53			
50	99215 63 minutes		63			
51	Other					
52	Total Office Visit Time			0	90	
53	Other Activity (please specify)					
54	End: with last office visit before end of global period					
55	MEDICAL SUPPLIES	CMS Code	Unit			
56	CANISTER, SUCTION	SD009	ITEM		3	
57	CATHETER, SCUTION	SD031	ITEM		3	
58	ENDOSHEATH	SD070	ITEM		3	
59	TUBING, SUCTION	SD132	ITEM		3	
60	STERILE GLOVES	SB024	PAIR			
61	STAFF GOWN	SB027	ITEM			
62	STERILE DRAPE	SB046	ITEM			
63	ENDOSCOPE CLEANING PACK	SA042	PACK		3	
64	MIN MULTI SPEC VISIT PACK	SA048	PACK		3	
65	NASAL SPRAY	SJ037	ITEM		3	
66	LIDOCAINE 4%	SH050	ML		3	
67	COTTONOID	SG031	ITEM		3	
68	RF PROBE	SD109	ITEM			
69	SUCTION TIP	SD122	ITEM		3	
70	NEEDLE 27G	SC029	ITEM			
71	SYRINGE 22-26G	SC083	ITEM			
72	POST-OP SUTURE KIT	SA054	PACK		1	
73	TONGUE BLADE	SJ061	ITEM		3	
74	RETURN GROUNDING ELECTRODE	SD059	ITEM			
75	SKIN MARKING PENCIL	SK073	ITEM			
76	DISPOSABLE MEASURING INSTRUMENT	?	ITEM			
77	SURGICAL GOWNS	SB021	ITEM			
78	INJECTABLE STERILE SALINE 30CC	?	ITEM		0	
79	VIAL SODIUM BICARBONATE	DH090	ITEM			
80	CHLORHEXIDINE ORAL RINSE	SH023	ITEM			
81	DISPOSABLE OXIMETER PROBE	?	ITEM			
82	SURGICAL MASK W/SHIELD	SB034	ITEM		3	
83	EMESIS BASIN				3	
84	Equipment	CMS Code				
85	CHAIR W/HEADREST	EF008			3	
86	HEADLIGHT	EQ170			3	
87	SUCTION PRESSURE CABINET	EQ234			3	
88	FIBERSCOPE	ES020			3	
89	VIDEO SYSTEM - ENDOSCOPY	ES031			3	
90						
91						

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

September 2007

Tongue Base Tissue Volume Reduction

With the increasing recognition of sleep disordered breathing due to retro-lingual airway narrowing, tongue base tissue volume reduction has become a commonly used method for surgical management as it is designed to create a larger oropharyngeal airway and help prevent obstruction at this site during sleep. To address this more commonly used method of surgical management, the CPT Editorial Panel replaced a Category III codes with a Category I code to describe tongue base tissue volume reduction.

The RUC reviewed 41530 *Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session*. The specialty presented data from 35 otolaryngologists. A recommendation slightly more than the 25 percentile of the survey data was not accepted by the RUC. The RUC garnered further information about the procedure including that 80 percent of these procedures are performed in a facility setting and 20 percent are performed in the non-facility setting. The service is performed under local anesthesia. Further, the RUC learned that typically there are no more than 6 sites ablated and it takes 6-10 minutes per site. The RUC reviewed the times and visits associated with this procedure and determined that the 2 office visits were appropriate in a the 010 day global period as there is a need to check for artery swelling.

The committee agreed with the specialty society that the surveyed code has the same intra-service intensity as compared to the reference code, 30520 *Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft* (Work RVU=6.85, IWPUP = 0.041). Therefore, the committee used a building block approach to evaluate the surveyed code. The committee used the specialty society recommended times and associated work RVUs as well as the reference service's IWPUP to compute a recommended value as described below:

Time	Intensity	Work RVU
25 minutes of Pre-Service Evaluation and Positioning Time	0.0224	0.56
15 minutes of Pre-Service Scrub, Dress & Wait Time	0.0081	0.12
30 minutes of Intra-Service Time	0.041	1.24
20 minutes of Post-Service Time	0.0224	0.45
0.5 – 99238	1.28	0.64

1.0 – 99212	0.45	0.45
1.0 – 99213	0.92	0.92
Total RVUs		4.38

The RUC agrees that 4.38 work RVUs is an appropriate value for this procedure as compared to other reference codes which have similar times and intensities including 62264 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day* (Work RVU=4.42) which has a pre-service time of 40 minutes, intra service times of 30 minutes and a post-service time of 20 minutes and 43887 *Gastric restrictive procedure, open; removal of subcutaneous port component only* (Work RVU=4.24) which has a pre-service time of 45 minutes, an intra-service time of 30 minutes and a post-service time of 20 minutes. An additional reference is 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (Work RVU=4.27) which has a pre-service time of 33 minutes, an intra-service time of 30 minutes and a post-service time of 20 minutes. Because of all of these reference services as well as further support from the building block methodology employed by the RUC, the RUC believes that 41530 is appropriately valued at 4.38 Work RVUs. **The RUC recommends 4.38 Work RVU for 41530.**

Practice Expense:

The RUC reviewed the proposed practice expense inputs for 41530 and modified them to reflect the appropriate number and level of office visits and include several pieces of supplies including an endoscope for the first office visit and equipment necessary to perform the procedure.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
●41530	C1	Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session	010	N/A	4.38
Category III					
D 0088T		Submucosal radiofrequency tissue volume reduction of tongue base, one or more sites, per session (ie, for treatment of obstructive sleep apnea syndrome)		N/A	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
		(0088T has been deleted. To report, use 41530)			

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

CPT Code: 41530	Tracking Number	Specialty Society Recommended RVU: 6.0
Global Period: 010		RUC Recommended RVU: 4.38

CPT Descriptor: Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57 year old, hypertensive male with a BMI of 35 kg/m² is diagnosed with severe obstructive sleep apnea by polysomnography. He exhibits an apnea-hypopnea index (AHI) of 52/hour and concomitant severe oxygen desaturation. He has failed both CPAP and BiPAP due to non-compliance. Prior nasal surgery and uvulopalatopharyngoplasty also failed to produce subjective or objective improvement of his sleep apnea. Examination shows macroglossia and fiberoptic laryngoscopy demonstrates retrolingual airway narrowing and collapse.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 11%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- *Write preadmission orders for preoperative medications
- *Review medical history, pathology and radiology reports
- *Review results of preadmission testing (lab, EKG)
- *Meet with patient and family to review planned procedure and post-operative management
- *Reexamine patient to make sure that physical findings have not changed and update H&P
- *Obtain informed consent
- *Review airway and medical management with anesthesiologist
- *Verify that all required instruments and supplies are available
- *Change into scrub clothes
- *Monitor/assist with positioning of patient - with placement of a transverse shoulder roll to provide neck extension.
- *Review radiographic images on view box.
- *Supervise anesthesia monitoring equipment set up to be certain it will not interfere with draping
- *Scrub and gown
- *Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: After topical oral and pharyngeal anesthesia, the surgeon has the patient rinse mouth with antibacterial rinse. The mouth is secured open with bite blocks, the tongue is protruded and held in position and immobilized. The tongue midline and circumvallate papillae are marked with a skin marker to maintain orientation. Planned probe insertion sites are similarly marked. Planned treatment sites are injected with lidocaine with epinephrine. For each treatment site, the physician injects saline, inserts the probe, verifies proper position away from the neurovascular bundle, and radio frequency (RF) energy is delivered to the submucosal tissues. The surgeon actively monitors the treatment sites as energy is delivered to assure complete submucosal application and no mucosal overlap of applied energy. This procedure is performed on each subsequent target site until all planned sites have been treated for this session.

Description of Post-Service Work:

POST-SERVICE HOSPITAL WORK:

*Monitor patient during reversal of anesthesia. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Review immediate postoperative care with hospital staff. Write postoperative orders. Discuss procedure and outcome with family in waiting area. Exam the

patient to insure proper hypoglossal nerve function. Write postoperative note. Dictate operative report and copy the referring physician.

*look for signs of infections

*Monitor overall status of patient including written entries in patient chart and discussions with nursing staff and other allied health personnel

*Convey information to patient and family when available and discuss the need for additional treatment, if appropriate

*Assure adequate level of pain control

*Write orders for follow-up, post-discharge labs, x-rays, home care

*Write prescriptions for medications and supplies needed post-discharge.

*Home restrictions (ie, diet, activity, bathing) 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, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		09/2007				
Presenter(s):		Peter Weber, MD; Samuel Mickelson, MD				
Specialty(s):		American Academy of Otolaryngology - Head and Neck Surgery				
CPT Code:		41530				
Sample Size: 143		Resp N: 35	Response: 24.4 %			
Sample Type: Panel						
		Low	25 th pctl	Median*	75 th pctl	High
Service Performance Rate		0.00	4.00	10.00	40.00	150.00
Survey RVW:		0.00	5.59	7.50	12.75	25.11
Pre-Service Evaluation Time:				15.0		
Pre-Service Positioning Time:				10.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		1.00	15.00	30.00	45.00	90.00
Immediate Post Service-Time:		20.00				
Post Operative Visits		Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):		70.0	99291x 1.0 99292x 0.0			
Other Hospital time/visit(s):		60.0	99231x 1.0 99232x 1.0 99233x 0.0			
Discharge Day Mgmt:		38.0	99238x 1.00 99239x 0.00			
Office time/visit(s):		63.0	99211x 0.0 12x 0.0 13x 1.0 14x 1.0 15x 0.0			
Prolonged Services:		0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 41530		
		<u>Specialty Recommended</u>
Physician Work RVU:		6.00
Pre-Service Evaluation Time:		15.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		30.00
Immediate Post Service-Time:	20.00	
<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>
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:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	39.0	99211x 0.0 12x 1.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
30520	090	6.85	RUC Time

CPT Descriptor Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

KEY MPC COMPARISON CODES:

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
-----------------------	---------------	-----------------------------------------	-----------------	--------------------

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 20.0 %

TIME ESTIMATES (Median)

	CPT Code: 41530	Key Reference CPT Code: 30520	Source of Time RUC Time
Median Pre-Service Time	40.00	15.00	
Median Intra-Service Time	30.00	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	38.0	0.00	
Median Office Visit Time	39.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	167.00	168.00	
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	4.14	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	3.00
Urgency of medical decision making	3.42	2.57

Technical Skill/Physical Effort (Mean)

Technical skill required	3.42	3.71
Physical effort required	3.14	3.42

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.28
Outcome depends on the skill and judgment of physician	4.00	3.85

Estimated risk of malpractice suit with poor outcome	3.57	3.28
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INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.77	3.25
Intra-Service intensity/complexity	3.40	3.31
Post-Service intensity/complexity	3.60	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.*

After a thorough analysis of the survey data and comparison to other services, the Academy believes that the survey data's median recommendation was too high a value. In addition, the 25th percentile did not appropriately capture the work and intensity involved in the service. Therefore, the specialty society is recommending a work RVU of 6.0.

In addition, for the post-operative visits, it is more likely that the physician will see the patient for post-discharge office visits, rather than for in-hospital visits.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

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

Procedure was previously reported via unlisted CPT 41599 (unlisted procedure, tongue, floor of mouth), then coding guidance from CMS re-categorized the procedure and changed the coding to 41120 (Glossectomy; less than one-half tongue). Since 2003, it has been reported using CPT Category III code 0088T (Submucosal radiofrequency tissue volume reduction of tongue base, one or more sites, per session (ie, for treatment of obstructive sleep apnea syndrome)).

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

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

Specialty Otolaryngology - Head & Neck 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? 59,000

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

Please explain the rationale for this estimate.

Approx 1200 physicians are trained to perform this procedure. Otolaryngologists (500) who have practices focusing on treatment of sleep apnea would perform this procedure about twice a week. Otolaryngologists (700) who have general practices might perform this procedure 10 times a year.

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

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

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

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
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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. 42720 Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach as this better captures the liability associated with this new procedure

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

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

CPT Long Descriptor:

Sample Size: 143___ Response Rate: (%):_24.4_ Global Period: _010_

Geographic Practice Setting %: Rural _2.85___ Suburban _51.42___ Urban _45.71___

Type of Practice %: 11.42___ Solo Practice
 _57.14___ Single Specialty Group
 _8.57___ Multispecialty Group
 _17.14___ Medical School Faculty Practice Plan

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

An expert panel of physicians familiar with practice expense methodology and the procedure in question reached consensus on the scope of work for clinical labor, and the supplies and equipment utilized in the procedure.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Completes pre-service diagnostic & referral form. Coordinates pre-surgery services. Provides the physician with test or exam results. Schedules space and equipment in the facility.. Provides pre-surgery patient education; obtains patient's consent. Conducts follow-up phone calls and gives prescription orders to patient.

Intra-Service Clinical Labor Activities:

Greets and escorts patient to the pre-surgery room; ensures the patients is gowned and prepped for surgery. Prepares the operating room, equipment and supplies. Positions patient. Obtains and records vital signs. Cleans room and equipment.

Post-Service Clinical Labor Activities:

Assists with monitoring of the patient during reversal of anesthesia. Assists in the transportation of the patient from operating room to recovery room. Evaluates patient's recovery from anesthesia. Discusses postoperative recovery care with physician. Reviews immediate postoperative care with physician. Discusses home care with the patient and family, including any restrictions on activity.

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

CPT Long Descriptor: Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session

Sample Size: 143___ Response Rate: (%):_24.4_ Global Period: _010_

Geographic Practice Setting %: Rural _2.86___ Suburban _51.42___ Urban _45.71___

Type of Practice %: 14.28___ Solo Practice
 _60.00___ Single Specialty Group
 _8.57___ Multispecialty Group
 _17.14___ Medical School Faculty Practice Plan

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

An expert panel of physicians familiar with practice expense methodology and the procedure in question reached consensus on the scope of work for clinical labor, and the supplies and equipment utilized in the procedure.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Completes pre-service diagnostic & referral form. Coordinates pre-surgery services, reviews test or exam results.

During office visit before the surgery, reviews the test results. Provides pre-surgery patient education; obtains patient's consent. Conducts follow-up phone calls and gives prescription orders to patient.

Greets and escorts the patient to the surgery room; assists with the gowning of patient. Notifies physician that the patient is ready. Prepares room, equipment and supplies. Positions patient. Obtains and records vital signs. Cleans room and equipment.

Intra-Service Clinical Labor Activities:

Provides nursing support to physician during surgery, readying supplies and equipment.

Post-Service Clinical Labor Activities:

Assists with the monitoring of the patient during reversal of anesthesia. Assists with the transport of the patient from operating room to recovery room. Discusses and reviews the postoperative recovery care with the physician. Manages the completion of diagnostic forms, lab requisitions. Coordinates post-op follow up visits and prescriptions.

With the patient, reiterates home restrictions from physician (ie, diet, activity, bathing), and goes over self-care instructions.

	A	B	C	D	E
1	AMA/Specialty Society Recommendation			41530	
2	Meeting Date: September 2007			Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD			10	10
5	TOTAL CLINICAL LABOR TIME			193.0	125.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	18.0	30.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	83.0	6.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	63.0	63.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	10
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	7	7
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3
16	Other Clinical Activity (please specify)				
17	End: When patient enters office/facility for surgery/procedure				
18	SERVICE PERIOD				
19	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
20	Review charts				
21	Greet patient and provide gowning	L037D	RN/LPN/MTA	3	
22	Obtain vital signs	L037D	RN/LPN/MTA	5	
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2	
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA	5	
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2	
27	Sedate/apply anesthesia				
28	Intra-service				
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	30	
30	Post-Service				
31	Monitor pt. following service/check tubes, monitors, drains				
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3	
33	Clean Scope			30	
34	Clean Surgical Instrument Package	L037D	RN/LPN/MTA		
35	Complete diagnostic forms, lab & X-ray requisitions				
36	Review/read X-ray, lab, and pathology reports				
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			3	
38	Discharge day management 99238 –12 minutes				6
39	Other Clinical Activity (please specify)				
40	End: Patient leaves office				
41	POST-SERVICE Period				
42	Start: Patient leaves office/facility				
43	Conduct phone calls/call in prescriptions				
44	Office visits: 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	1	1
48	99213 36 minutes		36	1	1
49	99214 53 minutes		53		
50	99215 63 minutes		63		
51	Other				
52	Total Office Visit Time			63	63
53	Other Activity (please specify)				
54	End: with last office visit before end of global period				

	A	B	C	D	E
1	AMA/Specialty Society Recommendation			41530	
2	Meeting Date: September 2007			Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
55	MEDICAL SUPPLIES	CMS Code	Unit		
56	CANISTER, SUCTION	SD009	ITEM	3	2
57	CATHETER, SCUTION	SD031	ITEM	3	2
58	ENDOSHEATH	SD070	ITEM	3	2
59	TUBING, SUCTION	SD132	ITEM	3	2
60	STERILE GLOVES	SB024	PACK	2	
61	STAFF GOWN	SB027	ITEM	2	
62	STERILE DRAPE	SB046	ITEM	1	
63	ENDOSCOPE CLEANING PACK	SA042	PACK	3	2
64	MIN MULTI SPEC VISIT PACK	SA048	PACK	3	2
65	NASAL SPRAY	SJ037	ITEM	3	2
66	LIDOCAINE 4%	SH050	ML	3	2
67	COTTONOID	SG031	ITEM	3	2
68	RF PROBE	SD109	ITEM	1	
69	SUCTION TIP	SD122	ITEM	3	2
70	NEEDLE 27G	SC029	ITEM	2	
71	SYRINGE 22-26G	SC083	ITEM	2	
72	POST-OP SUTURE KIT	SA054	PACK		
73	TONGUE BLADE	SJ061	ITEM	7	2
74	RETURN GROUNDING ELECTRODE	SD059	ITEM	1	
75	SKIN MARKING PENCIL	SK073	ITEM	1	
76	DISPOSABLE MEASURING INSTRUMENT	SK048	ITEM	1	
77	SURGICAL GOWNS	SB021	ITEM	2	
78	INJECTABLE STERILE SALINE 30CC	SL107	ITEM	1	
79	VIAL SODIUM BICARBONATE	DH090	ITEM	1	
80	CHLORHEXIDINE ORAL RINSE	SH023	ITEM	1	
81	DISPOSABLE OXIMETER PROBE	?	ITEM	1	
82	SURGICAL MASK W/SHIELD	SB034	ITEM	4	2
83					
84	Emesis Basin			3	2
85	Equipment	CMS Code			
86	CHAIR W/HEADREST	EF008		3	2
87	HEADLIGHT	EQ170		3	2
88	SUCTION PRESSURE CABINET	EQ234		3	2
89	FIBERSCOPE	ES020		3	2
90	VIDEO SYSTEM - ENDOSCOPY	ES031		3	2
91	OXIMETER W/PRINT CAPABILITY	EQ211		1	0
92	RF GENERATOR W/CORD ATTACHMENT	EQ214		1	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Cholangioscopy-Pancreatocopy

The clinical efficacy of cholangioscopy/pancreatocopy is well established in the diagnosis and treatment of pancreaticobiliary disease. The CPT Editorial Panel met in February 2008 and agreed that the current endoscopic retrograde cholangiopancreatography (ERCP) codes do not adequately describe a cholangioscopy / pancreatocopy procedure, which is a distinct and substantially different procedure from ERCP. The cholangioscopy / pancreatocopy procedure is additive to a variety of ERCP procedures and ERCP codes are inadequate to describe this procedure. The Editorial Panel created CPT code 43273 *Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)* to accurately report and describe the work associated with this complex procedure. It is estimated that 5-10% of all ERCPs will require this new service 43273.

The RUC reviewed the survey results from 55 practicing gastroenterologists for newly created add-code 43273. The survey respondents reported physician time in the pre and post period. As physician work is typically not performed in the pre and post period for an add-on code, the specialty concluded this was the result of the survey respondents' lack of familiarity with the concept of pre/intra/post time and the survey instrument for an add-on code. The societies concluded it would be appropriate to remove the pre- and post- time and back-out the associated work relative values from the survey median (3.25) to calculate their recommended work value of 2.24. The RUC calculated the work relative value for 43273 by taking the survey median $3.25 - ((25 \text{ minutes pre-service time} \times .0224) + (20 \text{ minutes post-service time} \times .0224)) = 2.24$. The value of 2.24 work RVUs lies between the survey median (3.25) and the 25th percentile (2.00).

The RUC compared 43273 to the specialty survey's key reference service code 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 2.39) and agreed that new service 43273 was similar; however, it is much more intense and requires more skill than code 43235. The RUC also questioned the intra-service time for this new service and was assured by the specialty society and other RUC members that the median survey intra-service time of 45 minutes was reasonable for the service provided. It was also explained that this new service can only be performed with an ERCP and not separately.

The RUC also compared the code 48400 *Injection procedure for intraoperative pancreatography (List separately in addition to code for primary procedure)* (work RVU = 1.95) and agreed that although both codes involve 45 minutes of intra-service time, a higher work value was justified because endoscopy is a more intense procedure requiring greater technical skill compared to an injection. The RUC agreed that the most accurate work value for new code 43273 is between the specialty's survey 25th percentile (2.00) and its median (3.25). The RUC also believed the specialty calculated value of 2.24 was reasonable and provided for the proper rank order amongst these reviewed services. **The RUC recommends a relative work value of 2.24 for CPT code 43273.**

Practice Expense:

The RUC recommends no direct practice expense inputs for this add-on code.

New Technology:

The RUC recommends that 43273 be added to the new technology list as this procedure utilizes new techniques.

Conscious Sedation

The RUC determined that conscious sedation was only inherent in code 43273.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
⊙●+43273	W1	Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure) <u>(Use 43273 in conjunction with 43260, 43261, 43263-43265, 43267-43272)</u>	ZZZ	2.24

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

CPT Code: 43273 Tracking Number W1

Specialty Society Recommended RVU: **2.24**

Global Period: ZZZ

RUC Recommended RVU: **2.24**

CPT Descriptor: Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)
(Use 432XX in conjunction with 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, and 43272)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year old male presents with severe epigastric pain with radiation to the back. An abdominal ultrasound shows a normal gallbladder without stones and normal gallbladder wall thickness. An abdominal CT scan reveals a markedly dilated pancreatic duct at 1cm in diameter and a normal biliary tree. An ERCP reveals an enlarged ampulla of Vater with a markedly dilated opening and mucin in the orifice. Pancreatotomy is performed to evaluate a presumed intraductal papillary mucinous neoplasm.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 61%

Is moderate sedation inherent to this procedure in the office setting? Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work:

Description of Intra-Service Work: After informed consent is obtained, the patient is brought to the therapeutic endoscopy suite. Sedation is administered intravenously, and the duodenoscope is introduced through the mouth with inspection of the esophagus, stomach and duodenum. Selective cannulation of the bile duct is obtained followed by multiple views of the cholangiogram under fluoroscopy. A guidewire is passed such that the tip is in the proximal biliary tree, and a standard biliary sphincterotomy is performed.

The cholangioscope is passed through the duodenoscope and into the biliary tree. Direct visualization is performed with careful inspection of the biliary and pancreatic epithelium. The mass lesion is identified and multiple biopsies are taken. The right and left intrahepatic biliary tree, common hepatic duct and common bile duct are all viewed. The cholangioscope is then withdrawn and then passed into the pancreatic duct. At the conclusion of the procedure, the cholangioscope is withdrawn and the physician proceeds with the remainder of the ERCP procedure.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Joel V. Brill, MD (AGA) and Klaus Mergener, MD, PhD (ASGE)				
Specialty(s):	American Gastroenterological Association (AGA) & American Society for Gastrointestinal Endoscopy (ASGE)				
CPT Code:	43273				
Sample Size:	195	Resp N:	55	Response: 28.2 %	
Sample Type: Convenience					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	6.00	10.00	25.00	120.00
Survey RVW:	0.60	2.00	3.25	5.08	20.00
Pre-Service Evaluation Time:			25.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	2.00	30.00	45.00	60.00	155.00
Immediate Post Service-Time:	<u>20.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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			
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	43273	Recommended Physician Work RVU: 2.24		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.0	0.0
Pre-Service Positioning Time:		0.00	0.0	0.0
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0
Intra-Service Time:		45.00		
Immediate Post Service-Time:	<u>0.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
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 0.0 99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0		
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
43235	000	2.39	RUC Time

CPT Descriptor 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)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
13133	ZZZ	2.19	RUC Time	9,840

CPT Descriptor 1 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
63048	ZZZ	3.47	RUC Time	117,239

CPT Descriptor 2 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
48400	ZZZ	1.95	RUC Time

CPT Descriptor Injection procedure for intraoperative pancreatography (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: 27 % of respondents: 49.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 43273	<u>Key Reference CPT Code:</u> 43235	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0 00	28.00	
Median Intra-Service Time	45 00	20.00	
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	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	45.00	63.00
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	4.56	3.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.59	2.96
Urgency of medical decision making	4.37	3.04

Technical Skill/Physical Effort (Mean)

Technical skill required	4.89	2.93
Physical effort required	4.59	2.89

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.48	2.33
Outcome depends on the skill and judgment of physician	4.70	2.89
Estimated risk of malpractice suit with poor outcome	4.41	3.00

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

Pre-Service intensity/complexity	4.11	3.07
Intra-Service intensity/complexity	4.85	3.22
Post-Service intensity/complexity	4.07	3.04

Additional Rationale

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

The American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) conducted a survey of code +43273, Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s). This code was approved during the February 2008 CPT Editorial Panel meeting. *After reviewing the survey data, the societies recommend a work relative value unit (WRVU) 2.24 WRVUs and 45 minutes physician time (intra-service). The recommended value of 2.24 WRVU is between the survey WRVU median (3.25) and 25th percentile (2.00).*

Survey Process

The survey was disseminated to 195 practicing gastroenterologists. A total of 55 responses (28% response rate) were received.

2.24 WRVU Recommendation Development

The societies convened an expert panel to review the survey data for code +43273.

+43273 SURVEY DATA

RVU	
Low	0.60
25 th	2.00
Median	3.25
75 th	5.08
High	20.00

PHY TIME	
Pre-Service Time	
Median	25
Intra Time	
Low	2
25 th	30
Median	45
75 th	60
High	155
Post Time	
Median	20

The survey respondents reported physician time in the pre and post period. As physician work is typically not performed in the pre and post period for an add-on (ZZZ) code, the societies concluded this was the result of the survey respondents' lack of familiarity with the concept of pre/intra/post time and the survey instrument for an add-on code. The societies concluded it would be appropriate to remove the pre- and post- time and back-out the associated WRVUs from the survey median:

Survey Median = 3.25 WRVU

$$3.25 - ((25 \times .0224) + (20 \times .0224)) = \underline{\underline{2.24 \text{ WRVU}}}$$

Using the Median intra-service time of 45 minutes, a WRVU of 2.24 results in an IWPUT of 0.050 (2.24/45). The value of 2.24 WRVU falls in between the survey median and 25th percentile. The expert panel concluded that this was an appropriate value for the service.

Data Evaluation

As a next step of analysis the advisors compared the recommended WRVU and time values of code +43273 with the reference code and other similar services.

Physician Time and WRVU Data for Reference and Other Related Services						
CPT Code	Pre Time	Intra Time	Post Time	Total Time	WRVU	IWPUT
43235* - Upper GI Endoscopy, Diagnosis	28	20	15	63	2.39	0.075
48400 – Injection, Intraop, Add-On		45		45	1.95	0.043
99358 – Prolonged E/M services, first hour		60		60	2.10	0.035

* Survey reference service

+43273 versus 43235

The expert panel compared +43273 to the reference service code 43235. 49% of the survey respondents chose this code as the reference service. The society is recommending a lower WRVU for +43273 (2.24) than the WRVU value of the reference service 43235 (2.39).

The advisors concluded that the relative relationship between these two codes was appropriate.

- The intra-service time of +43273 is more than twice as long as the intra-service period for 43235 (45 minutes versus 20 minutes). The value of the intra-service work portion of code 43235 is approximately 1.50 WRVU for 20 minutes of intra time.
 - $2.39 - ((18 \times .0224) + (5 \times .008) + (5 \times .0224) + (15 \times .0224)) = 1.4988 = 1.50$
- The recommended value for +43273 (2.24) is less than 50 percent higher when compared to the intra-service WRVU for code 43235. Code +43273 is a procedure of much greater complexity, involving intra time over twice as long.
 - Although the recommended RVU for +43273 results in a slightly lower IWPUT than for 43235, the respondents indicated the surveyed procedure was of greater intensity and required much more skill than code 43235. The expert panel agreed that +43273 was a more intense service than 43235, which supported the WRVU recommendation of 2.24.

+43273 versus 48400

The expert panel compared +43273 to 48400 which has a WRVU value of 1.95. The panel concluded that the relative relationship between these two codes was appropriate.

- While the two codes have the same intra-service time of 45 minutes, the expert panel concluded that the higher WRVU for code +43273 was justified because endoscopy was a more intense procedure requiring greater technical skill compared to injection.

+43273 versus 99358

The expert panel compared +43273 to 99358 which has a WRVU value of 2.10. The panel concluded that the relative relationship between these two codes was appropriate.

- Code 99358 has more intra-service time (60 minutes) but a lower WRVU (2.10) in comparison to +43273.
- Advisors concluded that this was justified because code 99358 reflected prolonged evaluation and management services, while code +43273 reflected a more intense procedural service requiring greater technical skill.

In view of the above, the AGA and ASGE recommend 2.24 WRVUs and physician time of 45 minutes (intra-service) for code +43273.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. The following CPT codes are identified as the primary or base code for the add-on code +432XX: 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272

Primary Codes for Add-On Code +432XX

	Code	Global	WRVU	Time Source	Pre-Time	Intra-Time	Post-Time
	43260	0	5.95	RUC	20	46	20
	43261	0	6.26	RUC	20	55	20
	43262	0	7.38	HARVARD	50	75	28
	43263	0	7.28	RUC	47.5	76	40
	43264	0	8.89	HARVARD	50	69	28
	43265	0	10.00	RUC	40	83.5	35
	43267	0	7.38	HARVARD	47	62	25
	43268	0	7.38	HARVARD	51	78	29
	43269	0	8.20	RUC	40	71	30
	43271	0	7.38	HARVARD	47	61	26
	43272	0	7.38	RUC	25	60	20

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Unique codes that describe cholangioscopy / pancreatoscopy currently do not exist. As such, current coding is very inconsistent. A variety of codes + modifiers are used when reporting a cholangioscopy / pancreatoscopy procedure including:

- 47999, Unlisted procedure, Biliary tract
- 48999, Unlisted procedure, pancreas
- 43260 + 47999, ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing + Unlisted procedure, Biliary tract
- 43260 + 48999, ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing + Unlisted procedure, pancreas
- 43260 - 22, ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing with Service Modifier
- 47550, Add-on code: Biliary Endoscopy, intraoperative (choledochoscopy)

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

Specialty Gastroenterology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Gastroenterology	Frequency 2000	Percentage 100.00 %
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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? 800

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The number is based on input from the manufacturer who has conducted an analysis of Medicare and private payor claims data.

Specialty Gastroenterology	Frequency 800	Percentage 100.00 %
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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? 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. 43260.

The expert panel concluded that one of the primary codes (ERCP codes: 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, and 43272) associated with the add-on code +432XX would make the most appropriate PLI crosswalk. The base ERCP code 43260 was selected by the expert panel.

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Laparoscopic Heller Myotomy

Surgical treatment via esophageal myotomy has been widely performed for correction of achalasia. Over the last 10 years practice patterns have changed and the thoracic approach has been largely supplanted by a laparoscopic, trans-abdominal approach. While the work-up and evaluation of the patient with achalasia are essentially unchanged, the operations are dramatically and substantially different in conduct, skill set, and management. Current CPT codes do not precisely describe the laparoscopic approach for an esophageal myotomy, and in February 2008, the CPT Editorial Panel created CPT code 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed* to allow for the proper reporting of this service.

43279

The RUC reviewed specialty society survey results from 117 surgeons who provide this service. The RUC found the survey results to be quite robust given the low median experience rate as this is a very low volume procedure. The key reference service chosen by those surveyed was 43330 *Esophagomyotomy (Heller type); abdominal approach* (work RVU = 22.06, 2nd Five Year Review RUC reviewed) which is a comparable open procedure but does not include a fundoplasty. The survey median RVW of 25.00 was too high to the RUC and specialty society, although there is more intra service time and work with new code 43279. New code 43279 includes a fundoplasty and survey data confirms additional intra-service time (150 compared to 120 minutes), but since it is laparoscopic there is significantly less post-service time.

The RUC also compared code 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)* (work RVU = 18.00) to the work of 43279. Code 43280 contains all the elements of 43279 with fundoplasty. Although the total physician time components are similar, the intra-operative intensity of 43279 is greater than 43280. Code 43280 involves the circumferential dissection of the esophagogastric (EG) junction leaving as much tissue on the outside of the esophagus and stomach as is available. The procedure is completed by the reconstructive part of the procedure the fundoplasty. Dissection takes place in gross anatomic planes and although it requires experience and skill to avoid hemorrhage or damage to local structures, the risk of perforation or entry into the lumen of the esophagus is low. On the other hand for new code 43279, between the first step of esophagomyotomy (identical mobilization of the EG junction to give access to the site for myotomy) and the fundoplasty, there is an additional step, the myotomy.

The myotomy is very intensive and involves the dissection through the adventitial coat of the esophagus and stomach is performed to expose the submucosa in the floor of the myotomy. To be an effective myotomy, in this delicate step, the surgeon must dissect in a non-anatomic plane, fully divide all overlying smooth muscle for a length of about 8 cm, while preserving the integrity of submucosa and mucosa and the vagus nerves. The layers are often scarred if the patient has had pneumatic dilatation or Botox injections (often tried before surgery), making the dissection even more difficult. This step is fraught with the risk of making a full thickness tear into the esophageal or gastric lumen that could be several cm long requiring extensive repair, or as small as a pin point and difficult to recognize. The clinical implications of any full thickness esophageal injury (that occur in up to 5% of cases) are profound. Thus the intraoperative intensity of work for the myotomy is amongst the most intense a surgeon ever performs. Moreover to optimize identification of tissue planes, the preparatory dissection of the esophagus and stomach for 43279 must be carried out with such precision to avoid bleeding and resultant tissue staining that the intensity of this part of the procedure is higher than for 43280.

The RUC reviewed the specialty survey work RVU statistics and believed that 43279 is essentially equal in total work to the open procedure 43330. The increased intra-time and increased intensity of 43279 balances out the increased post operative hospital work for 43330. The RUC and specialty society concurred that the recommended 25th percentile work RVU of 22.00 (IWPUT = 0.097) provides the correct physician work value and proper rank order amongst similar services. This value is also correspondingly greater than 43280 to account for the increased intra-work and increased intensity as described. **The RUC recommends a relative work value of 22.00 for CPT code 43279.**

Practice Expense:

The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

New Technology:

The RUC recommends that 43279 be added to the new technology list as this procedure utilizes new techniques.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●43279	V1	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed (For open approach, use 43330, 43331) (Do not report 43279 in conjunction with 43280)	090	22.00
43280		Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures) (Do not report 43280 in conjunction with 43279)	090	18.00 (No Change)
Surgery/ Digestive System Esophagus Repair				
43330		Esophagomyotomy (Heller type); abdominal approach (For laparoscopic esophagomyotomy procedure, use 43279)	090	22.06 (No Change)
43331		thoracic approach	090	22.93 (No Change)

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

CPT Code: 43279 Tracking Number V1

Specialty Society Recommended RVU: **22.00**

Global Period: 090

RUC Recommended RVU: **22.00**

CPT Descriptor: Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed
(Do not report in conjunction with 43280 Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures))

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man presents with a history of progressive dysphagia to solid and liquid food. After extensive evaluation a diagnosis of achalasia is confirmed. A laparoscopic esophagomyotomy with fundoplication is performed.

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

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

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

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

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

Description of Pre-Service Work:

- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Determine indication for intra-operative antibiotics and prescribe as necessary.
- Assess need for beta-blockers, order as required.
- Review preadmission work-up, with particular attention to imaging information and reports.
- Reexamine patient to make sure that physical findings have not changed, and update H&P.
- Record patient weight.
- Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products).
- Meet with patient and family to review planned procedure and post-operative management.
- Review and obtain informed consent, including witness.
- Review length and type of anesthesia with anesthesiologist and discuss need for measures to protect against aspiration because of retained fluid and solids in dilated, amotile esophagus.
- Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment.
- Assist in transfer of patient from gurney to operating table.
- Monitor/assist with positioning of patient.
- Install or supervise installation of Foley catheter (if needed).
- Assist anesthesia team with line placement and induction of anesthesia and intubation.
- Indicate areas of skin to be prepped and mark surgical incisions.
- Scrub and gown.
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: After induction of general anesthesia, prepping and draping, pneumoperitoneum is induced by insertion of a Veress needle, bladeless optical trocar, open insertion of the first port or other appropriate

technique. Additional trocars are placed based on the patient's anatomy and need for exposure. The left lateral segment of the liver is retracted to allow visualization of the esophageal hiatus. The proposed myotomy site is inspected for evidence of scarring resulting from prior non-surgical treatment for the achalasia. If the stomach is dilated, it is emptied with a gastric tube recognizing that introduction of the tube into the stomach may be impossible and another method such as needle aspiration may be necessary. The peritoneum overlying the phreno-esophageal ligament is incised and the distal esophagus is mobilized into the mediastinum. Caudal retraction is maintained on the stomach to allow further development of the esophagus in to the chest. A site is selected on the anterior surface of the esophagus to initiate the myotomy. At the starting point the longitudinal muscle fibers are split exposing the circular fibers which are carefully divided unroofing the submucosal layer. The myotomy is then extended cephalad into the mediastinum exposing the submucosa up to and above the level of the muscular hypertrophy. Care is taken to protect the vagus nerve during the dissection. The myotomy is then extended distally below the gastroesophageal junction 2 cm onto the stomach. The oblique muscle fibers in the stomach wall are divided to expose the gastric submucosa. The length and adequacy of the myotomy are confirmed and the myotomy extended as needed cephalad or caudad. Should a tear in the submucosa occur, it is meticulously repaired. Before proceeding the absence of leaks from the exposed submucosal floor of the myotomy is confirmed. If an esophago-gastric fundoplication is deemed necessary, it is then performed per the surgeon's preference. Possible configurations are an anterior or posterior partial fundoplication, total fundoplication or other maneuver designed to prevent reflux of gastric content into the esophagus. This may also include positioning of adjacent gastric fundus over or around the myotomy and fixation with multiple sutures to the stomach, esophagus, edge of the myotomy and the crura of the diaphragm. The operative field is carefully inspected to ensure hemostasis. The liver retraction is released, and the trocars are removed. The incisions are closed and sterile dressings applied.

Description of Post-Service Work:

Post-operative Work – Hospital:

- Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note with and place in chart and record. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s).
- Discontinue perioperative antibiotic therapy as appropriate.
- Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses. Order x-rays (e.g. barium esophagram) as per routine
- Examine patient, including reviewing vital signs and confirming as necessary.
- Auscultate heart, lungs, and abdomen for bowel sounds.
- Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection.
- Continue prophylaxis for DVT. Monitor daily for adequacy.
- Assess need for beta-blockers, order as required.
- Monitor and document patient progress.
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, x-rays, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Review available x-rays (if ordered)
- Answer patient and family questions. Answer nursing/other staff questions.
- Advance diet, as appropriate. Discuss in detail dietary restrictions for the immediate post-operative period (e.g. liquid or mechanical soft diet and its duration)
- Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy.
- Write prescriptions for medications needed post-discharge.
- Home restrictions (i.e., diet as above, activity, bathing) are discussed with the patient, family members and discharging nurse.
- The patient is discharged when there is return of bowel function, taking adequate nutrition, and adequate pain control with oral analgesics.

- All appropriate medical records are completed, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

Postoperative Work – In Office:

- Examine and talk with patient.
- Remove dressings, staples or sutures, when appropriate.
- Review activity and restrictions.
- Monitor healing of incisions with appropriate physical examination
- Arrange to return for review if necessary.
- Monitor diet caloric intake by weight.
- Answer patient/family questions.
- Write medication prescriptions.
- Post discharge labs/films are ordered and reviewed.
- Discuss progress with referring physician(s) (verbal and written).
- Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Michael Edye, MD, FACS; Charles Mabry, MD, FACS; Christopher Senkowski, MD, FACS				
Specialty(s):	general surgery; laparoscopic surgery				
CPT Code:	43279				
Sample Size:	400	Resp N:	117	Response: 29.2 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	1.00	4.00	10.00	40.00
Survey RVW:	18.00	22.00	25.00	27.00	35.00
Pre-Service Evaluation Time:			50.00		
Pre-Service Positioning Time:			20.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	90.00	120.00	150.00	180.00	250.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>60.00</u>	99231x 1.00 99232x 1.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>46.00</u>	99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	43279	Recommended Physician Work RVU: 22.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		20.00	3.00	17.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		150.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>60.00</u>	99231x 1.00 99232x 1.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>46.00</u>	99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
43330	090	22.06	RUC Time

CPT Descriptor Esophagomyotomy (Heller type); 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
43280	090	18.00	RUC Time

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

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

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

Number of respondents who choose Key Reference Code: 46 % of respondents: 39.3 %

TIME ESTIMATES (Median)

	CPT Code: 43279	Key Reference CPT Code: 43330	Source of Time RUC Time
Median Pre-Service Time	80.00	90.00	
Median Intra-Service Time	150.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	210.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	46.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	404.00	550.00	
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	3.84
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.18
Urgency of medical decision making	3.13	3.16

Technical Skill/Physical Effort (Mean)

Technical skill required	4.72	4.09
Physical effort required	4.04	3.84

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.43	4.22
Outcome depends on the skill and judgment of physician	4.61	4.36
Estimated risk of malpractice suit with poor outcome	4.08	3.91

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

Pre-Service intensity/complexity	4.02	3.93
Intra-Service intensity/complexity	4.46	4.11
Post-Service intensity/complexity	3.07	3.11

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 of general and laparoscopic surgeons selected pre-service time package #4 (difficult procedure/difficult patient, under general anesthesia). Seventeen minutes were added for a total of 20 minutes to position the patient, monitors, instruments, and anesthesia lines. This total time is the median survey statistic for positioning time and is similar to positioning time approved for other RUC reviewed general surgery laparoscopic procedures.

Key reference code 43330 *Esophagomyotomy (Heller type); abdominal approach* is the comparable open procedure but does not include a fundoplasty. The survey is remarkably robust even with median case experience of 4 since this is a very low volume procedure. The survey median RVW of 25.00 appears high, although compared to the open code there is intra work that is not included: new code 43279 includes a fundoplasty and survey data confirms additional intra-service time (but significantly less post-service times).

An important alternative reference code is 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)*. This has been RUC surveyed and in essence contains all the elements of the new code PLUS fundoplasty mentioned above. Although the total times are similar, the intra-operative intensity of 43279 is greater than 43280. Code 43280 involves the circumferential dissection of the esophagogastric (EG) junction leaving as much tissue on the outside of the esophagus and stomach as is available. The procedure is completed by the reconstructive part of the procedure - the fundoplasty. Dissection takes place in gross anatomic planes and although it requires experience and skill to avoid hemorrhage or damage to local structures, the risk of perforation or entry into the lumen of the esophagus is low. On the other hand for new code 43279, between the first step of esophagomyotomy (identical mobilization of the EG junction to give access to the site for myotomy) and the fundoplasty, there is an additional step, the myotomy. Dissection through the adventitial coat of the esophagus and stomach is performed to expose the submucosa in the floor of the myotomy. To be an effective myotomy, in this extremely delicate step, the surgeon must dissect in a non-anatomic plane, fully divide all overlying smooth muscle for a length of about 8 cm, while preserving the integrity of submucosa and mucosa and the vagus nerves. The layers are often scarred if the patient has had pneumatic dilatation or Botox injections (often tried before surgery), making the dissection even more difficult. This step is fraught with the risk of making a full thickness tear into the esophageal or gastric lumen that could be several cm long requiring extensive repair, or as small as a pin point and difficult to recognize. The clinical implications of any full thickness esophageal injury (that occur in up to 5% of cases) are profound. Thus the intraoperative intensity of work for the myotomy is amongst the most intense a surgeon ever performs. Moreover to optimize identification of tissue planes, the preparatory dissection of the esophagus and stomach for 43279 must be carried out with such precision to avoid bleeding and resultant tissue staining that the intensity of this part of the procedure is higher than for 43280.

The consensus panel reviewed the survey work RVU statistics and believe that 43279 is equal in total work to the open procedure 43330. The increased intra-time and increased intensity of 43279 balances out the increased post-hospital work for 43330. We are recommending the 25th percentile RVW of 22.00 (IWPUT = 0.097). This value is also correspondingly greater than 43280 to account for the increased intra-work and increased intensity as described.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

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

CPT Long Descriptor:

43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed
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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:

A consensus panel of surgeons representing general surgery and laparoscopic surgery reviewed the practice expense details for the survey codes relative to other facility-only 90-day global services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

The standard 12 minutes has been applied for these inpatient procedures for discharge day management related services.

Post-Service Clinical Labor Activities:

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

Supplies and Equipment:

Post-surgical supplies and equipment necessary for post-discharge surgical care have been indicated.

	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation			43279	
2	Meeting Date: April 2008			Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	
3	LOCATION	Code	Staff Type	Office	Facility
4	GLOBAL PERIOD			090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	144
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	72
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7
17	End: When patient enters office/facility for surgery/procedure				
18	SERVICE PERIOD				
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12
41	End: Patient leaves office/FACILITY				
42	POST-SERVICE Period				
43	Start: Patient leaves office/facility				
44	Conduct phone calls/call in prescriptions				
46	List Number and Level of Office Visits				
47	99211 16 minutes		16		
48	99212 27 minutes	L037D	27		
49	99213 36 minutes	L037D	36		2
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
54	Total Office Visit Time				72
55	Other Activity (please specify)				
56	End: with last office visit before end of global period				
57	MEDICAL SUPPLIES	CMS Code	Unit		
58	pack, minimum multi-specialty visit	SA048	pack		2
59	pack, post-op incision care (suture)	SA054	kit		1
60					
61					
62	Equipment	CMS Code	Utilization Percentage		
63	table, power	EF031	100%		72
64	light, exam	EQ168	100%		72

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Hemorrhoidectomy

The CPT Editorial Panel met in February 2008 and agreed to delete three codes and create a new code so that the destruction of internal and/or external hemorrhoids in current practice can more accurately be reported. The Panel deleted three CPT codes: 46934 *Destruction of hemorrhoids, any method; internal*, 46935 *Destruction of hemorrhoids, any method; external*, and 46936 *Destruction of hemorrhoids, any method; internal and external* to eliminate ambiguities in coding. The deletion of the three "any method" CPT codes, reference to specific incision and excision codes, and creation of a new code that more precisely describes the non-excisional procedure for internal hemorrhoid(s) was believed to allow for more accurate reporting. The Editorial Panel created 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)* for this purpose.

46930

The RUC reviewed the survey results of 50 colorectal and general surgeons who had indicated a median service performance rate of 15. The survey respondents selected CPT code 46221 *Hemorrhoidectomy, by simple ligature (eg, rubber band)* (work RVU = 2.31, RUC reviewed, MPC listed) as the key reference service for new code 46930. The RUC compared the two services for physician time, intensity, and complexity. The survey results indicated the physician work effort of 46930 was quite similar however the intra-service time and total physician time was shorter. The RUC also compared the new code to recently RUC reviewed CPT code 46600 *Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 0.55) which is a similar procedure and has an identical intra-service physician time, but requires much less physician work effort than code 46930. The RUC agreed that the correct physician work relative value was between the survey's key reference code 46221 and 46600.

The RUC and the specialty society concurred that code 46930 is less total work than 46221, yet the intra-service work intensity for both procedures is similar. The specialty and the RUC understood the survey median physician work RVU and 25th percentile RVW resulted in intra-service intensities that are greater than the key reference code. The specialty recommended and the RUC agreed to value new code 46930 at 1.56 relative value units which is supported by taking the value of CPT code 46600 anoscopy (RVW=0.55) plus a 99213 follow-up office visit (0.92) equal 1.47 work RVUs before taking into account the work and increased intra-intensity for the destruction of hemorrhoids. The RUC agreed with the specialty recommended work value of 1.56, which is less than the 25th

percentile survey results and places new code 46930 in proper rank order amongst similar procedures. **The RUC recommends a relative work value for CPT code 46930 of 1.56.**

Practice Expense: The RUC reviewed the direct practice expense input recommendation for CPT code 46930 and made minor edits so that the typical patient scenario was captured in the non-facility and facility settings.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●46930	X1	Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)	090	1.56
D 46934		Destruction of hemorrhoids, any method; internal	090	N/A
D 46935		Destruction of hemorrhoids, any method; external	090	N/A
D 46936		Destruction of hemorrhoids, any method; internal and external <u>(Codes 46934-46936 have been deleted. For incision of external thrombosed hemorrhoid(s), use 46083; for destruction of internal hemorrhoid(s) by thermal energy, use 46930; for destruction of hemorrhoid(s) by cryosurgery, use 46999; for excision of hemorrhoid(s), see 46250-46262, 46320; for injection, use 46500; for ligation, see 46221, 46945, 46946; for hemorrhoidopexy, use 46947)</u>	090	N/A

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

CPT Code:46930 Tracking Number X1

Specialty Society Recommended RVU: **1.56**

Global Period: 090

RUC Recommended RVU: **1.56**

CPT Descriptor: Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32-year-old male, with no past medical history, has had intermittent bright red rectal bleeding into the commode for the past 6 months. Office exam including anoscopy and/or sigmoidoscopy reveals Grade I internal hemorrhoids in the left lateral, right posterior, and right anterior quadrants that exhibit friability and contact bleeding. He undergoes thermal energy ablation of the hemorrhoid(s).

Note: (Codes 46934-46936 have been deleted. For incision of external thrombosed hemorrhoid(s), see 46083; for destruction of internal hemorrhoid(s) by thermal energy, use 4693X; for destruction of hemorrhoid(s) by cryosurgery, use 46999; for excision of hemorrhoid(s), see 46230-46262; for injection, use 46500; for ligation, see 46945, 46946; for hemorrhoidopexy, use 46947.)

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

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

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

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

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

Description of Pre-Service Work:

- Review the procedure and expected outcome(s) with patient and family.
- Obtain informed consent.
- Verify that all necessary instruments and supplies are readily available in the exam room.
- Assist with patient positioning, prepping and draping

Description of Intra-Service Work: The patient is placed in a kneeling position on a Ritter table. The patient's buttocks are effaced. Visual inspection of the perineum is performed. A lubricated anoscope is then placed in the anal canal. Once in the anal canal, the anoscope is rotated 180° and the obturator is removed. Thermal energy ablation (eg, infrared coagulation) is applied four to five times in an arc at the apex of the hemorrhoid complex(es). The anoscope is removed.

Description of Post-Service Work:

- Discuss procedure outcome with patient/family.
- Discuss diet, activity and hygiene with the patient/family
- Answer patient/family questions.
- Discuss follow-up with the patient/family, if symptoms not resolved.
- Write prescription orders
- Dictate notes for medical chart.
- Dictate procedure note and a letter to the PCP and/or insurance company.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Guy Orangio, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	colon and rectal surgery; general surgery				
CPT Code:	46930				
Sample Size:	250	Resp N:	50	Response: 20.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	15.00	39.00	150.00
Survey RVW:	1.00	1.64	2.26	2.51	4.70
Pre-Service Evaluation Time:			20.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	2.00	5.00	5.00	10.00	30.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>23.00</u>	99211x 0.00 12x 0.00 13x 1.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55), 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	46930	Recommended Physician Work RVU: 1.56		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		8.00	7.00	1.00
Pre-Service Positioning Time:		5.00	0.00	5.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		5.00		
Immediate Post Service-Time:	<u>5.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>23.00</u>	99211x 0.00 12x 0.00 13x 1.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
46221	010	2.31	RUC Time

CPT Descriptor Hemorrhoidectomy, by simple ligature (eg, rubber band)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 17 % of respondents: 34.0 %

TIME ESTIMATES (Median)

	CPT Code: 46930	Key Reference CPT Code: 46221	Source of Time RUC Time
Median Pre-Service Time	13.00	15.00	
Median Intra-Service Time	5.00	15.00	
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	23.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	46.00	68.00	
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	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.25	2.31
Urgency of medical decision making	1.94	1.94

Technical Skill/Physical Effort (Mean)

Technical skill required	3.31	3.31
Physical effort required	2.06	2.06

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.06	2.13
Outcome depends on the skill and judgment of physician	3.06	3.06
Estimated risk of malpractice suit with poor outcome	1.88	2.06

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

Pre-Service intensity/complexity	2.47	2.50
Intra-Service intensity/complexity	2.76	2.75
Post-Service intensity/complexity	2.18	2.06

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.*

Pre-Service Time:

The consensus panel of colon and rectal surgeons and general surgeons selected pre-service time package 5 (non-facility without anesthesia). One minute was added to the pre-service evaluation total time to account for work related to "check/set-up room, supplies, and equipment." It will be necessary for the physician to be certain that the thermal energy transfer device is available and in working order prior to the start of the procedure. Five minutes has

been added for positioning the patient. This is consistent with the RUC approved positioning time for the series of anoscopy codes 466XX. Total pre-service time is 13 minutes, which is similar to the pre-service time for 46600 (diagnostic anoscopy). The breakdown is 8 minutes for evaluation; 5 minutes for positioning; and 0 minutes for scrub, dress, wait time.

Intra-Service Time:

We recommend the survey median intra-service time of 5 minutes to place the anoscope, visualize the hemorrhoids, apply thermal energy, and remove the anoscope. The work is very similar to 46600 (diagnostic anoscopy).

Immediate Post-Service Time:

We recommend the survey median post-service time of 5 minutes. This is the same as the post-service time for 99213, which is a good comparison for work required after the procedure.

Post-Service Visits:

The patient would be seen within 4 to 6 weeks after the procedure to assess resolution of the symptoms. Because the exam would include an anoscopy, we agree with the survey median response of 1.0 x 99213.

Comparison to Key Reference and Work RVU Recommendation:

CPT 46221 *Hemorrhoidectomy, by simple ligature (eg, rubber band)* was cited most often as a reference for 46930. Both procedures are typically performed in an office. To assist in capturing information about the typical site of service for new code 46930, we added the following question to our survey:

SITE OF SERVICE	CPT 46930	
	Yes	No
Is this procedure typically performed in your office?		
If "no," is this procedure typically same-day discharge from outpatient hospital or ambulatory surgicenter?		
If not same-day surgery, what is the hospital length of stay (LOS) for the typical patient?	LOS =	

Of the 50 respondents to the survey, 90% indicated this procedure was typically performed in an office setting and the remaining 11% indicating same-day discharge from a facility.

The consensus panel believes code 46930 is less total work than 46221. However, we believe the intensity for both procedures is similar. Because the survey median RVW and 25th percentile RVW result in intra-service intensities that are greater than the key reference code, **we are recommending an RVW of 1.56 for code 4963X**. This value results in an intra-service intensity equal to 46221 (IWPUT=0.048). Additional support for this value is to consider that a 46600 anoscopy (RVW=0.55) plus a 99213 follow-up office visit (0.92) equal 1.47 work RVUs before taking into account the work and increased intra-intensity for the destruction of hemorrhoids.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

- ## FREQUENCY INFORMATION

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

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

CPT Long Descriptor:

46930 Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)

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 surgeons representing general surgery and colorectal surgery reviewed the practice expense details for the key reference code 46621 as a cross-walked for inputs.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Non-facility and facility times for 46221 were crosswalked to new code 46930.

Intra-Service Clinical Labor Activities:

Non-facility times for 46221 were crosswalked to new code 46930 – with the exception that no time was included for anesthesia and intra-time was adjusted to match physician time.

Post-Service Clinical Labor Activities:

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

Supplies and Equipment:

Non-facility supplies and equipment for 46221 were crosswalked to new code 46930 – with the exception that supplies and equipment related to banding and anesthesia were removed and supplies and equipment related to infrared coagulation were added. Note that an anoscopy will be performed at the followup office visit and supplies/equipment related to that are included.

See next page for pricing of new supplies/equipment

	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation			46930	
2	Meeting Date: April 2008 (Crosswalk PE details from 46221)			Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)	
3	LOCATION	Code	Staff Type	Office	Facility
4	GLOBAL PERIOD			090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	82	61
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	9	19
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	37	6
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	36	36
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3
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
16	Other Clinical Activity (please specify)	L037D	RN/LPN/MTA		
17	End: When patient enters office/facility for surgery/procedure				
18	SERVICE PERIOD				
19	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
20	Review charts	L037D	RN/LPN/MTA	3	
21	Greet patient and provide gowning	L037D	RN/LPN/MTA	3	
22	Obtain vital signs	L037D	RN/LPN/MTA	3	
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5	
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2	
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA		
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2	
27	Sedate/apply anesthesia	L037D	RN/LPN/MTA		
28	Intra-service				
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	5	
30	Post-Service				
31	Monitor pt following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	3	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3	
33	Clean Scope	L037D	RN/LPN/MTA	5	
34	Clean Surgical Instrument Package	L037D	RN/LPN/MTA		
35	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA		
36	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA		
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3	
38	Discharge day management 99238 --12 minutes, 99239 --15 minutes	L037D	RN/LPN/MTA		6
39	Other Clinical Activity (please specify)	L037D	RN/LPN/MTA		
40	End: Patient leaves office				
41	POST-SERVICE Period				
42	Start: Patient leaves office/facility				
43	Conduct phone calls/call in prescriptions				
45	List Number and Level of Office Visits				
46	99211 16 minutes		16		
47	99212 27 minutes		27		
48	99213 36 minutes		36	1	1
49	99214 53 minutes		53		
50	99215 63 minutes		63		
51	Other				
52	Total Office Visit Time	L037D	RN/LPN/MTA	36	36
53	Other cleaning scope parts at first POV @2/3 * 5min				
54	End: with last office visit before end of global period				

	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation			46930	
2	Meeting Date: April 2008 (Crosswalk PE details from 46221)			Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)	
3	LOCATION	Code	Staff Type	Office	Facility
55	MEDICAL SUPPLIES	Code	Unit		
56	pack, minimum multi-specialty visit	SA048	pack	2	1
57	mask, surgical, with face shield	SB034	item	1	
58	gown, staff, impervious	SB027	item	1	
59	cap, surgical	SB001	item	1	
60	shoe covers, surgical	SB039	pair	1	
61	canister, suction	SD009	item	1	
62	tubing, suction, non-latex (6ft uou)	SD132	item	1	
63	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1	
64	anoscope	SD003	item	2	1
65	lubricating jelly (K-Y) (5gm uou)	SJ032	item	8	4
66	pack, cleaning and disinfecting, endoscope	SA042	pack	1	1
67	sheath, for infrared light guide	NEW	item	1	
68	basin, emesis	SJ010	item		
69	swab-pad, alcohol	SJ053	item		
70	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml		
71	needle, 18-27g	SC029	item		
72	syringe 10-12ml	SC051	item		
73	rubber bands, sterile for ligation	SF032	item		
74	swab, procto 16in	SJ052	item		
75					
76	Equipment	Code			
77	table, power	EF031		73	36
78	light, surgical	EF014		73	36
79	light source, xenon	EQ167		73	36
80	suction machine (Gomco)	EQ235		37	
81	electrosurgical generator, gastrocautery	EQ113			
82	infrared coagulator (with hand applicator <u>& light guide</u>)	EQ136		37	
83					
84	Note need to edit description of EQ136 to include light guide				

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

September 2007

Laparoscopic Abdominal Wall Hernia Repair

In June 2007, the CPT Editorial Panel created six new CPT codes to describe the specific levels of work associated with abdominal hernia repairs that are being performed frequently with laparoscopic techniques. This new type of surgery is different from the open repair of abdominal wall hernia that involves placement of mesh prosthesis on the surface of the muscle layers through the incision, whereas these new procedure codes describe the laparoscopic placement of the mesh behind the fascia and muscle layers, where it is affixed to the abdominal wall muscles. All of these laparoscopic repairs are performed within the peritoneal cavity, in open procedures only enough abdominal wall for suture or mesh positioning would typically be exposed and in many circumstances entry into the peritoneal cavity would be avoided or limited. In these procedures, the laparoscope must be free to see the edges of the hernia defect and for trocar / instrument placement, therefore complete freedom of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement.

Laparoscopic repair procedures such as these are typically reserved for larger hernias, general anesthesia is always required, and a larger mesh is nearly always implanted. Although, these laparoscopic procedures result in significantly lower incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation of the sensitive peritoneal surface and are typically provided postoperative narcotics. Patients are also susceptible to postoperative ileus, and patients typically require inpatient hospital care and postoperative follow up visits with their physician.

The RUC reviewed the specialty society's survey results for these six new laparoscopic surgical repair of a hernia using mesh insertion and understood that the utilization for these types procedures would not change with this coding change. Therefore, the RUC believes that there will be no budget neutrality impact for these recommendations.

The RUC also understood that laparoscopic repairs such as these cannot be considered as simply laparoscopic equivalents for open repairs since these are performed within the peritoneal cavity and extensive adhesiolysis is typically a major part of each procedure. However RUC also believed the specialty survey median physician work values for 49652 – 49656 were greater than the typical patient scenario should warrant. The RUC therefore believed that these codes should be valued at the specialty society's 25th percentile survey results for physician work, and to insure proper rank order in work values and intra-service work intensities, the RUC reviewed all the codes as a family.

49652 F1 *Laparoscopy, surgical repair ventral, umbilical, Spigelian or epigastric hernia (includes mesh insertion, when performed); reducible* The RUC reviewed code 496X0 and believed that in relation to its key reference code 49560 *Repair initial incisional or ventral hernia; reducible* (work RVU = 11.84, 90 minutes intra-service time) the surveyed code has more post operative discharge day management time associated. The RUC also understood that the mesh implantation requires additional work (valued at 4.88 RVUs), however in relation to code 49654 the value would have to be lower than the sum of its parts (11.84 RVUs from code 49560 plus 4.88 equals 16.72). The RUC therefore believed that the specialty society's 25th percentile survey results of 12.80 reflected the true value for new code 49652. **The RUC recommends a work RVU of 12.80 for code 49652.**

49653 F2 *Laparoscopy, surgical repair ventral, umbilical, Spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated* The RUC reviewed the physician work of code 49657 as an anchor for this new code and the entire family of laparoscopic surgical abdominal wall hernia repair codes. The RUC reviewed the relativity amongst the family of codes and believed in maintaining rank order at the 25th percentile survey results while understanding the similarities in physician work between codes 49653 and 49657. The RUC also reviewed code key reference code 49566 *Repair recurrent incisional or ventral heria; incarcerated or strangulated* (work RVU = 15.45) in relation to 49653 and understood that with the mesh insertion the new code should be valued below code 15.45. In order to maintain the rank order between 49653, 49657, and 49566 related to the intra-service work per unit of time, the committee agreed and **recommends a work RVU of 14.95 for code 49653.**

49654 F3 *Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); reducible* The RUC believed in maintaining rank order in intensity and physician work throughout the family and therefore believed the 25th percentile specialty work RVU survey results were appropriate. The committee understood that the median physician work time (120 minutes) was also appropriate considering the key reference code 44180 *Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)* (work RVU = 15.19, 120 intra-service time) and mesh insertion. **The RUC recommends a relative work RVU of 16.10 for code 49654.**

49655 F4 *Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated*

The RUC reviewed code 49655 in relation to the anchor code, 49657, and understood that the recurrent procedure was more work and more intense than this code. However, the surveyed physician work and time is greater than 49656. The RUC believed the relative work value was between the 25th percentile survey results (17.20) and the median (20.00). The RUC agreed that code 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)* (work RVU = 18.00, 150 minutes of intra-service time) had similar overall physician work and required the same intra-service time. **The RUC recommends a work relative value of 18.00 for code 49655.**

49656 F5 *Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); reducible*
Within this new family of procedure codes, the RUC believed codes that are “reducible”, are slightly less intense than the “incarcerated or strangulated” codes. In relation to the specialty surveyed key reference service code 49565 *Repair recurrent incisional or ventral hernia; reducible* (work RVU = 12.29, 100 minutes intra-service time), the RUC believed the recommended value of 17.25 for 49656 was generous and that it was greater than the sum of its parts (key reference code for the repair plus the implantation of the mesh (code 49568 – work RVU 4.88 = 17.17). The RUC and specialty believed that to maintain physician work intensity rank order, the value should be lower. The committee also reviewed code 58545 *Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas* (work RVU = 15.45, 120 minutes of Intra-service time) in relation to the specialty’s 25th percentile survey results. The RUC agreed that the 25th percentile specialty survey results provided for the proper rank order with the family of codes and the proper work value. **The RUC recommends a relative work value of 15.00 work RVUs for code 49656.**

49657 F6- *Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated*
The RUC discussed new service 49657 in relation to its key reference service 49566 *Repair recurrent incisional or ventral hernia; incarcerated or strangulated* (Work RVU = 15.45) with the understanding that they are similar services, however the laparoscopic approach involves more work, time, and intensity than the open approach. Laparoscopic repair procedures such as these are typically reserved for larger hernias, general anesthesia is always required, and a larger mesh is nearly always implanted. These procedures are performed within the peritoneal cavity and extensive adhesiolysis is typically a major part of each procedure.

The committee also discussed the physician time components carefully and believed for the survey data reflected the typical patient scenario. The survey results supported a higher value than the key reference service and the committee linked the physician work intensity to MPC code 44140 *Colectomy, partial; with anastomosis* (Work RVU = 22.46, 150 minutes of intra-service time, IWPOT = 0.72). The committee believed code 49657 could serve as an anchor for the rest of this new family of codes. **The RUC recommends 22.00 work RVUs for code 49657**

Practice Expense: The practice expense for these facility only codes was reviewed and modified slightly to reflect the 090 day standard facility standard direct practice expense inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲+49568		Implantation of mesh or other prosthesis for <u>open</u> incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair)	ZZZ	4.88 (No Change)
●49652	F1	Laparoscopy, surgical repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	090	12.80
●49653	F2	incarcerated or strangulated	090	16.10
●49654	F3	Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); reducible	090	14.95
●49655	F4	incarcerated or strangulated	090	18.00
●49656	F5	Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); reducible	090	15.00
●49657	F6	incarcerated or strangulated (Do not report 49652-49657 in conjunction with 44180, 49568)	090	22.00

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

CPT Code: 49652 Tracking Number F1 Specialty Society Recommended RVU: **14.50**
 Global Period: 090 RUC Recommended RVU: **12.80**

CPT Descriptor: Laparoscopy, surgical repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old obese man presents with a new abdominal wall bulge first noted after exercise, which has been increasing in size over the last few months. It is occasionally painful, with tender edges. The hernia is reducible on exam. He is referred for a laparoscopic repair.

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:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review preadmission work-up, with particular attention to imaging information and reports.
- Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P.
- Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products).
- Meet with patient and family to review planned procedure and post-operative management.
- Mark the palpable edge of the hernia defect(s) and sites of the proposed skin incisions with cooperation of patient.
- Review and obtain informed consent, including witness.
- Review length and type of anesthesia with anesthesiologist.
- Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment.
- Assist in transfer of patient from gurney to operating table.
- Monitor/assist with positioning of patient.
- Install or supervise installation of Foley catheter (if needed).
- Assist anesthesia team with line placement and induction of anesthesia and intubation.
- Indicate areas of skin to be prepped and mark surgical incisions.
- Scrub and gown.
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: If hernia contents are present, they are manually reduced. Pneumoperitoneum is induced by insertion of a Veress needle, bladeless optical trocar, open insertion of the first port (described below) or other appropriate technique. Starting at a distance from the hernia location, for open insertion the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed, incised and the peritoneum opened carefully under direct vision avoiding underlying bowel, omentum or adhesions. The first trocar is inserted and secured with stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity is made prior to placing subsequent cannulae. With the camera viewing placement of each port, typically two more are positioned to allow two handed surgical technique, while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports,

viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process adhesions may require sharp and/or blunt lysis to allow adequate exposure. The hernia defect is identified and if necessary its contents reduced. An appropriate margin around the defect to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament. Hemostasis is secured before continuing and a careful check of intestine that has been handled or freed by adhesiolysis is made to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The size of the defect is measured and an appropriate sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and once inside is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points is intended to achieve adequate overlap of flat lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples and other defects, with and without insufflation, and corrected as needed. The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defect of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate a dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Post-operative Work – Hospital:

- Apply sterile adhesive strips and dressings. Apply elastic binder to fix dressings and compress the hernia site. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s).
- Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.
- Examine patient, including reviewing vital signs and confirming as necessary.
- Auscultate heart, lungs, and abdomen for bowel sounds.
- Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection.
- Continue prophylaxis for DVT. Monitor daily for adequacy.
- Assess need for beta-blockers, order as required.
- Monitor and document patient progress.
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, films, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Answer patient and family questions. Answer nursing/other staff questions.
- Advance diet, as appropriate.
- Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy.
- Write prescriptions for medications needed post-discharge.
- Home restrictions (i.e., diet, activity, bathing) are discussed with the patient, family members and discharging nurse.
- The patient is discharged when there is return of bowel function, taking adequate nutrition, and adequate pain control with oral analgesics.
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Postoperative Work – In Office:

- Examine and talk with patient.
- Remove staples or sutures, when appropriate.
- Review activity and restrictions.
- Monitor healing of incision with appropriate physical examination, including dealing with questions of patient and family.
- Check for presence of post-operative hematoma/seroma and assess need for aspiration. Arrange to return for review if necessary.
- Monitor diet caloric intake by weight.
- Answer patient/family questions.
- Write medication prescriptions.
- Post discharge labs/films are ordered and reviewed.
- Discuss progress with referring physician(s) (verbal and written).
- Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		09/2007			
Presenter(s):	Michael Edye, MD, FACS; Christopher K. Senkowski, MD, FACS; Guy R. Orangio, MD, FACS				
Specialty(s):	ACS; SAGES; ASCRS				
CPT Code:	49652				
Sample Size:	300	Resp N:	45	Response: 15.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	8.00	15.00	150.00
Survey RVW:	7.00	12.80	14.50	16.00	30.00
Pre-Service Evaluation Time:			45.0		
Pre-Service Positioning Time:			15.0		
Pre-Service Scrub, Dress, Wait Time:			15.0		
Intra-Service Time:	60.00	75.00	90.00	90.00	150.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>20.0</u>	99231x 1.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>38.0</u>	99238x 1.00	99239x 0.00		
Office time/visit(s):	<u>39.0</u>	99211x 0.0	12x 1.0	13x 1.0	14x 0.0 15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55), 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49652	
	<u>Specialty Recommended</u>
Physician Work RVU:	
Pre-Service Evaluation Time:	
Pre-Service Positioning Time:	
Pre-Service Scrub, Dress, Wait Time:	
Intra-Service Time:	
Immediate Post Service-Time:	
Post Operative Visits	Total Min** CPT Code and Number of Visits
Critical Care time/visit(s):	<u>0.0</u> 99291x 99292x
Other Hospital time/visit(s):	<u>0.0</u> 99231x 99232x 99233x
Discharge Day Mgmt:	<u>0.0</u> 99238x 99239x
Office time/visit(s):	<u>0.0</u> 99211x 12x 13x 14x 15x
Prolonged Services:	<u>0.0</u> 99354x 55x 56x 57x

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49560	090	11.84	RUC Time

CPT Descriptor Repair initial incisional or ventral hernia; reducible

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 33.3 %

TIME ESTIMATES (Median)

	CPT Code: 49652	Key Reference CPT Code: 49560	Source of Time RUC Time
Median Pre-Service Time	75.00	45.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	292.00	223.00	
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	2.53	2.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	2.69
Urgency of medical decision making	2.33	2.23

Technical Skill/Physical Effort (Mean)

Technical skill required	3.47	2.77
Physical effort required	3.20	2.77

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.93	2.62
Outcome depends on the skill and judgment of physician	3.33	2.92
Estimated risk of malpractice suit with poor outcome	3.27	3.00

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

Pre-Service intensity/complexity	2.67	2.46
Intra-Service intensity/complexity	3.07	2.46
Post-Service intensity/complexity	2.40	2.23

Additional Rationale

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

CPT approved a family of six codes for new - but well established - laparoscopic procedures for repair of abdominal wall hernias. These laparoscopic repairs are a significant technical departure from the open repairs for several reasons including the technical mechanics of performing the repair and the near universal placement of mesh prosthesis.

Laparoscopic repairs cannot be considered as simply laparoscopic equivalents for open repairs. All laparoscopic repairs are performed within the peritoneal cavity. Adhesiolysis is major part of each procedure and is typically extensive. In the open procedures, only enough abdominal wall for suture or mesh positioning would typically be exposed and in many circumstances entry into the peritoneal cavity would be avoided or limited. In the laparoscopic operation, since the laparoscope must be free to see the edges of the hernia defect, as well as have free areas for trocar / instrument placement, complete liberation of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement.

Mesh is usually placed behind the fascial and muscle layers of the abdominal wall, rather than on the surface of the muscle, as in the open setting. The mesh must be fixed securely in a circumferential pattern, to prevent displacement or herniation of viscera between mesh and muscle. Several methods to achieve fixation are available including staples, tacks and transfascial sutures that in and of themselves require specialized training for proper use. Although the net result is in a markedly decreased incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation to the sensitive peritoneal surface and they are prone to postoperative narcotics and postoperative ileus.

Finally, by avoiding an incision directly over the hernia, and fixing mesh behind the muscle containing the defect, the principal of the laparoscopic repair of an abdominal hernia is the same for all anatomic sites. For this reason a single code was formulated to include primary reducible umbilical, ventral and Spigelian hernia. In clinical practice, small hernias of these types are more commonly treated with open repair using mesh. Laparoscopic repair is typically reserved for larger hernias, general anesthesia is always required, and larger mesh is implanted.

F1 / 49652 Laparoscopy, surgical repair ventral, umbilical, Spigelian or epigastric hernia (includes mesh insertion, when performed); reducible

Ref 49560 Repair initial incisional or ventral hernia; reducible

In comparison to the reference code, 49652 requires similar pre-service work, the same intra-service time, and the same number of office visits. However, the patient requiring 49652 will be admitted as these laparoscopically treated hernias will be larger, typically require mesh, and ileus monitored. We recommend the survey median RVU of 14.50. This value is less than the reference code 49560 plus the mesh add-on code for open repair 49568 (11.84 + 4.88=16.72), but correlates with the recommendation of 16.00 for 49654, taking into account less total work required for 49652.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
- Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)
- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
 - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
 - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
 - ☐ Multiple codes are used to maintain consistency with similar codes.
 - ☐ Historical precedents.
 - ☐ Other reason (please explain)
2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49659 Unlisted laparoscopy procedure, hernioplasty, herniorraphy, herniotomy

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

Specialty general surgery	How often? Commonly
Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	How often? Rarely
Specialty	How often?

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

Specialty general surgery	Frequency	Percentage	%
Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	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?
 4,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. Given that 49659 is an unlisted code, and as such, may incorporate a large
 variety of laparoscopic hernia repairs, it is difficult to estimate frequencies for F1-F6. However, it is likely that the
 distribution of the new codes will mirror the existing open codes. The Medicare frequency for 49659 is approximately
 10,000. The estimate for codes F1-F6 are based on the distribution of the open codes multiplied by the total frequency
 for 49659.

Specialty general surgery	Frequency 3800	Percentage 95.00 %	
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Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	Frequency 200	Percentage 5.00 %	
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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? 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: 49653 Tracking Number F2 Specialty Society Recommended RVU: **18.00**
Global Period: 090 RUC Recommended RVU: **16.10**

CPT Descriptor: Laparoscopy, surgical repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old woman with no past surgical history presents with a large abdominal wall mass. She reports that it has been slowly increasing in size over the last 3-4 years. It would initially go away when she lay down, but has been non-reducible for the last year. It is increasingly tender and often painful. She has occasional nausea but no vomiting associated with it. On exam she is afebrile with normal vital signs. She has a chronically incarcerated ventral hernia and is referred for a laparoscopic repair.

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:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review preadmission work-up, with particular attention to imaging information and reports.
- Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P.
- Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products).
- Meet with patient and family to review planned procedure and post-operative management.
- Mark the palpable edge of the hernia defect(s) and sites of the proposed skin incisions with cooperation of patient.
- Review and obtain informed consent, including witness.
- Review length and type of anesthesia with anesthesiologist.
- Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment.
- Assist in transfer of patient from gurney to operating table.
- Monitor/assist with positioning of patient.
- Install or supervise installation of Foley catheter (if needed).
- Assist anesthesia team with line placement and induction of anesthesia and intubation.
- Indicate areas of skin to be prepped and mark surgical incisions.
- Scrub and gown.
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An attempt is made to reduce the hernia contents manually. Pneumoperitoneum is induced by insertion of a Veress needle, bladeless optical trocar, open insertion of the first port (described below) or other appropriate technique. Starting at a distance from the hernia location, for open insertion the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed, incised and the peritoneum opened carefully under direct vision avoiding underlying bowel, omentum or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity is made prior to placing subsequent cannulae. With the camera viewing placement of each port, typically two more are

positioned to allow two handed surgical technique, while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process adhesions may require sharp and/or blunt lysis to allow adequate exposure. The hernia defect is identified and if necessary its contents is reduced using a combination of external pressure, careful traction with the laparoscopic instruments and judicious adhesiolysis as necessary. An appropriate margin around the defect to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament. Hemostasis is secured before continuing and a careful check of intestine that has been reduced, handled or freed by adhesiolysis is made to confirm that it is intact. Devitalized tissue such as fat or omentum is excised and removed. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The size of the defect is measured and an appropriate sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and once inside is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points is intended to achieve adequate overlap of flat lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples and other defects, with and without insufflation, and corrected as needed. The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defect of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate a dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Post-operative Work – Hospital:

- Apply sterile adhesive strips and dressings. Apply elastic binder to fix dressings and compress the hernia site. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s).
- Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.
- Examine patient, including reviewing vital signs and confirming as necessary.
- Auscultate heart, lungs, and abdomen for bowel sounds.
- Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection.
- Continue prophylaxis for DVT. Monitor daily for adequacy.
- Assess need for beta-blockers, order as required.
- Monitor and document patient progress.
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, films, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Answer patient and family questions. Answer nursing/other staff questions.
- Advance diet, as appropriate.
- Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy.
- Write prescriptions for medications needed post-discharge.
- Home restrictions (i.e., diet, activity, bathing) are discussed with the patient, family members and discharging nurse.

- The patient is discharged when there is return of bowel function, taking adequate nutrition, and adequate pain control with oral analgesics.
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Postoperative Work – In Office:

- Examine and talk with patient.
- Remove staples or sutures, when appropriate.
- Review activity and restrictions.
- Monitor healing of incision with appropriate physical examination, including dealing with questions of patient and family.
- Check for presence of post-operative hematoma/seroma and assess need for aspiration. Arrange to return for review if necessary.
- Monitor diet caloric intake by weight.
- Answer patient/family questions.
- Write medication prescriptions.
- Post discharge labs/films are ordered and reviewed.
- Discuss progress with referring physician(s) (verbal and written).
- Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		09/2007				
Presenter(s):	Michael Edye, MD, FACS; Christopher K. Senkowski, MD, FACS; Guy R. Orangio, MD, FACS					
Specialty(s):	ACS; SAGES, ASCRS					
CPT Code:	49653					
Sample Size:	300	Resp N:	45	Response: 15.0 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	1.00	5.00	10.00	60.00
Survey RVW:		12.00	16.10	18.00	20.00	32.00
Pre-Service Evaluation Time:				45.0		
Pre-Service Positioning Time:				15.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		75.00	90.00	120.00	150.00	270.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0				
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0				
Discharge Day Mgmt:	38.0	99238x 1.00 99239x 0.00				
Office time/visit(s):	55.0	99211x 0.0 12x 2.0 13x 1.0 14x 0.0 15x 0.0				
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49653	
	<u>Specialty Recommended</u>
Physician Work RVU:	
Pre-Service Evaluation Time:	
Pre-Service Positioning Time:	
Pre-Service Scrub, Dress, Wait Time:	
Intra-Service Time:	
Immediate Post Service-Time:	
Post Operative Visits	Total Min** CPT Code and Number of Visits
Critical Care time/visit(s):	<u>0.0</u> 99291x 99292x
Other Hospital time/visit(s):	<u>0.0</u> 99231x 99232x 99233x
Discharge Day Mgmt:	<u>0.0</u> 99238x 99239x
Office time/visit(s):	<u>0.0</u> 99211x 12x 13x 14x 15x
Prolonged Services:	<u>0.0</u> 99354x 55x 56x 57x

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49566	090	15.45	RUC Time

CPT Descriptor Repair recurrent incisional or ventral hernia; incarcerated or strangulated

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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:** 37.7 %

TIME ESTIMATES (Median)

	CPT Code: 49653	Key Reference CPT Code: 49566	Source of Time RUC Time
Median Pre-Service Time	75.00	45.00	
Median Intra-Service Time	120.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	55.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	378.00	372.00	
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	2.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.18	3.20
Urgency of medical decision making	3.76	3.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.24	3.53
Physical effort required	3.82	3.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.82	3.60
Outcome depends on the skill and judgment of physician	3.94	3.60
Estimated risk of malpractice suit with poor outcome	3.94	3.67

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

Pre-Service intensity/complexity	3.59	3.27
Intra-Service intensity/complexity	3.94	3.60
Post-Service intensity/complexity	2.76	2.47

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.*

CPT approved a family of six codes for new - but well established - laparoscopic procedures for repair of abdominal wall hernias. These laparoscopic repairs are a significant technical departure from the open repairs for several reasons including the technical mechanics of performing the repair and the near universal placement of mesh prosthesis.

Laparoscopic repairs cannot be considered as simply laparoscopic equivalents for open repairs. All laparoscopic repairs are performed within the peritoneal cavity. Adhesiolysis is major part of each procedure and is typically extensive. In the open procedures, only enough abdominal wall for suture or mesh positioning would typically be exposed and in many circumstances entry into the peritoneal cavity would be avoided or limited. In the laparoscopic operation, since the laparoscope must be free to see the edges of the hernia defect, as well as have free areas for trocar / instrument placement, complete liberation of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement.

Mesh is usually placed behind the fascial and muscle layers of the abdominal wall, rather than on the surface of the muscle, as in the open setting. The mesh must be fixed securely in a circumferential pattern, to prevent displacement or herniation of viscera between mesh and muscle. Several methods to achieve fixation are available including staples, tacks and transfascial sutures that in and of themselves require specialized training for proper use. Although the net result is in a markedly decreased incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation to the sensitive peritoneal surface and they are prone to postoperative narcotics and postoperative ileus.

Finally, by avoiding an incision directly over the hernia, and fixing mesh behind the muscle containing the defect, the principal of the laparoscopic repair of an abdominal hernia is the same for all anatomic sites. For this reason a single code was formulated to include primary reducible umbilical, ventral and Spigelian hernia. In clinical practice, small hernias of these types are more commonly treated with open repair using mesh. Laparoscopic repair is typically reserved for larger hernias, general anesthesia is always required, and larger mesh is implanted.

F2 / 49653 Laparoscopy, surgical repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated

Ref 49566 Repair recurrent incisional or ventral hernia; incarcerated or strangulated

In comparison to the reference code, 49653 requires similar pre-service work, the same intra-operative time (although more difficult), one day less length of stay, and one extra post-op office visit. We recommend the survey median RVU of 18.00, which takes into account the shorter length of stay compared with the reference code 49566 plus the mesh add-on code for open repair 49568 (15.45 + 4.88=20.33). Additionally, the recommendation of 18.00 for 49653 correctly sets the RVUs for this code less than the recommendation for 49655 (20.00), which is essentially the same repair, but for a recurrent hernia that will require additional intra-operative time for what is typically more adhesiolysis and removal of adhered bowel from the hernia sac.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49659 Unlisted laparoscopy procedure, hernioplasty, herniorraphy, herniotomy

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

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

Specialty general surgery

How often? Commonly

Specialty colon and rectal surgery; vascular surgery;
plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology

How often? Rarely

Specialty

How often?

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

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

Please explain the rationale for this estimate. We are not able to estimate national frequency.

Specialty general surgery

Frequency

Percentage

%

Specialty colon and rectal surgery; vascular surgery;

plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology
 Percentage %

Frequency

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?
 1,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. Given that 49659 is an unlisted code, and as such, may incorporate a large
 variety of laparoscopic hernia repairs, it is difficult to estimate frequencies for F1-F6. However, it is likely that the
 distribution of the new codes will mirror the existing open codes. The Medicare frequency for 49659 is approximately
 10,000. The estimate for codes F1-F6 are based on the distribution of the open codes multiplied by the total frequency
 for 49659.

Specialty general surgery	Frequency 1450	Percentage 96.66 %
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Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	Frequency 50	Percentage 3.33 %
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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**

CPT Code: 49654 Tracking Number F3 Specialty Society Recommended RVU: **16.00**
Global Period: 090 RUC Recommended RVU: **14.95**

CPT Descriptor: Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old man with a prior laparotomy for a colectomy has developed a bulge in the midline incision. The defect has been increasing in size during follow-up. He has symptoms of pain and local tenderness. He has had no history of incarceration or bowel obstruction. On examination he is found to have a reducible incisional hernia. He is referred for laparoscopic repair.

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? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review preadmission work-up, with particular attention to imaging information and reports.
- Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P.
- Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products).
- Meet with patient and family to review planned procedure and post-operative management.
- Mark the palpable edge of the hernia defect(s) and sites of the proposed skin incisions with cooperation of patient.
- Review and obtain informed consent, including witness.
- Review length and type of anesthesia with anesthesiologist.
- Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment.
- Assist in transfer of patient from gurney to operating table.
- Monitor/assist with positioning of patient.
- Install or supervise installation of Foley catheter (if needed).
- Assist anesthesia team with line placement and induction of anesthesia and intubation.
- Indicate areas of skin to be prepped and mark surgical incisions.
- Scrub and gown.
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: If hernia contents are present they are gently reduced. Pneumoperitoneum is induced by open insertion of the first port (described below) or other appropriate technique. Starting at a distance from the hernia location, for open insertion the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed, incised and the peritoneum opened carefully under direct vision avoiding underlying bowel, omentum or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity to identify the pattern of adhesions is made prior to placing subsequent cannulae. With the camera viewing placement of each port, typically two more are positioned to allow two handed surgical technique, while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible

the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process adhesions may require sharp and/or blunt lysis to allow adequate exposure. There are several defects adjacent to each other containing suture loops from the first wound closure. Adhesions to the abdominal wall, between loops of bowel, and between bowel and other structures are meticulously lysed to free the entire anterior abdominal fascia. The hernia defects are identified and if necessary their contents reduced. An appropriate margin around the ensemble of defects to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament. Hemostasis is secured before continuing and a careful check of intestine that has been handled or freed by adhesiolysis is made to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The distribution of the defects is measured and an appropriate sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and once inside is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points is intended to achieve adequate overlap of flat lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples and other defects, with and without insufflation, and corrected as needed. The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defect of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate a dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Post-operative Work – Hospital:

- Apply sterile adhesive strips and dressings. Apply elastic binder to fix dressings and compress the hernia site. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s).
- Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.
- Examine patient, including reviewing vital signs and confirming as necessary.
- Auscultate heart, lungs, and abdomen for bowel sounds.
- Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection.
- Continue prophylaxis for DVT. Monitor daily for adequacy.
- Assess need for beta-blockers, order as required.
- Monitor and document patient progress.
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, films, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Answer patient and family questions. Answer nursing/other staff questions.
- Advance diet, as appropriate.
- Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy.
- Write prescriptions for medications needed post-discharge.
- Home restrictions (i.e., diet, activity, bathing) are discussed with the patient, family members and discharging nurse.
- The patient is discharged when there is return of bowel function, taking adequate nutrition, and adequate pain control with oral analgesics.

- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Postoperative Work – In Office:

- Examine and talk with patient.
- Remove staples or sutures, when appropriate.
- Review activity and restrictions.
- Monitor healing of incision with appropriate physical examination, including dealing with questions of patient and family.
- Check for presence of post-operative hematoma/seroma and assess need for aspiration. Arrange to return for review if necessary.
- Monitor diet caloric intake by weight.
- Answer patient/family questions.
- Write medication prescriptions.
- Post discharge labs/films are ordered and reviewed.
- Discuss progress with referring physician(s) (verbal and written).
- Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		09/2007				
Presenter(s):	Michael Edye, MD, FACS; Christopher K. Senkowski, MD, FACS; Guy R. Orangio, MD, FACS					
Specialty(s):	ACS; SAGES; ASCRS					
CPT Code:	49654					
Sample Size:	300	Resp N:	40	Response: 13.3 %		
Sample Type: Random						
		Low	25 th pctl	Median*	75 th pctl	High
Service Performance Rate		0.00	5.00	12.00	15.00	70.00
Survey RVW:		11.84	14.95	16.00	17.00	25.00
Pre-Service Evaluation Time:				45.0		
Pre-Service Positioning Time:				15.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		60.00	90.00	120.00	120.00	240.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	60.0	99231x 1.0	99232x 1.0	99233x 0.0		
Discharge Day Mgmt:	38.0	99238x 1.00	99239x 0.00			
Office time/visit(s):	39.0	99211x 0.0	12x 1.0	13x 1.0	14x 0.0 15x 0.0	
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49654	
	<u>Specialty Recommended</u>
Physician Work RVU:	
Pre-Service Evaluation Time:	
Pre-Service Positioning Time:	
Pre-Service Scrub, Dress, Wait Time:	
Intra-Service Time:	
Immediate Post Service-Time:	
<u>Post Operative Visits</u>	<u>Total Min**</u> <u>CPT Code and Number of Visits</u>
Critical Care time/visit(s):	<u>0.0</u> 99291x 99292x
Other Hospital time/visit(s):	<u>0.0</u> 99231x 99232x 99233x
Discharge Day Mgmt:	<u>0.0</u> 99238x 99239x
Office time/visit(s):	<u>0.0</u> 99211x 12x 13x 14x 15x
Prolonged Services:	<u>0.0</u> 99354x 55x 56x 57x

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
44180	090	15.19	RUC Time

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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 16 % of respondents: 40.0 %

TIME ESTIMATES (Median)

	CPT Code: 49654	Key Reference CPT Code: 44180	Source of Time RUC Time
Median Pre-Service Time	75.00	100.00	
Median Intra-Service Time	120.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	362.00	407.00	
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	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.06	3.00
Urgency of medical decision making	2.69	2.86

Technical Skill/Physical Effort (Mean)

Technical skill required	4.25	3.64
Physical effort required	4.13	3.93

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.57
Outcome depends on the skill and judgment of physician	4.56	4.21
Estimated risk of malpractice suit with poor outcome	4.44	4.21

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

Pre-Service intensity/complexity	3.31	3.31
Intra-Service intensity/complexity	3.94	3.69
Post-Service intensity/complexity	3.00	3.08

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.*

CPT approved a family of six codes for new - but well established - laparoscopic procedures for repair of abdominal wall hernias. These laparoscopic repairs are a significant technical departure from the open repairs for several reasons including the technical mechanics of performing the repair and the near universal placement of mesh prosthesis.

Laparoscopic repairs cannot be considered as simply laparoscopic equivalents for open repairs. All laparoscopic repairs are performed within the peritoneal cavity. Adhesiolysis is major part of each procedure and is typically extensive. In the open procedures, only enough abdominal wall for suture or mesh positioning would typically be exposed and in many circumstances entry into the peritoneal cavity would be avoided or limited. In the laparoscopic operation, since the laparoscope must be free to see the edges of the hernia defect, as well as have free areas for trocar / instrument placement, complete liberation of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement.

Mesh is usually placed behind the fascial and muscle layers of the abdominal wall, rather than on the surface of the muscle, as in the open setting. The mesh must be fixed securely in a circumferential pattern, to prevent displacement or herniation of viscera between mesh and muscle. Several methods to achieve fixation are available including staples, tacks and transfascial sutures that in and of themselves require specialized training for proper use. Although the net result is in a markedly decreased incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation to the sensitive peritoneal surface and they are prone to postoperative narcotics and postoperative ileus.

Finally, by avoiding an incision directly over the hernia, and fixing mesh behind the muscle containing the defect, the principal of the laparoscopic repair of an abdominal hernia is the same for all anatomic sites. For this reason a single code was formulated to include primary reducible umbilical, ventral and Spigelian hernia. In clinical practice, small hernias of these types are more commonly treated with open repair using mesh. Laparoscopic repair is typically reserved for larger hernias, general anesthesia is always required, and larger mesh is implanted.

F3 / 49654 Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); reducible

Ref 1 48180 Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)

Ref 2 49565 Repair recurrent incisional or ventral hernia; reducible

In comparison to the reference code, there is poor pre-service work correlation for 49654 (different disease processes), identical intra-operative time, two days shorter length of stay, and same post-op office visits. We recommend the survey median RVU of 16.00, which takes into account the shorter length of stay. Another and better comparison for total work would be 49565 plus the mesh add-on code for open repair 49568 (12.29 + 4.88=17.17).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
- Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)
- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
 - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
 - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
 - ☐ Multiple codes are used to maintain consistency with similar codes.
 - ☐ Historical precedents.
 - ☐ Other reason (please explain)
2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49659 Unlisted laparoscopy procedure, hernioplasty, herniorraphy, herniotomy

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

Specialty general surgery	How often? Commonly
Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	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?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We are not able to estimate national frequency.

Specialty general surgery	Frequency	Percentage	%
Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	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?
 2,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. Given that 49659 is an unlisted code, and as such, may incorporate a large
 variety of laparoscopic hernia repairs, it is difficult to estimate frequencies for F1-F6. However, it is likely that the
 distribution of the new codes will mirror the existing open codes. The Medicare frequency for 49659 is approximately
 10,000. The estimate for codes F1-F6 are based on the distribution of the open codes multiplied by the total frequency
 for 49659.

Specialty general surgery	Frequency 1900	Percentage 95.00 %
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Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	Frequency 100	Percentage 5.00 %
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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? 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: 49655 Tracking Number F4 Specialty Society Recommended RVU: **20.00**
 Global Period: 090 RUC Recommended RVU: **18.00**

CPT Descriptor: Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old man has a surgical history of a partial gastrectomy for ulcer disease. He has developed an incisional hernia in the midline incision. Over the past few months, it has become chronically protuberant. He reports increasing pain and discomfort associated with it. He has had episodes of worsening distention and occasionally vomiting with the episodes of pain. He is not able to reduce the hernia even when lying down. He is referred for laparoscopic repair.

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:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review preadmission work-up, with particular attention to imaging information and reports.
- Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P.
- Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products).
- Meet with patient and family to review planned procedure and post-operative management.
- Mark the palpable edge of the hernia defect(s) and sites of the proposed skin incisions with cooperation of patient.
- Review and obtain informed consent, including witness.
- Review length and type of anesthesia with anesthesiologist.
- Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment.
- Assist in transfer of patient from gurney to operating table.
- Monitor/assist with positioning of patient.
- Install or supervise installation of Foley catheter (if needed).
- Assist anesthesia team with line placement and induction of anesthesia and intubation.
- Indicate areas of skin to be prepped and mark surgical incisions.
- Scrub and gown.
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: If hernia contents are present they are gently reduced if possible. Pneumoperitoneum is induced by open insertion of the first port (described below) or other appropriate technique. Starting at a distance from the hernia location, for open insertion the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed, incised and the peritoneum opened carefully under direct vision avoiding underlying bowel, omentum or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity to identify the pattern of adhesions is made prior to placing subsequent cannulae. There are many adhesions to the anterior abdominal wall involving the small and large intestine.

The hernia contains both omentum and multiple loops of small bowel. The small bowel entering the hernia appears chronically dilated; the loops leaving are flat and decompressed. With the camera viewing placement of each port, typically two more are positioned to allow two handed surgical technique, while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process adhesions may require sharp and/or blunt lysis to allow adequate exposure. The hernia defect or defects are identified and if necessary the contents are reduced. Adhesions to the hernia(s), abdominal wall, between loops of bowel, and between bowel and other structures are slowly and meticulously lysed to free the entire anterior abdominal fascia. An appropriate margin around the defect(s) to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament or adjacent colon. Hemostasis is secured before continuing and a careful check of intestine that has been handled or freed by adhesiolysis is made to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The size/distribution of the defects is measured and an appropriate sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and once inside is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points is intended to achieve adequate overlap of flat lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect(s) may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples and other defects, with and without insufflation, and corrected as needed. The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defect of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate a dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Post-operative Work – Hospital:

- Apply sterile adhesive strips and dressings. Apply elastic binder to fix dressings and compress the hernia site. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s).
- Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.
- Examine patient, including reviewing vital signs and confirming as necessary.
- Auscultate heart, lungs, and abdomen for bowel sounds.
- Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection.
- Continue prophylaxis for DVT. Monitor daily for adequacy.
- Assess need for beta-blockers, order as required.
- Monitor and document patient progress.
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, films, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Answer patient and family questions. Answer nursing/other staff questions.
- Advance diet, as appropriate.
- Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy.
- Write prescriptions for medications needed post-discharge.

- Home restrictions (i.e., diet, activity, bathing) are discussed with the patient, family members and discharging nurse.
- The patient is discharged when there is return of bowel function, taking adequate nutrition, and adequate pain control with oral analgesics.
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Postoperative Work – In Office:

- Examine and talk with patient.
- Remove staples or sutures, when appropriate.
- Review activity and restrictions.
- Monitor healing of incision with appropriate physical examination, including dealing with questions of patient and family.
- Check for presence of post-operative hematoma/seroma and assess need for aspiration. Arrange to return for review if necessary.
- Monitor diet caloric intake by weight.
- Answer patient/family questions.
- Write medication prescriptions.
- Post discharge labs/films are ordered and reviewed.
- Discuss progress with referring physician(s) (verbal and written).
- Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		09/2007				
Presenter(s):	Michael Edey, MD, FACS; Christopher K. Senkowski, MD, FACS; Guy R. Orangio, MD, FACS					
Specialty(s):	ACS; SAGES; ASCRS					
CPT Code:	49655					
Sample Size:	300	Resp N:	40	Response: 13.3 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	3.00	8.00	12.00	25.00
Survey RVW:		16.00	17.40	20.00	22.00	30.00
Pre-Service Evaluation Time:				50.0		
Pre-Service Positioning Time:				15.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		90.00	120.00	150.00	180.00	250.00
Immediate Post Service-Time:		30.00				
Post Operative Visits		Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):		0.0	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):		60.0	99231x 1.0	99232x 1.0	99233x 0.0	
Discharge Day Mgmt:		38.0	99238x 1.00	99239x 0.00		
Office time/visit(s):		55.0	99211x 0.0	12x 2.0	13x 1.0	14x 0.0 15x 0.0
Prolonged Services:		0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23), 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49655	
	<u>Specialty Recommended</u>
Physician Work RVU:	
Pre-Service Evaluation Time:	
Pre-Service Positioning Time:	
Pre-Service Scrub, Dress, Wait Time:	
Intra-Service Time:	
Immediate Post Service-Time:	_____
Post Operative Visits	Total Min** CPT Code and Number of Visits
Critical Care time/visit(s):	<u>0.0</u> 99291x 99292x
Other Hospital time/visit(s):	<u>0.0</u> 99231x 99232x 99233x
Discharge Day Mgmt:	<u>0.0</u> 99238x 99239x
Office time/visit(s):	<u>0.0</u> 99211x 12x 13x 14x 15x
Prolonged Services:	<u>0.0</u> 99354x 55x 56x 57x

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49566	090	15.45	RUC Time

CPT Descriptor Repair recurrent incisional or ventral hernia; incarcerated or strangulated

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 16 **% of respondents:** 40.0 %

TIME ESTIMATES (Median)

	CPT Code: 49655	Key Reference CPT Code: 49566	Source of Time RUC Time
Median Pre-Service Time	80.00	45.00	
Median Intra-Service Time	150.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	55.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	413.00	372.00	
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	3.54
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	3.85
Urgency of medical decision making	3.81	3.77

Technical Skill/Physical Effort (Mean)

Technical skill required	4.56	4.08
Physical effort required	4.06	3.85

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.38	4.23
Outcome depends on the skill and judgment of physician	4.44	4.08
Estimated risk of malpractice suit with poor outcome	4.31	4.00

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

Pre-Service intensity/complexity	3.56	3.85
Intra-Service intensity/complexity	4.31	3.92
Post-Service intensity/complexity	3.06	3.23

Additional Rationale

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

CPT approved a family of six codes for new - but well established - laparoscopic procedures for repair of abdominal wall hernias. These laparoscopic repairs are a significant technical departure from the open repairs for several reasons including the technical mechanics of performing the repair and the near universal placement of mesh prosthesis.

Laparoscopic repairs cannot be considered as simply laparoscopic equivalents for open repairs. All laparoscopic repairs are performed within the peritoneal cavity. Adhesiolysis is major part of each procedure and is typically extensive. In the open procedures, only enough abdominal wall for suture or mesh positioning would typically be exposed and in many circumstances entry into the peritoneal cavity would be avoided or limited. In the laparoscopic operation, since the laparoscope must be free to see the edges of the hernia defect, as well as have free areas for trocar / instrument placement, complete liberation of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement.

Mesh is usually placed behind the fascial and muscle layers of the abdominal wall, rather than on the surface of the muscle, as in the open setting. The mesh must be fixed securely in a circumferential pattern, to prevent displacement or herniation of viscera between mesh and muscle. Several methods to achieve fixation are available including staples, tacks and transfascial sutures that in and of themselves require specialized training for proper use. Although the net result is in a markedly decreased incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation to the sensitive peritoneal surface and they are prone to postoperative narcotics and postoperative ileus.

Finally, by avoiding an incision directly over the hernia, and fixing mesh behind the muscle containing the defect, the principal of the laparoscopic repair of an abdominal hernia is the same for all anatomic sites. For this reason a single code was formulated to include primary reducible umbilical, ventral and Spigelian hernia. In clinical practice, small hernias of these types are more commonly treated with open repair using mesh. Laparoscopic repair is typically reserved for larger hernias, general anesthesia is always required, and larger mesh is implanted.

F4 / 49655 Repair recurrent incisional or ventral hernia; incarcerated or strangulated**Ref 49566 Repair recurrent incisional or ventral hernia; incarcerated or strangulated**

In comparison to the reference code, 496X3 requires similar pre-service work, 30 minutes more intra-operative time, on day less length of stay, and one extra post-op office visit. We recommend the survey

median RVU of 20.00, which takes into account longer and more difficult intraoperative work and shorter length of stay. This value is very similar to the sum of RVUs for the reference code 49566 plus the mesh add-on code for open repair 49568 ($15.45 + 4.88 = 20.33$).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49659 Unlisted laparoscopy procedure, hernioplasty, herniorraphy, herniotomy

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

Specialty general surgery How often? Commonly

Specialty colon and rectal surgery; vascular surgery;
plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology • How often? Rarely

Specialty How often?

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

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We are not able to estimate national frequency.

Specialty general surgery	Frequency	Percentage	%
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Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	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? 700

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Given that 49659 is an unlisted code, and as such, may incorporate a large variety of laparoscopic hernia repairs, it is difficult to estimate frequencies for F1-F6. However, it is likely that the distribution of the new codes will mirror the existing open codes. The Medicare frequency for 49659 is approximately 10,000. The estimate for codes F1-F6 are based on the distribution of the open codes multiplied by the total frequency for 49659.

Specialty general surgery	Frequency 675	Percentage 96.42 %
Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	Frequency 25	Percentage 3.57 %

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

CPT Descriptor: Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old woman has a surgical history of an open cholecystectomy 20 years ago. She developed an incisional hernia. She underwent a surgical repair of that hernia 10 years ago for increasing size and symptoms. That repair was performed as laparotomy with implantation of a synthetic mesh as an in-lay for closure. The patient has developed a recurrence of the hernia with new defects of varying sizes at multiple points around the margins of the in-lay mesh. She has symptoms of pain and tenderness at the sites. She is referred for laparoscopic repair of a recurrent Incisional hernia.

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? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review preadmission work-up, with particular attention to imaging information and reports.
- Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P.
- Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products).
- Meet with patient and family to review planned procedure and post-operative management.
- Mark the palpable edge of the hernia defect(s) and sites of the proposed skin incisions with cooperation of patient.
- Review and obtain informed consent, including witness.
- Review length and type of anesthesia with anesthesiologist.
- Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment.
- Assist in transfer of patient from gurney to operating table.
- Monitor/assist with positioning of patient.
- Install or supervise installation of Foley catheter (if needed).
- Assist anesthesia team with line placement and induction of anesthesia and intubation.
- Indicate areas of skin to be prepped and mark surgical incisions.
- Scrub and gown.
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: If hernia contents are present they are gently reduced. Pneumoperitoneum is induced by open insertion of the first port (described below) or other appropriate technique. Starting at a distance from the hernia location, for open insertion the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed, incised and the peritoneum opened carefully under direct vision avoiding underlying bowel, omentum or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity to identify the pattern of adhesions is made prior to placing

subsequent cannulae. Extensive adhesions of varying thickness and vascularity are found to the anterior abdominal wall and especially to the mesh in-lay. These involve the omentum, stomach, small and large intestine. With the camera viewing placement of each port, typically two more are positioned to allow two handed surgical technique, while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process adhesions may require sharp and/or blunt lysis to allow adequate exposure. The hernia defects are identified and if necessary the contents are reduced. Adhesions to the hernias, abdominal wall, between loops of bowel, and between bowel and other structures are meticulously lysed to free the entire anterior abdominal fascia. An appropriate margin around the defects to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament or adjacent colon. Hemostasis is secured before continuing and a careful check of intestine that has been handled or freed by adhesiolysis is made to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The size of the defect is measured and an appropriate sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and once inside is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points is intended to achieve adequate overlap of flat lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples and other defects, with and without insufflation, and corrected as needed. The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defect of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate a dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Post-operative Work – Hospital:

- Apply sterile adhesive strips and dressings. Apply elastic binder to fix dressings and compress the hernia site. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s).

- Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.
- Examine patient, including reviewing vital signs and confirming as necessary.
- Auscultate heart, lungs, and abdomen for bowel sounds.
- Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection.
- Continue prophylaxis for DVT. Monitor daily for adequacy.
- Assess need for beta-blockers, order as required.
- Monitor and document patient progress.
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, films, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Answer patient and family questions. Answer nursing/other staff questions.
- Advance diet, as appropriate.
- Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy.
- Write prescriptions for medications needed post-discharge.
- Home restrictions (i.e., diet, activity, bathing) are discussed with the patient, family members and discharging nurse.

- The patient is discharged when there is return of bowel function, taking adequate nutrition, and adequate pain control with oral analgesics.
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Postoperative Work – In Office:

- Examine and talk with patient.
- Remove staples or sutures, when appropriate.
- Review activity and restrictions.
- Monitor healing of incision with appropriate physical examination, including dealing with questions of patient and family.
- Check for presence of post-operative hematoma/seroma and assess need for aspiration. Arrange to return for review if necessary.
- Monitor diet caloric intake by weight.
- Answer patient/family questions.
- Write medication prescriptions.
- Post discharge labs/films are ordered and reviewed.
- Discuss progress with referring physician(s) (verbal and written).
- Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		09/2007				
Presenter(s):	Michael Edye, MD, FACS; Christopher K. Senkowski, MD, FACS; Guy R. Orangio, MD, FACS					
Specialty(s):	ACS; SAGES; ASCRS					
CPT Code:	49656					
Sample Size:	300	Resp N:	52	Response: 17.3 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	4.00	10.00	20.00	80.00
Survey RVW:		13.00	15.00	17.25	20.00	30.00
Pre-Service Evaluation Time:				45.0		
Pre-Service Positioning Time:				15.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		80.00	90.00	120.00	150.00	210.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	60.0	99231x 1.0	99232x 1.0	99233x 0.0		
Discharge Day Mgmt:	38.0	99238x 1.00	99239x 0.00			
Office time/visit(s):	39.0	99211x 0.0	12x 1.0	13x 1.0	14x 0.0	15x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49656			
		Specialty Recommended	
Physician Work RVU:			
Pre-Service Evaluation Time:			
Pre-Service Positioning Time:			
Pre-Service Scrub, Dress, Wait Time:			
Intra-Service Time:			
Immediate Post Service-Time:	_____		
Post Operative Visits	Total Min**	CPT Code and Number of Visits	
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x 99233x
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x
Office time/visit(s):	<u>0.0</u>	99211x	12x 13x 14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x 56x 57x

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49565	090	12.29	RUC Time

CPT Descriptor Repair recurrent incisional or ventral hernia; reducible

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 44.2 %

TIME ESTIMATES (Median)

	CPT Code: 49656	Key Reference CPT Code: 49565	Source of Time RUC Time
Median Pre-Service Time	75.00	45.00	
Median Intra-Service Time	120.00	100.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	90.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	362.00	342.00	
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	2.65	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	3.00
Urgency of medical decision making	2.61	2.53

Technical Skill/Physical Effort (Mean)

Technical skill required	4.09	3.21
Physical effort required	3.65	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.57	3.05
Outcome depends on the skill and judgment of physician	4.17	3.42
Estimated risk of malpractice suit with poor outcome	4.09	3.42

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

Pre-Service intensity/complexity	2.86	2.56
Intra-Service intensity/complexity	3.68	3.00
Post-Service intensity/complexity	2.64	2.44

Additional Rationale

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

CPT approved a family of six codes for new - but well established - laparoscopic procedures for repair of abdominal wall hernias. These laparoscopic repairs are a significant technical departure from the open repairs for several reasons including the technical mechanics of performing the repair and the near universal placement of mesh prosthesis.

Laparoscopic repairs cannot be considered as simply laparoscopic equivalents for open repairs. All laparoscopic repairs are performed within the peritoneal cavity. Adhesiolysis is major part of each procedure and is typically extensive. In the open procedures, only enough abdominal wall for suture or mesh positioning would typically be exposed and in many circumstances entry into the peritoneal cavity would be avoided or limited. In the laparoscopic operation, since the laparoscope must be free to see the edges of the hernia defect, as well as have free areas for trocar / instrument placement, complete liberation of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement.

Mesh is usually placed behind the fascial and muscle layers of the abdominal wall, rather than on the surface of the muscle, as in the open setting. The mesh must be fixed securely in a circumferential pattern, to prevent displacement or herniation of viscera between mesh and muscle. Several methods to achieve fixation are available including staples, tacks and transfascial sutures that in and of themselves require specialized training for proper use. Although the net result is in a markedly decreased incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation to the sensitive peritoneal surface and they are prone to postoperative narcotics and postoperative ileus.

Finally, by avoiding an incision directly over the hernia, and fixing mesh behind the muscle containing the defect, the principal of the laparoscopic repair of an abdominal hernia is the same for all anatomic sites. For this reason a single code was formulated to include primary reducible umbilical, ventral and Spigelian hernia. In clinical practice, small hernias of these types are more commonly treated with open repair using mesh. Laparoscopic repair is typically reserved for larger hernias, general anesthesia is always required, and larger mesh is implanted.

F5 / 49656 Repair recurrent incisional or ventral hernia; reducible**Ref 49565 Repair recurrent incisional or ventral hernia; reducible**

In comparison to the reference code, 496X4 requires similar pre-service work, 20 minutes more intra-operative time, same length of stay and post-op office visits. We recommend the survey median RVU of

17.25, which is only slightly greater than the sum of RVUs for the reference code 49565 plus the mesh add-on code for open repair 49568 (12.29 + 4.88=17.17).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49659 Unlisted laparoscopy procedure, hernioplasty, herniorraphy, herniotomy

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

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

Specialty general surgery

How often? Commonly

Specialty colon and rectal surgery; vascular surgery;
plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology

How often? Rarely

Specialty

How often?

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

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

Please explain the rationale for this estimate. We are not able to estimate national frequency.

Specialty general surgery	Frequency	Percentage	%
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Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	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?
 1,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. Given that 49659 is an unlisted code, and as such, may incorporate a large
 variety of laparoscopic hernia repairs, it is difficult to estimate frequencies for F1-F6. However, it is likely that the
 distribution of the new codes will mirror the existing open codes. The Medicare frequency for 49659 is approximately
 10,000. The estimate for codes F1-F6 are based on the distribution of the open codes multiplied by the total frequency
 for 49659.

Specialty general surgery	Frequency 950	Percentage 95.00 %
Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	Frequency 50	Percentage 5.00 %

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

CPT Code: 49657 Tracking Number F6 Specialty Society Recommended RVU: **22.00**
 Global Period: 090 RUC Recommended RVU: **22.00**

CPT Descriptor: Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old man presents with an irreducible mass in the midline of the abdomen. He has a history of a laparotomy for repair of perforated gastric ulcer in the distant past. He had an incisional hernia from that operation which was repaired electively with a mesh 5 years ago. He developed a recurrence from that repair which was being observed. Over the course of the last few months, it has been slowly increasing in size. It is now irreducible and tender. He is referred for laparoscopic repair of an incarcerated recurrent incisional hernia.

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:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review preadmission work-up, with particular attention to imaging information and reports.
- Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P.
- Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products).
- Meet with patient and family to review planned procedure and post-operative management.
- Mark the palpable edge of the hernia defect(s) and sites of the proposed skin incisions with cooperation of patient.
- Review and obtain informed consent, including witness.
- Review length and type of anesthesia with anesthesiologist.
- Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment.
- Assist in transfer of patient from gurney to operating table.
- Monitor/assist with positioning of patient.
- Install or supervise installation of Foley catheter (if needed).
- Assist anesthesia team with line placement and induction of anesthesia and intubation.
- Indicate areas of skin to be prepped and mark surgical incisions.
- Scrub and gown.
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: If hernia contents are present they are gently reduced if possible. Pneumoperitoneum is induced by open insertion of the first port (described below) or other appropriate technique. Starting at a distance from the hernia location, for open insertion the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed, incised and the peritoneum opened carefully under direct vision avoiding underlying bowel, omentum or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity to identify the pattern of adhesions is made prior to placing subsequent cannulae. With the camera viewing placement of each port, typically two more are positioned to allow two

handed surgical technique, while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. There are many adhesions to the anterior abdominal wall from the small and large intestine. The hernia contains multiple loops of small bowel with adhesions from the intestine to the prior mesh inlay. There are also adhesions from the omentum and colon to the exposed areas of mesh. Careful adhesiolysis proceeds very slowly to fully expose the hernia defect and the incarcerated contents. The viscera are gently reduced with a combination of intra-abdominal traction and extra-abdominal pressure. The area of recurrence is dissected free, and all the intra-abdominal adhesions are taken down to allow for deployment of a new mesh. After all the contents are reduced, careful inspection of the entire small and large bowel is performed to assess for any injury. Hemostasis is secured before continuing and a careful check of intestine that has been handled or freed by adhesiolysis is made to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The size of the defect is measured and an appropriate sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and once inside is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points is intended to achieve adequate overlap of flat lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples and other defects, with and without insufflation, and corrected as needed. The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defect of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate a dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Post-operative Work – Hospital:

- Apply sterile adhesive strips and dressings. Apply elastic binder to fix dressings and compress the hernia site. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s).
- Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.
- Examine patient, including reviewing vital signs and confirming as necessary.
- Auscultate heart, lungs, and abdomen for bowel sounds.
- Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection.
- Continue prophylaxis for DVT. Monitor daily for adequacy.
- Assess need for beta-blockers, order as required.
- Monitor and document patient progress.
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, films, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Answer patient and family questions. Answer nursing/other staff questions.
- Advance diet, as appropriate.
- Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy.
- Write prescriptions for medications needed post-discharge.
- Home restrictions (i.e., diet, activity, bathing) are discussed with the patient, family members and discharging nurse.

- The patient is discharged when there is return of bowel function, taking adequate nutrition, and adequate pain control with oral analgesics.
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Postoperative Work – In Office:

- Examine and talk with patient.
- Remove staples or sutures, when appropriate.
- Review activity and restrictions.
- Monitor healing of incision with appropriate physical examination, including dealing with questions of patient and family.
- Check for presence of post-operative hematoma/seroma and assess need for aspiration. Arrange to return for review if necessary.
- Monitor diet caloric intake by weight.
- Answer patient/family questions.
- Write medication prescriptions.
- Post discharge labs/films are ordered and reviewed.
- Discuss progress with referring physician(s) (verbal and written).
- Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		09/2007				
Presenter(s):	Michael Edye, MD, FACS; Christopher K. Senkowski, MD, FACS; Guy R. Orangio, MD, FACS					
Specialty(s):	ACS, SAGES; ASCRS					
CPT Code:	49657					
Sample Size:	300	Resp N:	52	Response: 17 3 %		
Sample Type: Random						
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	2.00	5.00	10.00	50.00
Survey RVW:		16.00	18.00	22.00	25.00	45.00
Pre-Service Evaluation Time:				60.0		
Pre-Service Positioning Time:				15.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		110.00	135.00	180.00	180.00	300.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0				
Other Hospital time/visit(s):	100.0	99231x 1.0 99232x 2.0 99233x 0.0				
Discharge Day Mgmt:	38.0	99238x 1.00 99239x 0.00				
Office time/visit(s):	55.0	99211x 0.0 12x 2.0 13x 1.0 14x 0.0 15x 0.0				
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49657	
	<u>Specialty Recommended</u>
Physician Work RVU:	
Pre-Service Evaluation Time:	
Pre-Service Positioning Time:	
Pre-Service Scrub, Dress, Wait Time:	
Intra-Service Time:	
Immediate Post Service-Time:	_____
Post Operative Visits	Total Min** CPT Code and Number of Visits
Critical Care time/visit(s):	<u>0.0</u> 99291x 99292x
Other Hospital time/visit(s):	<u>0.0</u> 99231x 99232x 99233x
Discharge Day Mgmt:	<u>0.0</u> 99238x 99239x
Office time/visit(s):	<u>0.0</u> 99211x 12x 13x 14x 15x
Prolonged Services:	<u>0.0</u> 99354x 55x 56x 57x

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49566	090	15.45	RUC Time

CPT Descriptor Repair recurrent incisional or ventral hernia; incarcerated or strangulated

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 69.2 %

TIME ESTIMATES (Median)

	CPT Code: 49657	Key Reference CPT Code: 49566	Source of Time RUC Time
Median Pre-Service Time	90.00	45.00	
Median Intra-Service Time	180.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	55.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	493.00	372.00	
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	3.28	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.45
Urgency of medical decision making	3.86	3.79

Technical Skill/Physical Effort (Mean)

Technical skill required	4.61	3.79
Physical effort required	4.14	3.59

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.39	3.69
Outcome depends on the skill and judgment of physician	4.53	3.83
Estimated risk of malpractice suit with poor outcome	4.42	3.55

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

Pre-Service intensity/complexity	3.71	3.39
Intra-Service intensity/complexity	4.54	3.75
Post-Service intensity/complexity	3.06	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.*

CPT approved a family of six codes for new - but well established - laparoscopic procedures for repair of abdominal wall hernias. These laparoscopic repairs are a significant technical departure from the open repairs for several reasons including the technical mechanics of performing the repair and the near universal placement of mesh prosthesis.

Laparoscopic repairs cannot be considered as simply laparoscopic equivalents for open repairs. All laparoscopic repairs are performed within the peritoneal cavity. Adhesiolysis is major part of each procedure and is typically extensive. In the open procedures, only enough abdominal wall for suture or mesh positioning would typically be exposed and in many circumstances entry into the peritoneal cavity would be avoided or limited. In the laparoscopic operation, since the laparoscope must be free to see the edges of the hernia defect, as well as have free areas for trocar / instrument placement, complete liberation of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement.

Mesh is usually placed behind the fascial and muscle layers of the abdominal wall, rather than on the surface of the muscle, as in the open setting. The mesh must be fixed securely in a circumferential pattern, to prevent displacement or herniation of viscera between mesh and muscle. Several methods to achieve fixation are available including staples, tacks and transfascial sutures that in and of themselves require specialized training for proper use. Although the net result is in a markedly decreased incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation to the sensitive peritoneal surface and they are prone to postoperative narcotics and postoperative ileus.

Finally, by avoiding an incision directly over the hernia, and fixing mesh behind the muscle containing the defect, the principal of the laparoscopic repair of an abdominal hernia is the same for all anatomic sites. For this reason a single code was formulated to include primary reducible umbilical, ventral and Spigelian hernia. In clinical practice, small hernias of these types are more commonly treated with open repair using mesh. Laparoscopic repair is typically reserved for larger hernias, general anesthesia is always required, and larger mesh is implanted.

F6 / 49657 Repair recurrent incisional or ventral hernia; incarcerated or strangulated**Ref 49566 Repair recurrent incisional or ventral hernia; incarcerated or strangulated**

In comparison to the reference code, 496X5 requires similar pre-service work, 60 minutes more intra-operative time, same length of stay, and one extra post-op office visit. We recommend the survey median

RVU of 22.00, which takes into account longer and more difficult intraoperative work and is only slightly greater than the sum of RVUs for the reference code 49566 plus the mesh add-on code for open repair 49568 (15.45 + 4.88=20.33).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49659 Unlisted laparoscopy procedure, hernioplasty, herniorraphy, herniotomy

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

Specialty general surgery How often? Commonly

Specialty colon and rectal surgery; vascular surgery;
plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology How often? Rarely

Specialty How often?

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

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We are not able to estimate national frequency.

Specialty general surgery	Frequency	Percentage	%
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Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	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? 500

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Given that 49659 is an unlisted code, and as such, may incorporate a large variety of laparoscopic hernia repairs, it is difficult to estimate frequencies for F1-F6. However, it is likely that the distribution of the new codes will mirror the existing open codes. The Medicare frequency for 49659 is approximately 10,000. The estimate for codes F1-F6 are based on the distribution of the open codes multiplied by the total frequency for 49659.

Specialty general surgery	Frequency 475	Percentage 95.00 %
Specialty colon and rectal surgery; vascular surgery; plastic surgery; cardiothoracic surgery; urology; obstetrics/gynecology	Frequency 25	Percentage 5.00 %

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 Update Process
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs**

CPT Long Descriptor:

F1	49652	Laparoscopy, surgical repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
F2	49653	Laparoscopy, surgical repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated
F3	49654	Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); reducible
F4	49655	Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated
F5	49656	Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); reducible
F6	49657	Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated

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 surgeons representing general surgery and colon and rectal surgery reviewed the practice expense details for the survey codes relative to other facility-only 90-day global services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

The standard 12 minutes has been applied for these inpatient procedures for discharge day management services.

Post-Service Clinical Labor Activities:

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

Supplies and Equipment:

Post-surgical supplies and equipment necessary for post-discharge surgical care have been indicated.

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation			F1		F2		F3	
2				49652		49653		49654	
3	Meeting Date: September 2007 RUC Recommendation			Laparoscopy, surgical repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible		Laparoscopy, surgical repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated		Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); reducible	
4	LOCATION	Code	Staff Type	NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			N/A	90	N/A	90	N/A	90
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	135	N/A	162	N/A	135
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60	N/A	60	N/A	60
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12	N/A	12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	63	N/A	90	N/A	63
10	PRE-SERVICE								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7
18	End: When patient enters office/facility for surgery/procedure								
19	SERVICE PERIOD								
20	Start: When patient enters office/facility for surgery/procedure								
40	Discharge day management 99238 --12 minutes 99239 --15 minutes	L037D	RN/LPN/MTA		12		12		12
41	Other Clinical Activity (please specify)								
42	End: Patient leaves office/FACILITY								
43	POST-SERVICE Period								
44	Start: Patient leaves office/facility								
45	Conduct phone calls/call in prescriptions								
47	List Number and Level of Office Visits								
48	99211 16 minutes		16						
49	99212 27 minutes	L037D	27		1		2		1
50	99213 36 minutes	L037D	36		1		1		1
51	99214 53 minutes		53						
52	99215 63 minutes		63						
53	Other								
54									
55	Total Office Visit Time			0	63	0	90	0	63
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		2		3		2
60	pack, post-op incision care (suture & staple)	SA053	kit		1		1		1
61									
62									
63	Equipment		CMS Code	Utilization Percentage					
64	table, power	EF031	100%		63		99		63
65	light, exam	EQ168	100%		63		99		63

	A	B	C	J	K	L	M	N	O
1	AMA/Specialty Society RVS Update Committee Recommendation			F4		F5		F6	
2				49655		49656		49657	
3	Meeting Date: September 2007 RUC Recommendation			Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated		Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); reducible		Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	
4	LOCATION	Code	Staff Type	NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			N/A	90	N/A	90	N/A	90
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	162	N/A	135	N/A	162
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60	N/A	60	N/A	60
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12	N/A	12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	90	N/A	63	N/A	90
10	PRE-SERVICE								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7
18	End: When patient enters office/facility for surgery/procedure								
19	SERVICE PERIOD								
20	Start: When patient enters office/facility for surgery/procedure								
40	Discharge day management 99238 –12 minutes 99239 –15 minutes	L037D	RN/LPN/MTA		12		12		12
41	Other Clinical Activity (please specify)								
42	End: Patient leaves office/FACILITY								
43	POST-SERVICE Period								
44	Start: Patient leaves office/facility								
45	Conduct phone calls/call in prescriptions								
47	List Number and Level of Office Visits								
48	99211 16 minutes		16						
49	99212 27 minutes	L037D	27		2		1		2
50	99213 36 minutes	L037D	36		1		1		1
51	99214 53 minutes		53						
52	99215 63 minutes		63						
53	Other								
54									
55	Total Office Visit Time			0	90	0	63	0	90
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		3		2		3
60	pack, post-op incision care (suture & staple)	SA053	kit		1		1		1
61									
62									
63	Equipment	CMS Code	Utilization Percentage						
64	table, power	EF031	100%		99		63		99
65	light, exam	EQ168	100%		99		63		99

AMA/Specialty Society RVS Update RUC
Summary of Recommendations

April 2008

Saturation Biopsies

In February 2008, the CPT Editorial Panel transitioned a Category III code (0137T) to a Category I code to capture the increasing utilization of transperineal stereotactic template guided saturation sampling of the prostate. CMS has indicated that they pathology reporting of speciime review still needs to be addressed through the CPT Editorial Board.

The RUC reviewed the specialty society survey results for code 55706 *Biopsies, prostate; needle, transperineal, stereotactic template guided saturation sampling including image guidance* and determined that the survey respondents overestimated the pre-service physician time required. The specialty society and the RUC determined that pre-service package 3 – straightforward patient/difficult procedure with an additional 2 minutes for specific positioning was appropriate. The RUC recommends 33 minutes pre-evaluation time, 5 minutes pre-positioning time and 15 minutes scrub, dress and wait time, totaling 53 minutes.

The survey respondents indicated that the intra-service time is 35 minutes. However, the respondents may have inappropriately allocated the intra-service time under the pre-service time. The RUC agreed with the specialty society recommended intra-service time of 45 minutes. The RUC determined 45 minutes was appropriate because typically 35-60 biopsies are performed to be sure cores are taken at intervals through the template grid. Additionally, each time the biopsy needle is reintroduced through the biopsy template sagittal and transverse ultrasound images are taken to insure precise localization of the biopsy needle. The RUC recommends 45 minutes intra-service time and the survey immediate post-service time of 15 minutes.

The RUC discussed the physician work required to perform 55706 and determined to use a building block approach as this service is a combination of the following: half the work RVU of 51702 *Insertion of temporary indwelling bladder catheter; simple (eg, Foley)* (work RVU = $0.50/2 = 0.25$), half the work RVU 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (work RVU = $0.67/2=0.34$), 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* (work RVU = 2.58), 99213 *Office visit* (work RVU = 0.92) and 99214 *Office visit* (Work RVU = 1.42) and a half day discharge day 99238 (work RVU = 0.64) to arrive at the appropriate work RVU of 6.15 ($0.25+0.34+2.58+0.64+0.92+1.42 = 6.15$). The RUC determined a 99214 was appropriate because of the severity of the problems these patients are presenting post-procedure. These patients have typically had 2-3 biopsies before this procedure, are anxious and

require a high level visit. The RUC also compared 55706 to code 49322 *Laparoscopy, surgical; with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)* (work RVU=5.96, pre-service time 45 minutes, intra-service time 45 minutes, immediate post-service 20 minutes and 1-99213). **The RUC recommends a work RVU of 6.15 for 55706.**

Building Block:

CPT Code			RVU
51702 (RVU=0.50)	Insertion of temporary indwelling bladder catheter; simple (eg, Foley)	Half the RVU	0.25
76942 (RVU=0.67)	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Half the RVU	0.34
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	1	2.58
99238 (RVU=1.28)	Hospital discharge day management	Half of a discharge day	0.64
99213	Evaluation and management of established patient, level 3, 15 minutes face-to-face	1	0.92
99214	Evaluation and management of established patient, level 4, 25 minutes face-to-face	1	1.42
		Total RVU =	6.15

Practice Expense

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

New Technology

The RUC recommends that code 55706 be added to the new technology list.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
55700		<p>Biopsy, prostate; needle or punch, single or multiple, any approach</p> <p>(For prostate needle biopsy saturation sampling for prostate mapping, use Category III code 0137T)</p> <p>(If imaging guidance is performed, use 76942)</p> <p>(For fine needle aspiration, see 10021, 10022)</p> <p>(For evaluation of fine needle aspirate, see 88172, 88173)</p> <p>(For transperineal stereotactic template guided saturation prostate biopsies, use 55706)</p>	000	<p>2.58</p> <p>(No Change)</p>
●55706	Y1	<p>Biopsies, prostate; needle, transperineal, stereotactic template guided saturation sampling including image guidance</p> <p>(Do not report 55706 in conjunction with 55700)</p>	010	6.15
D 0137T		<p>Biopsy, prostate, needle, saturation sampling for prostate mapping</p> <p>(Code 0137T has been deleted. For transperineal stereotactic template guided saturation prostate biopsies , use 55706)</p>		N/A

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

CPT Code: 55706 Tracking Number Y1

Specialty Society Recommended RVU: **6.25**

Global Period: 010

RUC Recommended RVU: **6.15**

CPT Descriptor: Biopsies, prostate; needle, transperineal, stereotactic template guided saturation sampling including image guidance

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old male previously presented four months ago with a PSA of 5.8 and a normal digital rectal exam. At that time, he underwent a standard 12 core transrectal biopsy which revealed high-grade prostatic intraepithelial neoplasia (PIN) involving the right mid-base and mid-apex of his prostate. He was followed carefully and a repeat PSA has now increased to 8.6. His digital rectal exam remains normal. Given his increasing PSA and prior history of high-grade PIN, it is elected to perform a transperineal stereotactic template guided saturation sampling of his prostate under general anesthesia.

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

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

Is moderate sedation inherent to this procedure in the office setting? Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)?

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

Description of Pre-Service Work:**Day Prior:**

- Check schedule for following day
- Be sure necessary instruments and personnel will be available
- Be sure ultrasound machine is available and working
- Be sure biopsy template (grid) and sled are available and operational
- Check with scheduling staff to see if patient is notified
- Review laboratory studies
- Be sure necessary imaging studies and prior pathology reports are available for review at time of planned procedure

Day of:

- Change into scrub clothes
- Review procedure, post-op recovery with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Check to be sure patient has taken enema and pre-operative antibiotics
- Check to be sure patient is off anti-coagulants and non-steroidal anti-inflammatory medications
- Position patient on table

Description of Intra-Service Work:

- Time out for patient identification
- Patient is placed under general or spinal anesthesia

- Patient is placed in lithotomy position
- Digital rectal exam repeated, anus dilated and any feces manually removed and rectum irrigated
- The patient is prepped and draped
- A Foley catheter is placed in the bladder
- The scrotum is placed out of the operative field by suturing it to the lower abdominal wall
- Preliminary transrectal ultrasound is carried out and the biopsy template (grid) is positioned so that precise and exact coordinates for the prostate biopsies can be taken
- The urologist transperineally inserts the needle of the biopsies 35-60 times to be sure cores are taken at intervals through the template (grid)
- Each specimen is removed from the biopsy needle, placed on telfa and the gun reloaded, then carefully reinserted through the biopsy template (grid).
- Each core is then placed in a container with formalin and each bottle labeled. Each time the biopsy needle is reintroduced through the biopsy template (grid), sagittal and transverse ultrasound images are taken to ensure precise localization of the biopsy needle
- Upon completion of the biopsies, the transrectal ultrasound probe is removed. The biopsy template (grid) and sled disassembled
- Perineal and rectal pressure is applied to prostate
- Sutures removed between scrotum and abdominal wall
- Patient taken out of lithotomy position

Description of Post-Service Work:

- Assist in transfer of patient from operating table to post-op stretcher
- Review recovery area care and medication with staff
- Meet with patient and family; discuss the procedure, expected outcome, planned post operative care
- Write prescriptions
- Conduct post-op pain assessment
- Discuss what the pathologist will do with the tissue and when the biopsy result will be available
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate operative report

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):	James G. Giblin, M.D.; Steven M. Schlossberg, M.D.; Richard N. Gilbert, M.D.					
Specialty(s):	American Urological Association (AUA)					
CPT Code:	55706					
Sample Size:	476	Resp N:	35	Response: 7.3 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.00	3.00	8.00	100.00
Survey RVW:		3.00	3.50	4.29	6.25	15.00
Pre-Service Evaluation Time:				15.00		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				15.00		
Intra-Service Time:		15.00	30.00	35.00	45.00	70.00
Immediate Post Service-Time:	15.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	20.00	99231x 1.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00			
Office time/visit(s):	63.00	99211x 0.00	12x 0.00	13x 1.00	14x 1.00	15x 0.00
Prolonged Services:	60.00	99354x 1.00	55x 0.00	56x 0.00	57x 0.00	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	55706	Recommended Physician Work RVU: 6.25		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.00	0.00
Pre-Service Positioning Time:		5.00	3.00	2.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		45.00		
Immediate Post Service-Time:	15.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	19.00	99238x 0.5 99239x 0.0		
Office time/visit(s):	63.00	99211x 0.00 12x 0.00 13x 1.00 14x 1.00 15x 0.00		
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
54163	010	3.27	RUC Time

CPT Descriptor Repair incomplete circumcision**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11646	010	6.21	RUC Time	11,014

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
38510	010	6.69	RUC Time	9,700

CPT Descriptor 2 Biopsy or excision of lymph node(s); open, deep cervical node(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 11 % of respondents: 31.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 55706	<u>Key Reference CPT Code:</u> 54163	<u>Source of Time</u> RUC Time
Median Pre-Service Time	53.00	25.00	
Median Intra-Service Time	45.00	30.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	63.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	195.00	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	3.55	2.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	2.36
Urgency of medical decision making	3.36	2.55

Technical Skill/Physical Effort (Mean)

Technical skill required	3.36	2.73
Physical effort required	3.18	2.45

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.09	2.36
Outcome depends on the skill and judgment of physician	3.27	2.82
Estimated risk of malpractice suit with poor outcome	3.00	2.91

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

Pre-Service intensity/complexity	3.36	2.55
Intra-Service intensity/complexity	3.64	3.00
Post-Service intensity/complexity	3.09	2.55

Additional Rationale

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

Our expert panel reviewed the data from our survey. We believe the survey respondents underestimated the work associated with this code for a number of reasons: Although the descriptor for this code includes ultrasound guidance, the vignette did not. Furthermore the reference service code selected, 54163, was chosen from a list of RUC reviewed 010 day global codes. More appropriate reference service codes might have been 55700 Biopsy, prostate; needle or

punch, single or multiple, any approach (000 global) (RVU of 2.58) or 55875 Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy (090 global) (RVU of 13.31).

An analysis of the components of the work associated with this code also supports the conclusion that our survey respondents undervalued this code:

CPT Code	Descriptor	RVU
51702	Insertion of temporary indwelling bladder catheter; simple (eg, Foley) – Half RVUs	0.25
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation – Half RVUs	0.34
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	2.58
99238	Half a discharge day management	0.64
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	0.92
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.	1.42
TOTAL		6.09

This value of 6.15 doesn't even take into account the additional work associated with taking a minimum of three times as many prostate biopsy cores (35-60 total) and the ultrasound work associated therewith.

Comparisons to other 010 day global codes that have been RUC reviewed with similar intra and total times and RVUs (as our 75th percentile) are:

CPT Code	Descriptor	Intra Time	Total Time	RVUs
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	45	136	6.48
38510	Biopsy or excision of lymph node(s); open, deep cervical node(s)	45	152	6.69

As a result of these considerations, our expert panel felt that the value for the 75th percentile of 6.25 more appropriate for this code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0137T

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

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

Specialty Urology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1800

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

Please explain the rationale for this estimate.

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

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? 900

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

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
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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? 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
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor: 55706 Biopsies, prostate; needle, transperineal, stereotactic template guided saturation sampling including image guidance

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

A group of urologists from across the country in both the academic and small and medium sized private practice setting met by conference call to discuss the practice expense inputs for the 55706 code. This procedure is performed in the facility setting. The panel recommends the standard pre-service time for the global period of 10 days performed in the facility and the clinical labor standards for a staff blend of RN/LPN/MTA.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic & referral forms
 Coordinate pre-surgery services
 Schedule space and equipment in facility
 Provide pre-service education/obtain consent
 Follow-up phone calls & prescriptions

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

Greet patient, escort to room
 Provide gowning
 Interval history & vital signs and chart
 Assemble previous test reports/results
 Assist physician during exam
 Assist physician with removal of catheter post-operatively
 Assist with dressings, wound care
 Prepare dx test, prescription forms
 Post service education, instruction, counseling
 Clean room/equip, check supplies
 Coordinate home or outpatient care

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			55706			
2	Meeting Date: April 2008	CMS Code		Biopsies , prostate; needle, transperineal, stereotactice template guided saturation sampling including image guidance			
3	LOCATION: Facility		Staff Type	Non Facility	Facility		
4	GLOBAL PERIOD: 010	L037D	RN/LPN/MTA				
5	TOTAL CLINICAL LABOR TIME			0.0	125.0		
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	30.0		
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	6.0		
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	89.0		
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure made						
11	Complete pre-service diagnostic & referral forms				5		
12	Coordinate pre-surgery services				10		
13	Schedule space and equipment in facility				5		
14	Provide pre-service education/obtain consent				7		
15	Follow-up phone calls & prescriptions				3		
16	Other Clinical Activity (please specify)				0		
17	End:When patient enters office/facility for surgery/procedure						
18	SERVICE PERIOD						
19	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure						
20	Review charts						
21	Greet patient and provide gowning						
22	Obtain vital signs						
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies						
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	Intra-service						
29	Assist physician in performing procedure						
30	Post-Service						
31	Monitor pt following service/check tubes, monitors, drains						
32	Clean room/equipment by physician staff						
33	Clean Scope						
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms, lab & X-ray requisitions						
36	Review/read X-ray, lab, and pathology reports						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
38	Discharge day management 99238 –12 minutes				6		
39	End: Patient leaves office						
40	POST-SERVICE Period						
41	Start: Patient leaves office/facility						
42	Conduct phone calls/call in prescriptions						
43	Office visits						
44	List Number and Level of Office Visits						
45	99211 16 minutes		16				
46	99212 27 minutes		27				
47	99213 36 minutes		36		1		
48	99214 53 minutes		53		1		
49	99215 63 minutes		63				
50	Other						
51	Total Office Visit Time			0	89		
52	Other Activity (please specify)						
53	End: with last office visit before end of global period						
54	MEDICAL SUPPLIES	CMS Code	Unit				
55	Pack, minimum multi-specialty visit	SA048	2		2		
56	Syringe, 10-12 ml	SC051	1		1		
57							
58	Equipment	CMS Code					
59	Table, power	EF031	1		1		

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Stereotactic Radiosurgery

The CPT Editorial Panel deleted one code, renumbered one code and added seven new codes to report frame/frameless, simple/complex and cranial/spine stereotactic radiosurgery. Additionally, previous codes did not allow for reporting multiple cranial lesions. These services were previously reported with one code which was created when the technology and technique of stereotactic radiosurgery was first emerging. Since then technology has allowed for broader indications for stereotactic radiosurgery and one code no longer adequately described these services. The specialty society indicated that 61793 had previously been reported with the -51 modifier for additional lesions. The specialty societies noted that any implantation of fiducial markers are inherent to this service and are not reported separately.

61800

The RUC reviewed code 61800 *Application of stereotactic headframe for stereotactic radiosurgery* and determined that there is pre- and post-service time associated with this add-on code. In this procedure typically the patient must be moved from the room in which the headframe is applied to the radiosurgery unit. The RUC determined additional pre-service time is required in order to check local anesthetic and equipment, prep the patient's skin, check preoperative radiographic images to assure the appropriate placement of the head ring and then take the patient to the radiosurgery unit for the scan. Additionally, pre-time is appropriate because these services are not part of the intensity for the entire intra-service time of the procedure.

The RUC reviewed the physician time and work required to perform this procedure from the specialty society survey. The RUC agreed with the specialty society and the survey respondents that pre-service package 1A – straightforward patient/procedure (no sedation/anesthesia) with a three minute decrement in evaluation time and no scrub dress and wait time is appropriate. The RUC determined that 20 minutes intra-service time is appropriate when compared to key reference code 61517 *Implantation of brain intracavitary chemotherapy agent* (work RVU = 1.38) as well as 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)* (work RVU = 4.00, intra-service time = 30 minutes). The RUC determined 10 minutes of immediate post-service time is required to place the patient on a stretcher, take him/her back to the separate room and remove the headframe.

The RUC determined that the physician work for 61800 is significantly less than 20660 but the intra service time is similar. The RUC also compared the physician work for 61800 to key reference service code 61517 and determined that the correct work RVU for 61800 is between the work RVUs of reference codes 20660 and 61517, 4.00 and 1.38 respectively. The RUC determined that the survey 25th percentile work RVU of 2.25 placed this service in the proper rank order for this family of codes as well as relative to other services. **The RUC recommends the survey 25th percentile work RVU of 2.25 for code 61800.**

61796

The RUC reviewed code 61796 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); 1 simple cranial lesion* and determined that the physician work required would be the same as previously reported code 61793 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions* (work RVU= 17.75) minus the application of the head frame which was included in 61793. Therefore, the RUC determined the work for 61796 should be 15.50 ($17.75 - 2.25 = 15.50$), which is below the specialty society's survey 25th percentile. The specialty society clarified the physician work involved for this procedure indicating that the neurosurgeon targets the lesion and reviews the scan to view the lesions, whereas the radiation oncologist adjusts the dosimeter and confirms the dose.

The RUC reviewed the physician time required to perform 61796 and determined the pre-service package 2A - Facilitation difficult patient/straightforward procedure (no sedation/anesthesia) was appropriate. The RUC compared the intra-service time required for this procedure with the key reference code 61751 *Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance* (work RVU = 18.64, intra-service = 90 minutes) and determined it was exactly the same. The RUC agreed with the specialty society that the survey immediate post-time was appropriate at 15 minutes. Additionally, a half day discharge day and 2- 99213 office visits are required to review post-operative reports and conduct neurological exams. **The RUC recommends a work RVU of 15.50 for code 61796.**

61797

The RUC reviewed the specialty society survey results for code 61797 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, simple* determined that an additional lesion requires less physician work than the initial lesion. The RUC compared 61797 to the key reference service 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar* (work = 3.47, intra-service = 45 minutes) and determined that 61797 required slightly less work, but similar intensity as the physician is required to be attentive to the surround structure for each additional lesion. The RUC determined the survey 25th percentile work RVU of 3.48 and survey intra-service time of 30 minutes appropriate accounts for the physician work required to perform code 61797.

The specialty society indicated that the typical number of lesion is 2 and the maximum number of lesions is 5. The RUC determined that this procedure was previously valued at 50% of code 61793 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator)*, one or more sessions, with the use of modifier -51. However, the previous coding was specified per sessions and did not address the number of lesions. The recommended work RVU of 3.48 is a much lower RVU and is therefore work neutral. **The RUC recommends the survey 25th percentile work RVU of 3.48 for code 61797.**

61798

The RUC reviewed code 61798 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one complex cranial lesion* and determined this procedure is more complex than the previously reported code 61793 as it did not account for complexity or number of lesions. The RUC also determined that 61798 is appropriately more complex than 61796. The RUC examined the survey results and determined that the respondents may have included the physician work required to apply the headframe when valuing 61798. The RUC determined the survey 25th percentile minus the value proposed value for the application of the head frame, 61800 (22.00-2.25 = 19.75) was appropriate. The RUC determined the increments recommended place this family of codes in the appropriate rank order.

The RUC determined that pre-service package 2A – facility difficult patient/straightforward procedure (no sedation/anesthesia), 120 minutes of intra-service time and 15 minutes immediate post-service time are required to perform this service. Additionally, a half day discharge day and 2- 99213 office visits are required to review post-operative reports and conduct neurological exams. A work RVU of 19.75 for 61798 appropriately places this service less than the key reference service 61510 *Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma* (work RVU = 30.63), which requires 80 additional minutes of intra-service time and an increased number of hospital visits. **The RUC recommends a work RVU of 19.75 for code 61798.**

61799

The RUC reviewed code 61799 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, complex* and determined that the additional complex lesion was less complex than the initial complex lesion. The RUC compared 61799 to the key reference 61864 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array* (work RVU= 4.49, intraservice = 68 minutes) and determined that although 61799 requires 8 less minutes of intra-service time, it is more intense as the neurosurgeon is required to be attentive to the surround structure for each additional lesion. **The RUC recommends the survey 25th percentile work RVU of 4.81 for code 61799.**

|

63620

The RUC reviewed code 63620 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one spinal lesion* and determined that it is appropriate to crosswalk this code to code 61796 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one simple cranial lesion* (proposed work RVU = 15.50) as these single lesion stereotactic services are analogous. The RUC determined that the physician times are exactly the same for 63620 and 61796, 25 minutes pre-service time, 90 minutes intra-service time and 15 minutes immediate post-service time. The post-operative visits are the same for both codes with a half day discharge day and two-99213 visits. Additionally, the physician work required to perform both of these services is similar. **The RUC recommends a work RVU of 15.50 for code 63620.**

63621

The RUC reviewed the specialty society survey results for add-on code 63621 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)*. To be consistent with accepting the survey 25th percentile work RVUs as the RUC recommended for the other stereotactic radiosurgery ZZZ codes (61797 and 61799) at this meeting, the Committee determined that the survey 25th percentile work RVU of 4.00 was appropriate for code 61798. The survey respondents clearly indicated that an additional lesion requires less physician work than the first lesion. This work RVU of 4.00 is slightly higher than the key reference service 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar* (work RVU=3.47) which is appropriate as 61798 requires 15 minutes more intra-service time than 63048. **The RUC recommends the survey 25th percentile work RVU of 4.00 for code 63621.**

Practice Expense

The RUC recommends the standard 090-day direct practice expense inputs and zero inputs for the ZZZ codes as these services are always performed in the facility setting.

New Technology

The RUC requests that the spinal stereotactic radiosurgery codes 63620 and 63621 be placed on the new technology list.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 61793		Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one or more sessions (61793 has been deleted. To report, see 61796-61800 or 63620-63621)	090	N/A
●61796	Z1	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); 1 simple cranial lesion (Do not report 61796 more than once per course of treatment) (Do not report 61796 with 61798)	090	15.50
●+61797	Z2	each additional cranial lesion, simple (List separately in addition to code for primary procedure) (Use 61797 in conjunction with 61796, 61798) (For each course of treatment, 61797 and 61799 may be reported no more than once per lesion. Do not report any combination of 61797 and 61799 more than 4 times for entire course of treatment regardless of number of lesions treated)	ZZZ	3.48
●61798	Z3	1 complex cranial lesion (Do not report 61798 more than once per course of treatment) (Do not report 61798 with 61796)	090	19.75

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●+61799	Z4	<p>each additional cranial lesion, complex (List separately in addition to code for primary procedure)</p> <p>(Use 61799 in conjunction with 61796 or 61798)</p> <p>(For each course of treatment, 61797 and 61799 may be reported no more than once per lesion. Do not report any combination of 61797 and 61799 more than 4 times for entire course of treatment regardless of number of lesions treated)</p>	ZZZ	4.81
●+61800	Z5	<p>Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code with primary procedure)</p> <p>(Report 61800 in conjunction with 61796, 61798)</p>	ZZZ	2.25
+61795		Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure)	ZZZ	4.03 (No Change)
●63620	Z6	<p>Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); 1 spinal lesion</p> <p>(Do not report 63620 more than once per course of treatment)</p>	090	15.50

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●+63621	Z7	<p>each additional spinal lesion (List separately in addition to code for primary procedure)</p> <p>(Report 63621 only in conjunction with 63620)</p> <p>(For each course of treatment, 63621 may be reported no more than once per lesion. Do not report 63621 more than 2 times for entire course of treatment regardless of number of lesions treated)</p>	ZZZ	4.00
77432		<p><i>Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of one session)</i></p> <p><u>(Stereotactic radiosurgery is performed jointly by a surgeon and a radiation oncologist. The surgeon reports radiosurgery with 61796-61800)</u></p>	XXX	7.92 (No Change)
77435		<p><i>Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions</i></p> <p><u>(When stereotactic radiation therapy is performed jointly by a surgeon and a radiation oncologist (ie, spinal or cranial), the surgeon reports radiosurgery with 61793 61796-61800 for cranial lesion(s) and 63620, 63621 for spinal lesion(s))</u></p>	XXX	13.00 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 61796 Tracking Number Z1

Specialty Society Recommended RVU: **15.75**

Global Period: 090

RUC Recommended RVU: **15.50**

CPT Descriptor: Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one simple cranial lesion
 (Do not report 61796 more than once per course of treatment)
 (Do not report 617960 with 61798)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old male with a history of renal cell carcinoma, metastatic to the right cerebellum. He has headaches, dizziness and compression of the fourth ventricle as seen on MRI scan. No other lesions are evident, and the chest exam is normal. The lesion enhances and is 2 cm in diameter. He undergoes stereotactic radiosurgery of the lesion.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

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

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

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

Description of Pre-Service Work: Pre-service includes: a review of previous medical records, evaluation of the imaging studies and appropriate lab and screening studies; and informed consent with the patient and family.

Description of Intra-Service Work: The intra-service work begins with the patient transported to Radiology where stereotactic computerized imaging studies are obtained. This may be either MRI or angiography (Radiology reported separately). The neurosurgeon must position and secure the patient on the imaging table and attach an appropriate stereotactic localizer. He then works with a radiologist or technician to identify the precise areas to be imaged by adjustment of the scanning geometry and by timing of the contrast injection(s). Finally, the neurosurgeon verifies that the target is optimally imaged. Dosimetry planning follows in conjunction with radiation oncology and a radiation physicist as well a computer programmer. The programmer computer processes all of the stereotactic images into the a dose planning computer program during this phase. This dose planning involves use of a computer based planning module to achieve an optimal dosimetry plan for the patient. A test is then done using the radiosurgical device to assure correct targeting and dosimetry. The patient is then placed in the device while still in the frame. Positioning is more complex due to the use of a stereotactic head frame that requires coordinate indexing to the patient table. The treatment is then delivered. For each isocenter treated, the neurosurgeon must set the stereotactic coordinates, verified by other team members. Removal of the frame is done at the end of the service period.

Description of Post-Service Work: Includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of complications. The recovery room visit and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care completed during the 90 day global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	John Wilson, MD, Frederick Boop, MD, Alexander Mason, MD				
Specialty(s):	AANS, CNS				
CPT Code:	61796				
Sample Size:	100	Resp N:	25	Response: 25.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.00	30.00	60.00	150.00
Survey RVW:	15.00	18.00	20.00	28.00	42.00
Pre-Service Evaluation Time:			65.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			10.00		
Intra-Service Time:	30.00	60.00	90.00	120.00	0.30
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	19.00	99238x 0.50 99239x 0.00			
Office time/visit(s):	46.00	99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2a-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	61796	Recommended Physician Work RVU: 15.75		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		18.00	18.00	0.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		6.00	6.00	0.00
Intra-Service Time:		90.00		
Immediate Post Service-Time:	15.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	19.00	99238x 0.5 99239x 0.0		
Office time/visit(s):	46.00	99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00		
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61751	090	18.64	RUC Time

CPT Descriptor Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance

KEY MPC COMPARISON CODES:

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
37215	090	19.58	RUC Time	10,406

CPT Descriptor 1 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
49002	090	17.55	RUC Time	5460

CPT Descriptor 2 Reopening of recent laparotomy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61863	090	20.56	RUC Time

CPT Descriptor Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 24.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 61796	<u>Key Reference CPT Code:</u> 61751	<u>Source of Time</u> RUC Time
Median Pre-Service Time	25.00	128.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	40.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	46.0	69.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	195.00	395.00
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	2.50	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	2.83
Urgency of medical decision making	2.17	2.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.33
Physical effort required	2.33	2.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.17	3.17
Outcome depends on the skill and judgment of physician	3.33	3.50
Estimated risk of malpractice suit with poor outcome	2.67	3.33

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

Pre-Service intensity/complexity	2.67	3.20
Intra-Service intensity/complexity	3.00	3.20
Post-Service intensity/complexity	2.33	3.00

Additional Rationale

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

Code 61793 has been the code used to describe all stereotactic radiosurgery procedures. When it was first presented at CPT and valued at the RUC it was utilized predominantly for a single, straightforward intracranial lesion as was described in the original

vignette. The procedure evolved over the years and became an excellent treatment alternative for multiple cerebral metastases. As treatment of multiple metastases became more common, there has been confusion and disagreement as to the appropriate way to code for multiple lesions. A CPT Assistant article was published to help clarify this issue. This article stated that it was appropriate to code multiple intracranial lesions with multiple instances of 61793 utilizing the -51, -59 modifiers. It was agreed that no more than five lesions should be coded for in this fashion. In 2007 this coding convention was called into question and at the request of the CPT Editorial Panel neurosurgery agreed to submit a code change proposal to include codes for multiple intracranial lesions. The CPT proposal ultimately accepted by the Editorial Panel included a family of seven codes, three base codes for simple and complex intracranial, and spinal lesions with ZZZ codes for additional lesions for each. There is also a code (61800) for placement and removal of a stereotactic head frame. In the past this was included in 61793 but technology has evolved so that some radiosurgery systems now do not require the placement of a head frame. Having the head frame code as an add-on accounts for that circumstance.

New code 61796 is the base code for a single simple intracranial lesion. This is the code most analogous to the original code 61793. The vignette describes treatment of a single solitary metastatic lesion to the cerebellum. The RVW for 61793 is 17.75. The median survey RVW for 61796 is 20.00 and the 25th percentile is 18.00. This is less than the 25 percentile of the survey. We feel our respondents did not adequately consider the work of placing and removing the head frame which will now be coded separately as 61800. We therefore derived this value by subtracting the proposed RVW for 61800 of 2.25, from 61793 (17.75-2.25). The 25th percentile was felt by our expert panel to represent more accurately the work involved in SRS for a simple intracranial lesion. This also puts the combined value of 61796 and 61800 appropriately less than our key reference service which has an identical intra time but two fewer hospital visits.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

3.	CPT	GLOBAL	RVW	PRE	INTRA	POST
4.	61796	90	15.75	25	90	80
5.	61800	ZZZ	2.25(proposed)	11	20	10
6.	TOTAL		18.00	36	110	90

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61793

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

Specialty neurosurgery

How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10,000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database shows that 61793 was reported 10,696 times in 2006.

We estimate that simple cranial lesions represent the vast majority of lesions treated with SRS. The most common diagnoses in most centers are cerebral metastasis and tic doloreaux (combined total of 57% in Medicare population in 2006), both of which would be simple lesions. However, a significant percentage of the times 61793 has been coded would have been for multiple lesions with modifier-51. Those cases will now be coded with the new additional level codes. Therefore we estimate that this service will be provided approximately 1/4 as frequently as 61793 was in prior years. Overall the medicare population comprises approx 40% of the patient population receiving this procedure resulting in an estimate of approximately 10,000 patients receiving this service.

Specialty neurosurgery	Frequency 9000	Percentage 90.00 %
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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? 3,300 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database shows that 61793 was reported 10,696 times in 2006. We estimate that simple cranial lesions represent the vast majority of lesions treated with SRS. The most common diagnoses in most centers are cerebral metastasis and tic doloreaux (combined total of 57% in Medicare population in 2006), both of which would be simple lesions. However, a significant percentage of the times 61793 has been coded would have been for multiple lesions with modifier-51. Those cases will now be coded with the new additional level codes. Therefore we estimate that this service will be provided approximately 1/3 as frequently as 61793 was in prior years.

Specialty neurosurgery	Frequency 3000	Percentage 90.90 %
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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**

CPT Code: 61797 Tracking Number Z2

Specialty Society Recommended RVU: **3.48**

Global Period: ZZZ

RUC Recommended RVU: **3.48**

CPT Descriptor: Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, simple

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 37-year-old woman presents with a history of breast cancer and two tumors metastatic to her brain. Both tumors are in the right frontal lobe and are 1.5 cm in diameter. They are 3 cm from each other. She has undergone stereotactic radiosurgery for the first tumor and now during the same session undergoes stereotactic radiosurgery for the second tumor.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

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

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

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

Description of Pre-Service Work:

Description of Intra-Service Work: During the course of stereotactic radiosurgery treatment planning for multiple lesions, the patient has already undergone application of the stereotactic head frame under local anesthesia. The patient has previously been transported to Radiology where stereotactic computerized imaging studies were obtained. The neurosurgeon works with a radiologist or technician to identify the additional area to be imaged by adjustment of the scanning geometry and by timing of the contrast injection(s). The neurosurgeon verifies that the additional target is optimally imaged. Additional dosimetry planning for the additional lesion follows in conjunction with radiation oncology and a radiation physicist. The computer processes all of the stereotactic images in a dose planning program during this phase. This dose planning involves use of a computer based planning module to achieve an optimal dosimetry plan for the patient. Because of the existing treatment plan for the first lesion, several plans are developed for the additional lesion using different prescribed doses and delivery geometry. The plan that achieves the greatest radiation dose to the additional lesion (taking into account the treatment plan for the first lesion) and with the least radiation to the brainstem, retinas, optic nerve and optic tract is finally chosen. A test is then done using the radiosurgical device to assure correct targeting and dosimetry. The patient is then placed in the device while still in the frame for stereotactic radiosurgery of both lesions. Positioning is more complex due to the multiple lesions and more complex treatment geometry required. The treatment is then delivered. For the additional lesion, the neurosurgeon must set the stereotactic coordinates, verified by other team members.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	John Wilson, MD, Frederick Boop, MD, Alexander Mason, MD				
Specialty(s):	AANS, CNS				
CPT Code:	61797				
Sample Size:	100	Resp N:	22	Response: 22.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	20.00	50.00	100.00
Survey RVW:	2.00	3.48	5.50	8.00	12.00
Pre-Service Evaluation Time:			7.50		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	10.00	20.00	30.00	45.00	90.00
Immediate Post Service-Time:	<u>0.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	61797	Recommended Physician Work RVU: 3.48		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		30.00		
Immediate Post Service-Time:	<u>0.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
63048	ZZZ	3.47	RUC Time

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
35600	ZZZ	4.94	RUC Time	5,263

CPT Descriptor 1 Harvest of upper extremity artery, one segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
60512	ZZZ	4.44	RUC Time	1,828

CPT Descriptor 2 Parathyroid autotransplantation (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61517	ZZZ	1.38	RUC Time

CPT Descriptor Implantation of brain intracavitary chemotherapy agent (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: 4 % of respondents: 18.1 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 61797	<u>Key Reference CPT Code:</u> 63048	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	45.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	30.00	45.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.07	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.07	2.50
Urgency of medical decision making	3.00	1.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.07	2.50
Physical effort required	3.07	2.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.47	2.50
Outcome depends on the skill and judgment of physician	3.67	2.50
Estimated risk of malpractice suit with poor outcome	3.20	3.00

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

Pre-Service intensity/complexity	2.80	2.33
Intra-Service intensity/complexity	2.93	2.67
Post-Service intensity/complexity	2.67	2.67

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 61793 has been the code used to describe all stereotactic radiosurgery procedures. When it was first presented at CPT and valued at the RUC it was utilized predominantly for a single, straightforward intracranial lesion as was described in the original

vignette. The procedure evolved over the years and became an excellent treatment alternative for multiple cerebral metastases. As treatment of multiple metastases became more common, there has been confusion and disagreement as to the appropriate way to code for multiple lesions. A CPT Assistant article was published to help clarify this issue. This article stated that it was appropriate to code multiple intracranial lesions with multiple instances of 61793 utilizing the -51, -59 modifiers. It was agreed that no more than five lesions should be coded for in this fashion. In 2007 this coding convention was called into question and at the request of the CPT Editorial Panel neurosurgery agreed to submit a code change proposal to include codes for multiple intracranial lesions. The CPT proposal ultimately accepted by the Editorial Panel included a family of seven codes, three base codes for simple and complex intracranial, and spinal lesions with ZZZ codes for additional lesions for each. There is also a code (61800) for placement and removal of a stereotactic head frame. In the past this was included in 61793 but technology has evolved so that some radiosurgery systems now do not require the placement of a head frame. Having the head frame code as an add-on accounts for that circumstance.

Code 61796 is the base code for a single simple intracranial lesion. This is the code most analogous to the original code of 61793. The vignette describes treatment of a single solitary metastatic lesion to the cerebellum. The RVW for 61793 is 17.75. The recommended RVW for 61XX0 is 15.75. Previously additional lesions would have been reported as 61793-51. **We recommend an RVW of 3.48 which is the 25th percentile of our survey.** The survey respondents clearly felt that an additional lesion is significantly less physician work than the first lesion. Our expert panel felt the 25th percentile resulted in the appropriate decrement in RVW relative to the recommended RVW for 61796 (the base code for this add-on code). In addition, this value is virtually identical to the key reference service which has 15 minutes more intra time but is significantly less intense. Furthermore, a majority of the survey respondents added preservice time (median 7 minutes) which the expert panel could not account for and was therefore not recommended.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

3.	3.	CPT	GLOBAL	RVW	PRE	INTRA	POST
4.	4.	61XX0	90	15.75	25	90	80
5.	5.	61XX4	ZZZ	2.25(proposed)	11	20	10
6.		61XX1	ZZZ	3.48	0	30	0
7.	6.	TOTAL		21.48	36	140	90

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61793-51

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

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

Specialty Neurosurgery

How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database shows that 61793 was reported 10,696 times in 2006.

We estimate that simple cranial lesions represent the vast majority of lesions treated with SRS. The most common diagnoses in most centers are cerebral metastasis and tic doloreaux (combined total of 57% in Medicare population in 2006), both of which would be simple lesions. However, a significant percentage of the times 61793 has been coded would have been for multiple lesions with modifier-51. Those cases will now be coded with the new additional level codes. Therefore we estimate that this service will be provided approximately 1/4 as frequently as 61793 was in prior years. Overall the medicare population comprises approx 40% of the patient population receiving this procedure resulting in an estimate of approximately 10,000 patients receiving this service.

Specialty Neurosurgery	Frequency 10000	Percentage 100.00 %
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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?

3,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database shows that 61793 was reported 10,696 times in 2006.

We estimate that simple cranial lesions represent the vast majority of lesions treated with SRS. The most common diagnoses in most centers are cerebral metastasis and tic doloreaux (combined total of 57% in Medicare population in 2006), both of which would be simple lesions. However, a significant percentage of the times 61793 has been coded would have been for multiple lesions with modifier-51. Those cases will now be coded with the new additional level codes. Therefore we estimate that this service will be provided approximately 1/3 as frequently as 61793 was in prior years.

Specialty Neurosurgery	Frequency 3500	Percentage 100.00 %
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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? No

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code: 61798 Tracking Number Z3

Specialty Society Recommended RVU: **19.75**

Global Period: 090

RUC Recommended RVU: **19.75**

CPT Descriptor: Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one complex cranial lesion
(Do not report 61798 more than once per course of treatment)
(Do not report 61798 with 61796)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old female with a residual suprasellar meningioma after partial resection of the tumor. The tumor is 3mm from the optic chiasm. She undergoes stereotactic radiosurgery of the tumor.

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

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

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

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

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

Description of Pre-Service Work: Pre-service includes: a review of previous medical records, evaluation of the imaging studies and appropriate lab and screening studies; and informed consent with the patient and family.

Description of Intra-Service Work: The patient is then transported to Radiology where stereotactic computerized imaging studies are obtained. This may be either MRI or angiography (Radiology reported separately). The neurosurgeon must position and secure the patient on the imaging table and attach an appropriate stereotactic localizer. He then works with a radiologist or technician to identify the precise areas to be imaged by adjustment of the scanning geometry and by timing of the contrast injection(s). Finally, the neurosurgeon verifies that the target is optimally imaged. Complex dosimetry planning follows in conjunction with radiation oncology and a radiation physicist. The computer processes all of the stereotactic images in a dose planning program during this phase. This dose planning involves use of a computer based planning module to achieve an optimal dosimetry plan for the patient. Because of the complex nature of the lesion and its proximity to critical radiosensitive structures, several plans are developed using different prescribed doses and delivery geometry. The plan that achieves the greatest radiation dose to the target with the least radiation to the brainstem, retinas, optic nerve and optic tract is finally chosen. A test is then done using the radiosurgical device to assure correct targeting and dosimetry. The patient is then placed in the device while still in the frame. Positioning is more complex due to the use of a stereotactic frame that requires coordinate indexing to the patient table. The treatment is then delivered. For each isocenter treated, the neurosurgeon must set the stereotactic coordinates, verified by other team members. Removal of the frame is done at the end of the service period.

Description of Post-Service Work: Includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of complications. The recovery room visit and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care completed during the 90 day global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	John Wilson, MD, Frederick Boop, MD, Alexander Mason, MD				
Specialty(s):	AANS, CNS				
CPT Code:	61798				
Sample Size:	100	Resp N:	25	Response: 25.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	12.00	20.00	40.00	200.00
Survey RVW:	15.00	22.00	30.00	32.00	60.00
Pre-Service Evaluation Time:			60.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	30.00	90.00	120.00	210.00	420.00
Immediate Post Service-Time:	<u>15.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.50 99239x 0.00			
Office time/visit(s):	<u>46.00</u>	99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2a-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	61798	Recommended Physician Work RVU: 19.75		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		18.00	18.00	0.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		6.00	6.00	0.00
Intra-Service Time:		120.00		
Immediate Post Service-Time:	<u>15.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.5 99239x 0.0		
Office time/visit(s):	<u>46.00</u>	99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61510	090	30.63	RUC Time

CPT Descriptor Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
37215	090	19.58	RUC Time	10,406

CPT Descriptor 1 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
38100	090	19.47	RUC Time	3499

CPT Descriptor 2 Splenectomy; total (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61863	090	20.56	RUC Time

CPT Descriptor Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array

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

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

TIME ESTIMATES (Median)

	CPT Code: 61798	Key Reference CPT Code: 61510	Source of Time RUC Time
Median Pre-Service Time	25.00	105	
Median Intra-Service Time	120.00	200.00	
Median Immediate Post-service Time	15.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	160.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	46.0	92.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	225.00	635.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.15	3.83
Urgency of medical decision making	3.38	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.15	3.83
Physical effort required	3.15	3.58

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.31	4.25
Outcome depends on the skill and judgment of physician	4.62	4.33
Estimated risk of malpractice suit with poor outcome	4.38	4.25

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

Pre-Service intensity/complexity	3.92	3.80
Intra-Service intensity/complexity	4.54	3.91
Post-Service intensity/complexity	3.50	3.50

Additional Rationale

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

Code 61793 has been the code used to describe all stereotactic radiosurgery procedures. When it was first presented at CPT and valued at the RUC it was utilized predominantly for a single, straightforward intracranial lesion as was

described in the original vignette. The procedure evolved over the years and became an excellent treatment alternative for multiple cerebral metastases. As treatment of multiple metastases became more common, there has been confusion and disagreement as to the appropriate way to code for multiple lesions. A CPT Assistant article was published to help clarify this issue. This article stated that it was appropriate to code multiple intracranial lesions with multiple instances of 61793 utilizing the -51, -59 modifiers. It was agreed that no more than five lesions should be coded for in this fashion. In 2007 this coding convention was called into question and at the request of the CPT Editorial Panel neurosurgery agreed to submit a code change proposal to include codes for multiple intracranial lesions. The CPT proposal ultimately accepted by the Editorial Panel included a family of seven codes, three base codes for simple and complex intracranial, and spinal lesions with ZZZ codes for additional lesions for each. There is also a code (61800) for placement and removal of a stereotactic head frame. In the past this was included in 61793 but technology has evolved so that some radiosurgery systems now do not require the placement of a head frame. Having the head frame code as an add-on accounts for that circumstance.

Code 61798 is the base code for a complex intracranial lesion. This new code is more complex than the original code of 61793. The vignette for 61798 describes treatment of a complex lesion adjacent to the optic chiasm. The RVW for 61793 is 17.75. The median survey RVW for 61798 is 30.00 and the 25th percentile is 22.00. **We recommend a calculated RVW of 19.75.** This is less than the 25th percentile of the survey. We feel our respondents did not adequately consider the work of placing and removing the head frame which will now be coded separately as 61800. We therefore derived this value by subtracting the proposed RVW for 61800 of 2.25, from the 25 percentile. The 25 percentile was felt by our expert panel to represent more accurately the work involved in SRS for complex intracranial lesions. The recommended value is very close to the value obtained when adding the proposed RVW of 61796 with the value of an additional 30 minutes times the IWPOT of 61796 (which is 0.128) ($15.75 + 3.84 = 19.59$) This also puts the value of 61798 appropriately less than our key reference service which has 80 minutes more intra time as well as an increased number of hospital visits.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) The majority of the time this code would be reported with 61800

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

3.	3.	CPT	GLOBAL	RVW	PRE	INTRA	POST
4.	4.	61798	90	19.75	25	120	80
5.	5.	61800	ZZZ	2.25(proposed)	11	20	10
6.	6.	TOTAL		22.00	36	140	90
7.							

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61793

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

Specialty Neurosurgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database shows a Medicare frequency of 10,696 for CPT Code 61793. We estimate that complex lesions would account for about 15 % of the lesions treated. Therefore, we estimate that 61798 would be reported about 1600 times in the Medicare population. We estimate that in the general population this procedure would be performed about 2 1/2 times more often than in the Medicare population and we estimate that this procedure would be performed about 4000 times.

Specialty Neurosurgery	Frequency 4000	Percentage 100.00 %
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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? 1,600 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database shows a Medicare frequency of 10,696 for CPT Code 61793. We estimate that complex lesions would be reported about 15% of the time. Therefore, we estimate that 61798 would be reported about 1600 times in the Medicare population.

Specialty Neurosurgery	Frequency 1600	Percentage 100.00 %
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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? No

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code: 61799

Tracking Number Z4

Specialty Society Recommended RVU: **4.81**

Global Period: 090

RUC Recommended RVU: **4.81**

CPT Descriptor: Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, complex

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 33-year-old male presents with NF2 (Neurofibromatosis type 2) and bilateral vestibular schwannomas (acoustic neuromas). He has undergone stereotactic radiosurgery for the first tumor and now during the same session undergoes stereotactic radiosurgery for the second tumor.

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

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

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

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

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

Description of Pre-Service Work:

Description of Intra-Service Work: During the course of stereotactic radiosurgery treatment planning for multiple lesions, the patient has already undergone application of the stereotactic head frame under local anesthesia. The patient has previously been transported to Radiology where stereotactic computerized imaging studies were obtained. The neurosurgeon works with a radiologist or technician to identify the additional area to be imaged by adjustment of the scanning geometry and by timing of the contrast injection(s). The neurosurgeon verifies that the additional target is optimally imaged. Additional complex dosimetry planning for the additional complex lesion follows in conjunction with radiation oncology and a radiation physicist. The computer processes all of the stereotactic images in a dose planning program during this phase. This dose planning involves use of a computer based planning module to achieve an optimal dosimetry plan for the patient. Because of the complex nature of the additional lesion and its proximity to critical radiosensitive structures, and because of the existing treatment plan for the first complex lesion, several plans are developed for the additional complex lesion using different prescribed doses and delivery geometry. The plan that achieves the greatest radiation dose to the additional lesion (taking into account the treatment plan for the first lesion) and with the least radiation to the brainstem, retinas, optic nerve and optic tract is finally chosen. A test is then done using the radiosurgical device to assure correct targeting and dosimetry. The patient is then placed in the device while still in the frame for stereotactic radiosurgery of both lesions. Positioning is more complex due to the multiple lesions and more complex treatment geometry required. The treatment is then delivered. For the additional lesion, the neurosurgeon must set the stereotactic coordinates, verified by other team members.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	John Wilson, MD, Frederick Boop, MD, Alexander Mason, MD				
Specialty(s):	AANS, CNS				
CPT Code:	61799				
Sample Size:	100	Resp N:	22	Response: 22.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	5.00	10.00	60.00
Survey RVW:	3.00	4.81	8.00	11.99	21.00
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	10.00	45.00	60.00	60.00	180
Immediate Post Service-Time:	<u>0.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	61799	Recommended Physician Work RVU: 4.81		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	<u>0.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61864	ZZZ	4.49	RUC Time

CPT Descriptor Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
35600	ZZZ	4.94	RUC Time	5,263

CPT Descriptor 1 Harvest of upper extremity artery, one segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
60512	ZZZ	4.44	RUC Time	1,828

CPT Descriptor 2 Parathyroid autotransplantation (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
63048	ZZZ	3.47	RUC Time

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (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: 3 % of respondents: 13.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 61799	<u>Key Reference CPT Code:</u> 61864	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	68.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	60.00	68.00
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	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	2.50
Urgency of medical decision making	2.33	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.67	3.00
Physical effort required	1.67	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.67	3.00
Outcome depends on the skill and judgment of physician	3.67	3.00
Estimated risk of malpractice suit with poor outcome	4.33	3.50

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

Pre-Service intensity/complexity	3.33	2.67
Intra-Service intensity/complexity	3.67	3.33
Post-Service intensity/complexity	2.33	2.33

Additional Rationale

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

Code 61793 has been the code used to describe all stereotactic radiosurgery procedures. When it was first presented at CPT and valued at the RUC it was utilized predominantly for a single, straightforward intracranial lesion as was described in the original vignette. The procedure evolved over the years and became an excellent treatment alternative for multiple cerebral metastases. As treatment of multiple metastases became more common, there has been confusion and disagreement as to the appropriate way to code for multiple lesions. A CPT Assistant article was published to help clarify this issue. This article stated that it was appropriate to code multiple intracranial lesions with multiple instances of 61793 utilizing the -51, -59 modifiers. It was agreed that no more than five lesions should be coded for in this fashion. In 2007 this coding convention was called into question and at the request of the CPT Editorial Panel neurosurgery agreed to submit a code change proposal to include codes for multiple intracranial lesions. The CPT proposal ultimately accepted by the Editorial Panel included a family of seven codes, three base codes for simple and complex intracranial, and spinal lesions with ZZZ codes for additional lesions for each. There is also a code (61800) for placement and removal of a stereotactic head frame. In the past this was included in 61793 but technology has evolved so that some radiosurgery systems now do not require the placement of a head frame. Having the head frame code as an add-on accounts for that circumstance.

Code 61798 is the base code for a single complex intracranial lesion. This code is more complex than the original code of 61793. The vignette for 61798 describes treatment of a complex lesion adjacent to the optic chiasm. The RVW for 61793 is 17.75. The recommended RVW for 61798 is 19.75, below the 25th percentile. Previously additional lesions would have been reported as 61793-51. **We recommend an RVW of 4.81 which is the 25th percentile of our survey.** The survey respondents clearly felt that an additional lesion is significantly less physician work than the first lesion. Our expert panel felt the 25th percentile resulted in the appropriate decrement in RVW relative to the recommended RVW for 61798 (the base code for this add-on code). In addition, this value is very close to that of the key reference service which has similar intra time as well. Furthermore, a majority of the survey respondents added preservice time (median 10 minutes) which the expert panel could not account for and was therefore not recommended.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

3.	CPT	GLOBAL	RVW	PRE	INTRA	POST
4.	61798	90	19.75	25	120	80
5.	61799	ZZZ	4.81	0	60	0
6.	61800	ZZZ	2.25(proposed)	11	20	10
7.	TOTAL		26.81	36	200	90

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61793-51

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

Specialty Neurosurgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database shows a Medicare frequency of 10,696 for CPT Code 61793. We estimate that complex lesions would account for about 15% of the lesions treated. Therefore, we estimate that 61799 would be reported about 1600 times in the Medicare population. We estimate that in the general population this procedure would be performed about 2 1/2 times more often than in the Medicare population and we estimate that this procedure would be performed about 4000 times.

Specialty Neurosurgery Frequency 4000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,600 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database shows a Medicare frequency of 10,696 for CPT Code 61793. We estimate that complex lesions would be reported about 15% of the time. Therefore, we estimate that 61799 would be reported about 1600 times in the Medicare population.

Specialty Neurosurgery Frequency 1600 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code: 61800 Tracking Number Z5

Specialty Society Recommended RVU: **2.25**

Global Period: ZZZ

RUC Recommended RVU: **2.25**

CPT Descriptor: Application of stereotactic headframe for stereotactic radiosurgery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male with a left occipital arterio-venous malformation is to undergo stereotactic radiosurgery for obliteration of the lesion. The frame is applied prior to the radiosurgery procedure.

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

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

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

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

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

Description of Pre-Service Work: The surgeon meets the patient in the radiosurgery clinic. The equipment and local anesthetic is checked, the preoperative radiographic images are checked to assure appropriate placement of the head ring, the patient is positioned on a stretcher or wheelchair, and a surgical "time out" is performed.

Description of Intra-Service Work: In the radiosurgery clinic, the surgeon's assistant stabilized the head ring. The skin is prepped and local anesthesia is injected into the scalp and the ring is rigidly attached to patients skull.

Description of Post-Service Work: After the completion of the radiosurgical procedure the patient is removed from the radiosurgery device and placed on a stretcher. The stereotactic head frame is removed, the pin sites are checked for hemostasis with pressure being applied as necessary. The pin sites are cleaned and a sterile dressing is applied.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):	John Wilson, MD, Frederick Boop,MD, Alexander Mason,MD					
Specialty(s):	AANS, CNS					
CPT Code:	61800					
Sample Size:	100	Resp N:	22	Response: 22.0 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	3.00	18.00	63.00	225.00
Survey RVW:		0.00	2.25	3.25	4.73	12.00
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		0.00	18.00	20.00	30.00	65.00
Immediate Post Service-Time:	10.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00				
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00				
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00				
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00				
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	61800	Recommended Physician Work RVU: 2.25			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		10.00	13.00	-3.00	
Pre-Service Positioning Time:		1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:		0.00	6.00	-6.00	
Intra-Service Time:		20.00			
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61517	ZZZ	1.38	RUC Time

CPT Descriptor Implantation of brain intracavitary chemotherapy agent (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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
13122	ZZZ	1.44	RUC Time	12,966

CPT Descriptor 1 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
13133	ZZZ	2.19	RUC Time	9,840

CPT Descriptor 2 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
63048	ZZZ	3.47	RUC Time

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (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: 5 % of respondents: 22.7 %

TIME ESTIMATES (Median)

	CPT Code: 61800	Key Reference CPT Code: 61517	Source of Time RUC Time
Median Pre-Service Time	11.00	0.00	
Median Intra-Service Time	20.00	15.00	
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	

Prolonged Services Time	0.0	0.00
Median Total Time	41.00	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	1.25	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.25	2.00
Urgency of medical decision making	1.25	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	1.50	2.00
Physical effort required	1.75	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.25	2.00
Outcome depends on the skill and judgment of physician	1.75	2.33
Estimated risk of malpractice suit with poor outcome	1.50	2.33

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

Pre-Service intensity/complexity	1.00	2.20
Intra-Service intensity/complexity	1.40	2.00
Post-Service intensity/complexity	1.20	2.00

Additional Rationale

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

In October 2006, the CPT Editorial Panel CPT Modifier Workgroup recommended 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)* be removed from the modifier -51 exempt list. Code 20660 had never been surveyed nor discussed at the RUC previously. The RUC understood that it was tasked with considering whether 20660 should be retained on the modifier -51 exempt list. If not, then the RUC should determine whether there is compelling evidence for revaluation of 20660. The RUC heard a full description of the service and the history of its value. The specialty societies and the RUC understood that the service did have significant time in the pre-service and post service periods which disqualifies 20660 from the -51 modifier exempt list (according to the CPT's criteria for inclusion on the list). The RUC agreed that removal from the -51 exempt modifier list was an adequate reason for re-valuation. This code was valued at 4.00 RVW with 30 minutes intra time and 50 minutes pre and post service evaluation time. **We recommend an RVW of 2.25 which is the 25th percentile of our survey.** Code 61800 has 20 minutes intra time with 21 minutes of pre and post evaluation time. Our expert panel felt the 25th percentile represented the most appropriate relationship with the recently valued and closely related code 20660. In addition, the key reference service 61517 has an RVW of 1.38 with an intra time of 15 minutes and no pre- or post-time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. can be added to simple or complex lesion codes X0 or X2:

3.	CPT	GLOBAL	RVW	PRE	INTRA	POST
4.	61796	90	15.75	25	90	80
5.	61800	ZZZ	2.25(proposed)	11	20	10
6.	TOTAL		18.00	36	110	90
7.						
8.	CPT	GLOBAL	RVW	PRE	INTRA	POST
9.	61798	90	19.75	25	120	80
10.	61800	ZZZ	2.25(proposed)	11	20	10
11.	TOTAL		22.00	36	140	90

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61793

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

Specialty Neurosurgery

How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 23250

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database shows a Medicare frequency of 10,696 for CPT Code 61793, which includes placement of the headframe. We estimate that about 85 % of stereotactic radiosurgery procedures use a headframe. Therefore, we estimate that this code might be provided to Medicare patients about 9,300 times in a one-year period. We estimate that the procedure is performed in the general population about 2 1/2 times more often than in the Medicare population and, therefore, we estimate that the procedure if performed in the general population about 23,250 times.

Specialty Neurosurgery	Frequency 23250	Percentage 100.00 %
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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? 9,300 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database shows a Medicare frequency of 10,696 for CPT Code 61793, which includes placement of the headframe. We estimate that about 85 % of stereotactic radiosurgery procedures use a headframe. Therefore, we estimate that this code might be provided to Medicare patients about 9,300 times in a one-year period

Specialty Neurosurgery	Frequency 9300	Percentage 100.00 %
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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**

CPT Code: 63620 Tracking Number Z6

Specialty Society Recommended RVU: **18.00**

Global Period: 090

RUC Recommended RVU: **15.50**

CPT Descriptor: Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one spinal lesion
(Do not report 63620 more than once per course of treatment)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male presents with prostate cancer metastatic to the C4 vertebral body and epidural space, resulting in mild narrowing of the central canal. He undergoes stereotactic spinal radiosurgery for the single metastatic tumor.

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

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

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

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

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

Description of Pre-Service Work: Pre-service includes: a review of previous medical records, evaluation of the imaging studies and appropriate lab and screening studies; and informed consent with the patient and family

Description of Intra-Service Work: The intra-service work begins with the patient being transported to Radiology where stereotactic computerized imaging studies are obtained. This may be either MRI or angiography (Radiology reported separately). The neurosurgeon then works with a radiologist to verify that the target is optimally imaged. Complex dosimetry planning follows in conjunction with radiation oncology and a radiation physicist. The computer processes all of the stereotactic images in a dose planning program during this phase. The neurosurgeon carefully outlines the target lesion where it appears on each consecutive image. The neurosurgeon also outlines the spinal cord on the same images. This dose planning involves use of a computer based planning module to achieve an optimal dosimetry plan for the patient. Because of the nature of the lesion and its proximity to the spinal cord, several plans are developed using different prescribed doses and delivery geometry. The plan that achieves the greatest radiation dose to the target with the least radiation to the spinal cord is finally chosen. The patient is then brought to the treatment device and positioned on the treatment table. The neurosurgeon is available to make changes in the treatment plan if optimal positioning cannot be achieved. The device automatically obtains positioning radiographs and compensates for the patient's actual position in the treatment device so that the expected treatment geometry matches the actual treatment geometry based on the bony landmarks of the spine. The neurosurgeon is available to make more changes in the treatment plan if this image fusion resulting in registration of the spine fails. The treatment is then delivered.

Description of Post-Service Work: Includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of complications. The recovery room visit and discharge day management are included. Discharge records are prepared and post-discharge office visits for general care are completed during the 90 day global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	John Wilson, MD, Frederick Boop, MD, Alexander Mason, MD				
Specialty(s):	neurosurgery				
CPT Code:	63620				
Sample Size:	100	Resp N:	28	Response: 28.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	10.00	30.00	150.00
Survey RVW:	11.00	18.00	22.50	29.27	34.00
Pre-Service Evaluation Time:			65.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	20.00	60.00	90.00	120.00	210.00
Immediate Post Service-Time:	<u>15.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.50 99239x 0.00			
Office time/visit(s):	<u>46.00</u>	99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2a-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	63620	Recommended Physician Work RVU: 18.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		18.00	18.00	0.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		6.00	6.00	0.00
Intra-Service Time:		90.00		
Immediate Post Service-Time:	<u>15.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.5 99239x 0.0		
Office time/visit(s):	<u>46.00</u>	99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61751	090	18.64	RUC Time

CPT Descriptor Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance

KEY MPC COMPARISON CODES:

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 5 % of respondents: 17.8 %

TIME ESTIMATES (Median)

	CPT Code: 63620	Key Reference CPT Code: 61751	Source of Time RUC Time
Median Pre-Service Time	75.00	128.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	40.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	46.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	245.00	395.00	
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	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.20
Urgency of medical decision making	3.00	3.40

Technical Skill/Physical Effort (Mean)

Technical skill required	2.60	3.00
Physical effort required	2.40	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.40	3.40
Outcome depends on the skill and judgment of physician	3.20	3.00
Estimated risk of malpractice suit with poor outcome	3.40	3.60

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

Pre-Service intensity/complexity	3.80	3.80
Intra-Service intensity/complexity	3.20	3.60
Post-Service intensity/complexity	2.60	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.*

Code 61793 has been the code used to describe all stereotactic radiosurgery procedures. As treatment of multiple metastases became more common, there has been confusion and disagreement as to the appropriate way to code for multiple lesions. In 2007, the CPT Editorial Panel requested more precise coding. The CPT proposal ultimately accepted by the Editorial Panel included a family of seven codes, three base codes for simple and complex intracranial, and spinal lesions with ZZZ codes for additional lesions for each. There is also a code (61800) for placement and

removal of a stereotactic head frame. In the past this was included in 61793 but technology has evolved so that some radiosurgery systems now do not require the placement of a head frame. Having the head frame code as an add-on accounts for that circumstance.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61793

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

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

Specialty neurosurgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 400

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

Please explain the rationale for this estimate. Total estimated patients = 10,000. 8% are spinal lesions (800). 50% are 63620 and 50% are 636X2 (400 each).

Specialty neurosurgery Frequency 400 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? 160

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

explain the rationale for this estimate. Total estimated patients = 10,000. 40% are Medicare (4,000). 8% are spinal lesions (320). 50% are 63620 and 50% are 63621 (160 each).

Specialty neurosurgery	Frequency 160	Percentage 100.00 %
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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? No

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code: 63621 Tracking Number Z7

Specialty Society Recommended RVU: **4.00**

Global Period: ZZZ

RUC Recommended RVU: **4.00**

CPT Descriptor: Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)
(Use 63621 only in conjunction with 63621)
(For each course of treatment, 63621 may be reported no more than once per lesion. Do not report 63621 more than 2 times for entire course of treatment regardless of number of lesions treated)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman presents who has breast cancer metastatic to the vertebral body and epidural space of T2 and T5. She has undergone stereotactic spinal radiosurgery for the first tumor and now during the same session undergoes stereotactic spinal radiosurgery for the second tumor.

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

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

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

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

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

Description of Pre-Service Work:

Description of Intra-Service Work: The patient has already been transported to Radiology where stereotactic computerized imaging studies are obtained. This may be either MRI or angiography (Radiology reported separately). The neurosurgeon then works with a radiologist to verify that additional target is optimally imaged. Complex dosimetry planning follows in conjunction with radiation oncology and a radiation physicist. The computer processes all of the stereotactic images in a dose planning program during this phase. The neurosurgeon carefully outlines the additional target lesion where it appears on each consecutive image. The neurosurgeon also outlines the spinal cord on the same images. This dose planning involves use of a computer based planning module to achieve an optimal dosimetry plan for the patient. Because of the multiple lesions and their proximity to each other and to the spinal cord, several plans are developed using different prescribed doses and delivery geometry. The plan that achieves the greatest radiation dose to the additional lesion (taking into account the treatment plan for the first lesion) without interfering with the first lesion treatment plan and achieves least radiation to the spinal cord is finally chosen. The patient is then brought to the treatment device and positioned on the treatment table. The neurosurgeon is available to make changes in the treatment plan for the additional lesion if optimal positioning cannot be achieved. The device automatically obtains positioning radiographs and compensates for the patient's actual position in the treatment device for the additional lesion so that the expected treatment geometry matches the actual treatment geometry based on the bony landmarks of the spine. The neurosurgeon is available to make more changes in the treatment plan for the additional lesion if this image fusion resulting in registration of the spine fails. The treatment is then delivered.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	John Wilson, MD, Frederick Boop, MD, Alexander Mason, MD, Charles Mick, MD,				
Specialty(s):	neurosurgery; orthopaedic surgery; spine surgery				
CPT Code:	63621				
Sample Size:	100	Resp N:	17	Response: 17.0 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	4.00	23.00	120.00
Survey RVW:	3.20	4.00	8.00	12.56	25.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	30.00	40.00	60.00	90.00	180.00
Immediate Post Service-Time:	<u>7.50</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	63621	Recommended Physician Work RVU: 4.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	<u>0.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
63048	ZZZ	3.47	RUC Time

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22525	ZZZ	4.47	RUC Time	11,483

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22534	ZZZ	5.99	RUC Time	455

CPT Descriptor 2 Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22522	ZZZ	4.30	RUC Time

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)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 17.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 63621	<u>Key Reference CPT Code:</u> 63048	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	60.00	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	2.33	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.00
Urgency of medical decision making	2.33	1.50

Technical Skill/Physical Effort (Mean)

Technical skill required	2.33	3.50
Physical effort required	1.33	3.50

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	3.00	3.50
Estimated risk of malpractice suit with poor outcome	2.67	4.00

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

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	2.00	3.00
Post-Service intensity/complexity	1.67	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.*

Code 61793 has been the code used to describe all stereotactic radiosurgery procedures. As treatment of multiple metastases became more common, there has been confusion and disagreement as to the appropriate way to code for multiple lesions. In 2007, the CPT Editorial Panel requested more precise coding. The CPT proposal ultimately accepted by the Editorial Panel included a family of seven codes, three base codes for simple and complex intracranial, and spinal lesions with ZZZ codes for additional lesions for each. There is also a code (61800) for placement and removal of a stereotactic head frame. In the past this was included in 61793 but technology has evolved so that some radiosurgery systems now do not require the placement of a head frame. Having the head frame code as an add-on accounts for that circumstance.

New code 63620 is the base code for a single spinal lesion. Previously additional lesions would have been reported as 61793-51. **We recommend an RVW of 4.00 which is the 25th percentile of our survey.** The survey respondents clearly felt that an additional lesion is significantly less physician work than the first lesion. Our expert panel felt the 25th percentile resulted in the appropriate decrement in RVW relative to the recommended RVW for 63620 (the base code for this add-on code). In addition, this value is slightly greater than the key reference service, taking into account the difference in time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

3.	CPT	GLOBAL	RVW	PRE	INTRA	POST
4.	63620	90	18.00	25	90	80
5.	63621	ZZZ	4.00	0	60	0
6.	TOTAL		22.00	25	150	80

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61793-51

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

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

Specialty neurosurgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 400

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Total estimated patients = 10,000. 8% are spinal lesions (800). 50% are 636X1 and 50% are 636X2 (400 each).

Specialty neurosurgery	Frequency 400	Percentage 100.00 %
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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? 160

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Total estimated patients = 10,000. 40% are Medicare (4,000). 8% are spinal lesions (320). 50% are 63620 and 50% are 63621 (160 each).

Specialty neurosurgery	Frequency 160	Percentage 100.00 %
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

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

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

Professional Liability Insurance Information (PLI)

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

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

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

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
090 Day Global Periods
Facility Direct Inputs**

CPT Long Descriptor:

61796	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one simple cranial lesion
61798	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one complex cranial lesion
63620	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one spinal lesion

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 neurosurgeons and orthopaedic surgeons (including surgeons specializing in the spine) reviewed the practice expense details for the survey codes relative to other facility-only 90-day global services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

The standard 6 minutes has been applied for these outpatient procedures for discharge day management related services.

Post-Service Clinical Labor Activities:

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

Supplies and Equipment:

Post-surgical supplies and equipment necessary for post-discharge surgical care have been indicated.

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation			61796		61798		63620	
2	Meeting Date: April 2008			Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one simple cranial lesion		Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one complex cranial lesion		Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one spinal lesion	
3	LOCATION	Code	Staff Type	Office	Facility	Office	Facility	Office	Facility
4	GLOBAL PERIOD			090	090	090	090	090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	138	N/A	138	N/A	138
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60	N/A	60	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	6	N/A	6	N/A	6
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	72	N/A	72	N/A	72
9	PRE-SERVICE								
10	Start: Following visit when decision for surgery or procedure made								
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		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	End: When patient enters office/facility for surgery/procedure								
18	SERVICE PERIOD								
39	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		6		6		6
41	End: Patient leaves office/FACILITY								
42	POST-SERVICE Period								
43	Start: Patient leaves office/facility								
44	Conduct phone calls/call in prescriptions								
46	List Number and Level of Office Visits								
47	99211 16 minutes		16						
48	99212 27 minutes	L037D	27						
49	99213 36 minutes	L037D	36		2		2		2
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	Other								
54	Total Office Visit Time	L037D	RN/LPN/MTA		72		72		72
55	Other Activity (please specify)								
56	End: with last office visit before end of global period								
57	MEDICAL SUPPLIES								
58	pack, minimum multi-specialty visit	SA048	pack		2		2		2
59									
60									
61	Equipment								
62	table, power	EF031	100%		72		72		72
63	light, exam	EQ168	100%		72		72		72

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
ZZZ Day Global Periods
Facility Direct Inputs**

CPT Long Descriptor:

- 61796** Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)
- 61799** Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)
- 61800** Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code with primary procedure)
- 63621** Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)

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

A consensus panel of neurosurgeons and orthopaedic surgeons (including surgeons specializing in the spine) recommend no direct practice expense for these add-on codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

Supplies and Equipment:

N/A

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			61797	61799	61800	63621
2	Meeting Date: April 2008			Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)	Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code with primary procedure)	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)
3	LOCATION	Code	Staff Type	Facility	Facility	Facility	Facility
4	GLOBAL PERIOD			ZZZ	ZZZ	ZZZ	ZZZ
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure made						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	0	0	0	0
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	0	0	0	0
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	0	0	0
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0	0	0	0
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	0	0	0	0
17	End: When patient enters office/facility for surgery/procedure						
18	SERVICE PERIOD						
41	End: Patient leaves office/FACILITY						
42	POST-SERVICE Period						
43	Start: Patient leaves office/facility						
44	Conduct phone calls/call in prescriptions						
46	List Number and Level of Office Visits						
47	99211 16 minutes		16				
48	99212 27 minutes	L037D	27				
49	99213 36 minutes	L037D	36				
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
54	Total Office Visit Time	L037D	RN/LPN/MTA	0	0	0	0
55	Other Activity (please specify)						
56	End: with last office visit before end of global period						
57	MEDICAL SUPPLIES						
58	pack, post-op incision care (suture)	SA054	kit			1	
59							
60	Equipment						
61							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Interdiscal Percutaneous Aspiration

In February 2008, the CPT Editorial Panel created a new code to report a percutaneous disc, nucleus pulposus or paravertebral aspiration of fluid and/or cells for diagnostic purposes.

The RUC reviewed the specialty society survey results for code 62267 *Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes* and compared it to key reference service 62290 *Injection procedure for discography, each level; lumbar* (work RVU = 3.00). The RUC determined that the physician work required to perform these services are similar in that they both involve inserting a needle into a disc, 62290 is for the injection of contrast and 62267 is for the aspiration of the disc. Additionally, both services' intra-service times are similar, 35 and 30 minutes respectively. The RUC recommends the survey 25th percentile work RVU of 3.00 for code 62267.

The RUC reviewed the physician time required to perform this service as indicated by the specialty society and survey respondents and determined that the specialty society recommended pre-service pack 1B – straightforward patient procedure (with sedation/anesthesia) is appropriate. The specialty society recommends a decrement of 5 minutes evaluation time as moderate sedation is not inherent in this procedure, an additional 9 minutes for specific positioning of the patient to the prone position and an additional scrub, dress, wait time of 5 minutes. The RUC recommends 14 minutes evaluation time, 10 minutes positioning time and 10 minutes scrub, dress, wait time. The RUC determined that the survey intra-service time of 30 minutes and survey immediate post-service time of 15 minutes adequately represented the time required to perform this service.

The RUC recommends the survey 25th percentile work RVU of 3.00 for code 62267.

Practice Expense

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
10021		Fine needle aspiration; without imaging guidance	XXX	1.27 (No Change)
10022		<p>with imaging guidance</p> <p>(For radiological supervision and interpretation, see 76942, 77002, 77012, 77021)</p> <p>(For percutaneous needle biopsy other than fine needle aspiration, see 20206 for muscle, 32400 for pleura, 32405 for lung or mediastinum, 42400 for salivary gland, 47000, 47001 for liver, 48102 for pancreas, 49180 for abdominal or retroperitoneal mass, 60100 for thyroid, 62269 for spinal cord, 62267 for nucleus pulposus, intervertebral disc, or paravertebral tissue)</p> <p>(For evaluation of fine needle aspirate, see 88172, 88173)</p>	XXX	1.27 (No Change)
62287		<p>Aspiration or Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous discectomy, percutaneous laser discectomy)</p> <p>(For fluoroscopic guidance, use 77002 77003)</p> <p>(Do not report 62287 in conjunction with 62267)</p>	090	8.88 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●62267	AA1	Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes (For imaging, see 77003, 77012) (Do not report 62267 in conjunction with 10022, 20225, 62287, 62290, and 62291)	000	3.00
77003		Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction (Injection of contrast during fluoroscopic guidance and localization [77003] is included in 22526, 22527, 62263, 62264, 62267, 62270-62282, 62310-62319, 0027T)	XXX	0.60 (No Change)

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

CPT Code: 62267 Tracking Number AA1

Specialty Society Recommended RVU: **3.00**

Global Period: 000

RUC Recommended RVU: **3.00**

CPT Descriptor: Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes

(For imaging, see 77003, 77012)

(Do not report 62267 in conjunction with 10022, 20225, 62287, 62290, and 62291)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 70 year old diabetic female developed increasing, severe low back pain over the past 3 weeks. Lumbar MRI with contrast is consistent with possible discitis of the L5-S1 disc with some fluid seen around the disc and adjacent soft tissue. The patient wishes to proceed with a percutaneous needle aspiration of the disc fluid in order to determine if a bacterial infection exists and help guide future treatment options.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 77%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 29%

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

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

Description of Pre-Service Work:

- Review imaging studies
- Review clinical records and laboratory results
- Examine patient
- Explain consent and obtain patient signature
- Assure that all necessary instruments and supplies are present and available
- Perform time out and appropriate performance measures
- Position patient in lateral or prone position on the operating table
- Scrub and glove for the procedure
- Prep and drape patient
- Drape imaging equipment

Description of Intra-Service Work:

- Administer local anesthesia at the proposed puncture site
- Insert a 6-8 inch 20-22 gauge needle under image guidance (separately coded)
- Advance and adjust needle until positioned in the disc or surrounding paraspinal tissues
- Aspirate fluid/tissue
- Adjust needle and take additional samples
- Inoculate cultures
- Withdraw needle and apply dressing

Description of Post-Service Work:

- Monitor patient prior to discharge including wound check, neurologic check and basic vitals.
- Complete lab slips and send fluid sample to lab
- Dictate and write and sign procedure report
- Write post-procedure orders
- Contact referring physician and arrange follow up
- Discuss results and post procedure instructions with patient and family

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Charles Mick MD, John Wilson MD, Robert Barr MD, Frederick Boop MD, Dale Blaiser MD, Geraldine McGinty, MD, Jonathan Berlin, MD, Alexander Mason, MD, Steven Falcone, MD				
Specialty(s):	NASS, AANS, CNS, ASNR, ACR, AAOS				
CPT Code:	62267				
Sample Size:	5226	Resp N:	137	Response: 2.6 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	4.00	12.00	160.00
Survey RVW:	1.00	3.00	3.40	4.00	12.00
Pre-Service Evaluation Time:			40.00		
Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			10.00		
Intra-Service Time:	10.00	20.00	30.00	35.00	120.00
Immediate Post Service-Time:	<u>15.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	62267	Recommended Physician Work RVU: 3.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		14.00	19.00	-5.00
Pre-Service Positioning Time:		10.00	1.00	9.00
Pre-Service Scrub, Dress, Wait Time:		10.00	5.00	5.00
Intra-Service Time:		30.00		
Immediate Post Service-Time:	<u>15.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62290	000	3.00	Harvard Time

CPT Descriptor Injection procedure for discography, each level; 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36556	000	2.50	RUC Time	614,232

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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
19103	000	3.69	RUC Time	85,622

CPT Descriptor 2 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 71 % of respondents: 51.8 %

TIME ESTIMATES (Median)

	CPT Code: 62267	Key Reference CPT Code: 62290	Source of Time Harvard Time
Median Pre-Service Time	34.00	17.00	
Median Intra-Service Time	30.00	35.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	79.00	62.00	

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	3.13	2.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.08
Urgency of medical decision making	3.39	2.44

Technical Skill/Physical Effort (Mean)

Technical skill required	3.54	3.43
Physical effort required	2.82	2.77

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.02	2.82
Outcome depends on the skill and judgment of physician	3.32	3.44
Estimated risk of malpractice suit with poor outcome	3.06	3.06

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

Pre-Service intensity/complexity	3.00	2.93
Intra-Service intensity/complexity	3.45	3.24
Post-Service intensity/complexity	2.33	2.31

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.*

We performed a standard RUC survey with 137 respondents and are recommending the 25th percentile with a value of 3.0. This is the identical work value for the most commonly selected reference code 62290. These two procedures are very similar technically. They both involve inserting a needle into a disc (typically in the lumbar spine). Once the needle is placed, code 62290 is for injection of contrast, code 62267 is for aspiration of the disc. Code 62290

has Harvard time values. The intra service times are similar. We have selected pre-service package 1B straightforward patient/straightforward procedure (With sedation/anesthesia care). These patients all require moderate sedation which may be given by either the operating surgeon or by anesthesia staff. Moderate sedation administered by the operating physician, however, is not inherent (greater than 90% of the time). We therefore subtracted 5 minutes from the Pre-Service Evaluation (period A iwput=0.0224) - the time for moderate sedation/observe (wait) anesthesia care and moved this time to (Observe (wait anesthesia care) (period C iwput=0.0081). This procedure requires prone positioning. Survey respondents recommended a median value of 10 minutes for positioning. We agree and have increased positioning time in the 1B package from 1 minute to 10 minutes to account for turning the patient, securing the arms without tension or pressure away from the field and airway management.

The recommended work value of 3.00 fits nicely between the two MPC reference codes

cpt code	RVW	pre time	intra time	post time	total time
36556	2.5	25	15	10	35
622X1	3	35	30	15	79
19103	3.69	20	30	15	65

The IWPUT of the reference code is 0.068. The IWPUT of the survey code is also 0.068

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) An imaging codes is reported with this code

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

CPT code	global	work RVU	pre time	intra time	post time
62267	OOO	3.0	44	30	15
77002	XXX	0.54		12	
TOTAL		3.54	44	42	15

OR

CPT code	global	work RVU	pre time	intra time	post time
62267	OOO	3.0	44	30	15
77012	XXX	1.16		22	
TOTAL		4.16	44	52	15

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There was no previous code to accurately report this service. An unlisted code was recommended although some physicians reported this procedure using code 62290, 62291, 62287 or 20225.

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 spine surg How often? Commonly

Specialty radiology How often? Commonly

Specialty asa How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 4000

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

Please explain the rationale for this estimate. based upon experience of survey results and multispecialty experience

Specialty spine surgery	Frequency 1900	Percentage 47.50 %
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Specialty radiology	Frequency 1900	Percentage 47.50 %
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Specialty anesthesiology	Frequency 200	Percentage 5.00 %
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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.

Please explain the rationale for this estimate. based upon experience of svey results and multispecialty experience

Specialty spine surgery	Frequency 950	Percentage 47.50 %
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Specialty radiology	Frequency 950	Percentage 47.50 %
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Specialty anesthesiology	Frequency 100	Percentage 5.00 %
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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? 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
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Non Facility Direct Inputs**

CPT Long Descriptor:

Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes

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

AAOS, AANS/CNS, ASNR, ACR and NASS utilized consensus panels to develop the direct practice expense recommendations. For the consensus panel, attention was paid to the geographic distribution, practice type (academic, private practice) and practice size of the representatives. A joint consensus between AAOS, AANS/CNS, ASNR, ACR and NASS was reached for the final practice expense recommendation for this new code.

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 prescriptions

Intra-Service Clinical Labor Activities:

- Review charts
- Greet patient and provide gowning
- Obtain vital signs
- Prepare room, equipment, supplies
- Prepare and position the patient
- Assist the physician with the procedure
- Check dressing and wound/home care instructions
- Clean room

Post-Service Clinical Labor Activities:

- Conduct phone call

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

CPT Long Descriptor:

Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes

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

AAOS, AANS/CNS, ASNR, ACR and NASS utilized consensus panels to develop the direct practice expense recommendations. For the consensus panel, attention was paid to the geographic distribution, practice type (academic, private practice) and practice size of the representatives. A joint consensus between AAOS, AANS/CNS, ASNR, ACR and NASS was reached for the final practice expense recommendation for this new code.

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
- Provide pre-service education/obtain consent
- Follow-up phone calls and prescriptions

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

- Conduct phone calls

	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation			62267	
2		CMS Code		Percutaneous aspiration within	
3	LOCATION		Staff Type	Non Facility	Facility
4	GLOBAL PERIOD			0	0
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	60.0	23.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	16.0	20.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	41.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3.0	3.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	7	7
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3
16	Other Clinical Activity (please specify)				
17	orders, review the chart to incorporate relevant clinical information	L041 B	RT		
18	End: When patient enters office/facility for surgery/procedure				
19	SERVICE PERIOD				
20	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
21	Review charts	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				
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2	
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	3	
28	Sedate/apply anesthesia				
29	Intra-service				
30	Assist physician in performing procedure	L037D	RN/LPN/MTA	20	
31	Post-Service				
32	Monitor pt following service				
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	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	L037D	RN/LPN/MTA	5	
39	Discharge day management 99238 -12 minutes				
40	Other Clinical Activity (please specify)				
41	End: Patient leaves office				
42	POST-SERVICE Period				
43	Start: Patient leaves office/facility				
44	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3
45	Office visits				
46	List Number and Level of Office Visits				
47	99211 16 minutes		16		
48	99212 27 minutes		27		
49	99213 36 minutes		36		
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
53	Total Office Visit Time			0	0
54	Other Activity (please specify)				
55	End: with last office visit before end of global period				
56	MEDICAL SUPPLIES		Unit		
57	anerobic culture tube			1	
58	culture swab system (Culturette)	SL033		1	
59	needle, 18-26g 1 5-3 5 in, spinal	SC028		1	
60	needle, Chiba	SC035		1	
61	pack, basic injection	SA041		1	
62	pack, minimum multi-specialty visit	SA048		1	
63	Equipment				
64	pulse oximeter w- printer	EQ211		X	
65	room, radiographic - fluoroscope	EL014		X	
66	stretcher	EF018		X	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Anesthetic Agent Nerve Injection

CPT code 64416 *Injection, anesthetic agent; trigeminal nerve, any division or branch brachial plexus, continuous infusion by catheter (including catheter placement)* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work.

Because the descriptor originally stated "including daily management for anesthetic agent administration" it could not logically be assigned a 000-day global period. The RUC requested that CMS assign a 000-day global period to code 64416 and that the specialty society resurvey this service with the revised descriptor. CMS notified the RUC that a 000-day global period would be acceptable and assigned code 64416 a 00-day global period. Additionally, the specialty society indicated that this descriptor discrepancy would be applicable to three other codes within this family. Therefore, the specialty society also requested revision to the descriptors and global periods for codes 64446, 64448 and 64449. In February 2008, the CPT Editorial Panel revised the descriptors to eliminate this language. The specialty society resurveyed codes 64416, 64446, 64448 and 64449 and presented recommendations to the RUC at the April 2008 meeting.

64416, 64446 and 64449

The RUC obtained a clear understanding of the services described by these revised codes as well as the correct rank order. The RUC reviewed the survey results from 36-44 physicians who perform these services and found that the survey respondents indicated that these services required more technical skill, mental effort and present more psychological stress upon the physician in comparison to the key reference codes 62318 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic* (work RVU = 2.04, total physician time = 120 minutes) and 62319 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)*

(work RVU = 1.87, total physician time = 108 minutes). Although the reference codes require more overall time, the intensity and complexity measures indicated a higher level of work per unit of time.

Therefore, while understanding the intensity and complexity of the services, the RUC developed a building block type approach to establish appropriate values for this family of codes by comparing them to the following single injection codes:

64415 *Injection, anesthetic agent; brachial plexus, single* (work RVU= 1.48)

64445 *Injection, anesthetic agent; sciatic nerve, single* (work RVU= 1.48)

The increment between the single injection service 62311 *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)* (work RVU=1.54) and the continuous injection code 62319 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)* (work RVU = 1.87) is 0.33 work RVUs ($1.87 - 1.54 = 0.33$). To develop the appropriate work RVUs for codes 64416, 64446 and 64449, the RUC used codes 64415 and 64445 (each has a work RVU = 1.48) as the base code and added the single injection increment of 0.33 RVUs to account for the catheter placement and continuous injection ($1.48 + 0.33 = 1.81$). **The RUC recommends a work RVU of 1.81 for codes 64416, 64446 and 64449.**

64448

The RUC determined that although the surveyed key reference code 62319 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)* (work RVU = 1.87, total physician time = 108 minutes) requires more overall time, the intensity and complexity measures indicated a higher level of work per unit of time.

To develop the appropriate work RVU for code 64448 the RUC used the same building block methodology except that the incremental difference added to its base single shot injection was 0.13. The RUC established this increment by taking the difference between codes 62310 *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic* (work RVU=1.91) and the key reference service 62318 *Injection,*

including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic (work RVU = 2.04) (2.04-1.91=0.13). To develop the appropriate work RVU for 64448, the RUC used the single injection base code 64447 *Injection, anesthetic agent; femoral nerve, single* (work RVU= 1.50) and added the increment of 0.13 to account for the catheter placement and continuous injection (1.50 + 0.13 = **1.63**). The specialty society indicated and the RUC agreed that the catheter placement is less difficult for 64448 than the other three continuous infusion codes 64416, 64446 and 64449. The RUC determined that these values established the correct rank order among this family of revised codes. **The RUC recommends a work RVU of 1.63 for code 64448.**

Practice Expense:

CPT Codes 64416, 64446, 64448 and 64449 are typically performed in the facility setting, therefore the RUC does not recommend any direct practice expense inputs at this time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
64400		Injection, anesthetic agent; trigeminal nerve, any division or branch	000	1.11 (No Change)
▲64416	CC1	brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration	000	1.81
▲64446	CC2	sciatic nerve, continuous infusion by catheter (including catheter placement), including daily management for anesthetic agent administration	000	1.81
▲64448	CC3	femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration	000	1.63

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲64449	CC4	lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration	000	1.81

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

CPT Code: 64416 Tracking Number CC1

Specialty Society Recommended RVU: **1.90**

Global Period: 000

RUC Recommended RVU: **1.81**

CPT Descriptor: Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36-year-old male suffered traumatic amputation of his thumb and forefinger on the right hand in an auto accident. He has had these digits replanted under a general anesthetic and five hours of surgery. The digits are ischemic in appearance and cold with poor capillary filling despite a good surgical repair and anastomoses of the digital arteries. The surgeon requests a block with continuous infusion to manage post-operative pain and provide vasodilatation to the arterial supply to the hand and digits in an effort to improve survival of the re-implanted digits. A continuous brachial plexus block using a catheter placed in the brachial plexus at the axilla and the infusion of local anesthetic is planned to provide pain relief and to provide vasodilatation of the arterial supply to the hand and digits.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 55%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 17%

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

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

Description of Pre-Service Work: The patient's medical record is reviewed, the patient is interviewed and examined and informed consent is obtained. Particular attention is paid to any history of epilepsy, evidence of infection, and bleeding disorders as these increase the risk of complication from the procedure. The patient is positioned supine. Blood pressure cuff, pulse oximeter and electrocardiographic monitors are applied.

Description of Intra-Service Work: An intravenous infusion is initiated and supplemental oxygen is provided. His right arm is abducted at the shoulder and flexed at the elbow with his hand positioned above his right shoulder. The infra- and supraclavicular regions are prepped with an antiseptic solution and the skin is anesthetized with a small amount of local anesthetic via a small gauge needle (27G). A stimulating needle is inserted into either the infra- or supraclavicular area and advanced until the proper location of the needle is ascertained with the use of a nerve stimulator, the elicitation of paresthesias and/or the use of an ultrasound image (ultrasound guidance, when used, is separately reported). At that point, a nerve block catheter is inserted into the brachial plexus sheath. The needle is removed and the plastic cannula left in position. Next an epidural-type plastic catheter is inserted through the cannula into the brachial plexus sheath and secured in place. A bacterial filter is attached. An brachial plexus block using the injection of about 30-40 ml of local anesthetic (usually 1 to 1.5% lidocaine, 0.25 to 0.375% bupivacaine or 1 to 1.5% mepivacaine) is now performed after using a small test dose of the local anesthetic and frequent aspiration during the injection. The density and function of the block is then assessed over the next 30 minutes as well as signs and symptoms of local anesthetic toxicity. A continuous infusion of local anesthetic is now started (0.25% bupivacaine at 5-10 ml/hr.). Movement of the head and neck post placement make scrupulous attention to patient comfort in choice of tunneling length, direction and technique important in the affixation of the brachial plexus catheter.

Description of Post-Service Work: A procedure note is dictated and medical record requirements are completed. In addition to the usual complications of a brachial plexus block, infection, injury to the neurovascular bundle with hematoma formation and vascular insufficiency, systemic local anesthetic toxicity pneumo/hemothorax are all possible complications of the continuous catheter technique.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):		Tripti Kataria, MD, MPH				
Specialty(s):		American Society of Anesthesiologists				
CPT Code:		64416				
Sample Size: 137		Resp N: 40		Response: 29.1 %		
Sample Type: Panel						
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.00	2.00	10.00	100.00
Survey RVW:		1.58	1.99	2.23	2.55	20.00
Pre-Service Evaluation Time:				25.00		
Pre-Service Positioning Time:				8.00		
Pre-Service Scrub, Dress, Wait Time:				6.50		
Intra-Service Time:		10.00	15.00	20.00	30.00	240.00
Immediate Post Service-Time:		15.00				
Post Operative Visits		Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):		0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):		0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:		0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):		0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:		0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	64416	Recommended Physician Work RVU: 1.90		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		19.00	19.00	0.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		20.00		
Immediate Post Service-Time:	15.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0		
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62318	000	2.04	RUC Time

CPT Descriptor Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic

KEY MPC COMPARISON CODES:

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
62270	000	1.37	RUC Time	81,700

CPT Descriptor 1 Spinal puncture, lumbar, diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36556	000	2.50	RUC Time	614,232

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62319	000	1.87	RUC Time

CPT Descriptor Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 32.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 64416	<u>Key Reference CPT Code:</u> 62318	<u>Source of Time</u> RUC Time
Median Pre-Service Time	25.00	50.00	
Median Intra-Service Time	20.00	40.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	60.00	120.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.15	3.08
--------------------------------------------------------------------------------------------------	------	------

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

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

Technical Skill/Physical Effort (Mean)

Technical skill required	4.15	3.85
--------------------------	------	------

Physical effort required	3.46	3.46
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.31	3.46
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	3.92	3.69
--------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	3.62	4.00
------------------------------------------------------	------	------

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

Pre-Service intensity/complexity	3.15	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.85	3.69
------------------------------------	------	------

Post-Service intensity/complexity	3.15	3.15
-----------------------------------	------	------

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 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) These procedures are often performed on patients who are undergoing a surgical procedure that requires a general anesthetic. They may be placed pre- intra- or post-operatively. When this occurs, they are separate, distinct and independent from the anesthesia service described by codes 00100-01999.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 00100-01999

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64416

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? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 12000

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

Please explain the rationale for this estimate.

Specialty Anesthesiology Frequency 10987 Percentage 91.55 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

3,732 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty Anesthesiology Frequency 3417 Percentage 91.55 %

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code: 64446 Tracking Number CC2

Specialty Society Recommended RVU: **1.87**

Global Period: 000

RUC Recommended RVU: **1.81**

CPT Descriptor: Injection, anesthetic agent; sciatic nerve plexus, continuous infusion by catheter (including catheter placement)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male suffers a crushed left foot in an automobile accident. He undergoes major reconstruction of his left foot and ankle under general anesthesia. The surgeon requests a block with continuous infusion to manage post-operative pain and facilitate rehabilitation. In order to provide post-operative pain control, a continuous sciatic nerve block is performed at the end of surgery.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 63%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 23%

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

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

Description of Pre-Service Work: The patient's medical record is reviewed, the patient is interviewed and examined and informed consent is obtained. Particular attention is paid to any history of epilepsy, evidence of infection, and bleeding disorders as these increase the risk of complication from the procedure. In the post-anesthesia recovery room or in the operating room, the patient is placed in the right lateral position. Blood pressure cuff, pulse oximeter and electrocardiographic monitors are applied.

Description of Intra-Service Work: An intravenous infusion is initiated and supplemental oxygen is provided. The thigh is flexed on the hip to 45 degrees. The greater femoral trochanter and ischial tuberosity are marked and a line drawn from the popliteal fossa to midway between the two landmarks. After antiseptic skin preparation and placement of a small amount of local anesthetic via a small gauge needle (e.g., 27G), 20 gauge insulated needle is introduced vertically to the skin, just medial to the upper end of the marked line to determine the depth of the sciatic nerve. A brisk motor response in the ankle, foot or toes is noted with less than 0.4 mA stimulation. It is possible to use ultrasound imaging to guide needle placement. When performed, this is separately reported. Next an insulated Tuohy needle is advanced from approximately 5 cm cephalad and angled to intersect the tip of the first needle. Nerve stimulation is again noted, and a catheter then advanced through the Tuohy needle and 50 to 100 mm beyond its tip. The electrical connection is then transferred to the catheter and nerve stimulation again evaluated. The Tuohy needle is removed, the catheter secured in place, a bacterial filter is attached and 15-20 ml of 0.5% bupivacaine injected through the catheter. Block of the sciatic nerve is then assessed over the next 15-30 minutes and an infusion of 0.375% bupivacaine at 0.1 ml/kg/hr (~7 ml/hr) is started. Required infusion rates typically range from 2 to 12 ml/hr. Occasionally bolus injections (10-15 ml) are required. Subcutaneous tunneling, affixation, and dressing of the catheter must be done carefully as this area is prone to bacterial contamination both during and after the procedure.

Description of Post-Service Work: A procedure note is dictated and medical record entries are made. In addition to the usual complications of a sciatic block, infection, hematoma formation and systemic local anesthetic toxicity are all possible complications of the continuous catheter technique.

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SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):		Tripti Kataria, MD, MPH				
Specialty(s):		American Society of Anesthesiologists				
CPT Code:		64446				
Sample Size: 137		Resp N: 38	Response: 27.7 %			
Sample Type: Panel						
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.00	1.50	15.00	72.00
Survey RVW:		1.61	1.87	2.16	2.68	20.00
Pre-Service Evaluation Time:				20.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				10.00		
Intra-Service Time:		6.00	15.00	20.00	28.75	300.00
Immediate Post Service-Time:		15.00				
Post Operative Visits		Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):		0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):		0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:		0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):		0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:		0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	64446	Recommended Physician Work RVU: 1.87		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		19.00	19.00	0.00
Pre-Service Positioning Time:		5.00	1.00	4.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		20.00		
Immediate Post Service-Time:	15.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00 57x 0.00

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62318	000	2.04	RUC Time

CPT Descriptor Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epdiural or subarachnoid; cervical or thoracic

KEY MPC COMPARISON CODES:

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
62270	000	1.37	RUC Time	81,700

CPT Descriptor 1 Spinal puncture, lumbar, diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36556	000	2.50	RUC Time	614,232

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62319	000	1.87	RUC Time

CPT Descriptor Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epdiural or subarachnoid; lumbar, sacral (caudal)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 28.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 64446	<u>Key Reference CPT Code:</u> 62318	<u>Source of Time</u> RUC Time
Median Pre-Service Time	29.00	50.00	
Median Intra-Service Time	20.00	40.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	64.00	120.00
Other time if appropriate		

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

The number of possible diagnosis and/or the number of management options that must be considered	3.27	3.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.09	3.45
Urgency of medical decision making	3.36	3.18

Technical Skill/Physical Effort (Mean)

Technical skill required	4.36	3.91
Physical effort required	3.82	3.55

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.64	3.82
Outcome depends on the skill and judgment of physician	4.00	3.82
Estimated risk of malpractice suit with poor outcome	3.73	3.91

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

Pre-Service intensity/complexity	3.45	3.64
Intra-Service intensity/complexity	4.00	3.82
Post-Service intensity/complexity	3.45	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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) These procedures are often performed on patients who are undergoing a surgical procedure that requires a general anesthetic. They may be placed pre- intra- or post-operatively. When this occurs, they are separate, distinct and independent from the anesthesia service described by codes 00100-01999.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 00100-01999

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64446

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? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Anesthesiology Frequency 7875 Percentage 78.75 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,355 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Anesthesiology Frequency 2642 Percentage 78.74 %

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

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: 64448 Tracking Number CC3

Specialty Society Recommended RVU: **1.70**

Global Period: 000

RUC Recommended RVU: **1.63**

CPT Descriptor: Injection, anesthetic agent; femoral nerve plexus, continuous infusion by catheter (including catheter placement)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male undergoes a right total knee replacement (CPT code 27447) under general anesthesia. The surgeon requests a block with continuous infusion to manage post-operative pain and facilitate rehabilitation. In order to provide post-operative pain control and increased mobility in his knee, a continuous femoral nerve block is performed.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 61%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 20%

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

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

Description of Pre-Service Work: The patient's medical record is reviewed, the patient is interviewed and examined and informed consent is obtained. Particular attention is paid to any history of epilepsy, evidence of infection, and bleeding disorders as these increase the risk of complication from the procedure. In the post-anesthesia recovery room or in the operating room, the patient is placed in the supine position. Blood pressure cuff, pulse oximeter and electrocardiographic monitors are applied.

Description of Intra-Service Work: An intravenous infusion is initiated and supplemental oxygen is provided. The patient's right groin is prepped with an antiseptic solution and a 22-gauge short-bevel 10 cm insulated needle is inserted into an 18 gauge long plastic cannula. To access the femoral nerve sheath, a small amount of local anesthetic is injected with a small gauge needle at a point located approximately 1 cm lateral to the femoral artery and 1 cm caudad from the inguinal ligament.. The needle is placed through the wheal of local anesthetic and proper location of the needle is ascertained with the use of a nerve stimulator or with the elicitation of paresthesias, or both. An ultrasound imaging system may also improve the ability to discover the femoral sheath's location. When performed, ultrasound guidance is separately reported. The plastic cannula is then advanced over the needle into the sheath of the femoral nerve. Next, between 20 and 30 ml of 0.25% to 0.5% bupivacaine or other long-acting anesthetic with epinephrine 1:200,000 is injected carefully through the cannula and with frequent aspiration and monitoring of the ECG and pulse oximeter to avoid the possibility of intravascular injection. A 20-gauge epidural catheter is threaded through the cannula and the cannula removed. The catheter is secured in place, sterilely dressed and a bacterial filter is attached. Bupivacaine 0.25 to 0.125% at 0.14 ml/kg/hr (~10 ml/hr) is then infused. Subcutaneous tunneling, affixation and dressing of the catheter must be done carefully as this area is prone to bacterial contamination both during and after the procedure.

Description of Post-Service Work: A procedure note is dictated and medical record entries are made after each visit. The complications of a femoral nerve block include possible infection, injury to the femoral artery with hematoma

formation, systemic local anesthetic toxicity and nerve injury from direct trauma, intraneural injection or compressive-ischemic injury.

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Tripti Kataria, MD, MPH				
Specialty(s):	American Society of Anesthesiologists				
CPT Code:	64448				
Sample Size:	137	Resp N:	44	Response: 32.1 %	
Sample Type:	Panel				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	5.00	20.00	150.00
Survey RVW:	1.54	1.85	2.06	2.52	12.00
Pre-Service Evaluation Time:			20.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			5.50		
Intra-Service Time:	5.00	15.00	15.00	20.00	180.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	64448	Recommended Physician Work RVU: 1.70		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		19.00	19.00	0.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		15.00		
Immediate Post Service-Time:	15.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0		
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62319	000	1.87	RUC Time

CPT Descriptor Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization of epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)

KEY MPC COMPARISON CODES:

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
6227	000	1.37	RUC Time	21,700

CPT Descriptor 1 Spinal puncture, lumbar, diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36556	000	2.50	RUC Time	614,232

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 19 % of respondents: 43.1 %

TIME ESTIMATES (Median)

	CPT Code: 64448	Key Reference CPT Code: 62319	Source of Time RUC Time
Median Pre-Service Time	25.00	48.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	55.00	108.00	

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	2.68	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.63	3.00
Urgency of medical decision making	2.63	2.74

Technical Skill/Physical Effort (Mean)

Technical skill required	3.79	3.63
Physical effort required	3.26	3.16

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.95	3.32
Outcome depends on the skill and judgment of physician	3.63	3.58
Estimated risk of malpractice suit with poor outcome	3.05	3.26

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

Pre-Service intensity/complexity	2.63	2.89
Intra-Service intensity/complexity	3.26	3.11
Post-Service intensity/complexity	2.84	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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) These procedures are often performed on patients who are undergoing a surgical procedure that requires a general anesthetic. They may be placed pre- intra- or post-operatively. When this occurs, they are separate, distinct and independent from the anesthesia service described by codes 00100-01999.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 00100-01999

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64448

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? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 90000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Anesthesiology Frequency 82386 Percentage 91.54 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 30,513 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Anesthesiology Frequency 27932 Percentage 91.54 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code: 64449 Tracking Number CC4

Specialty Society Recommended RVU: **1.90**

Global Period: 000

RUC Recommended RVU: **1.81**

CPT Descriptor: Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old female undergoes a left total knee replacement (CPT code 27447) under general anesthesia. The surgeon requests a block with a continuous infusion to manage post-operative pain and facilitate rehabilitation. In order to provide post-operative pain control and increased mobility in her knee, a continuous lumbar plexus block is performed.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 63%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 19%

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

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

Description of Pre-Service Work: History, physical, laboratory review are performed, focusing on relative and absolute contraindications to the procedure (infection, coagulopathy, neural deficits, anatomic abnormalities, etc). The risks and procedures of the catheter placement and infusion are discussed with the patient and consent is obtained. When placing a left lumbar plexus block, the patient is placed in the right lateral decubitus position with the thighs and knees flexed. Blood pressure cuff, pulse oximeter and electrocardiographic monitors are applied.

Description of Intra-Service Work: An intravenous infusion is initiated and supplemental oxygen is provided. A line is drawn between the iliac crests, i.e., Tuffier's line. A second line is made 3-5 cm parasagittally to the left. A mark for the needle insertion is made where the two lines intersect. The low back is prepped with a topical antiseptic. After infiltrating the skin and deeper tissues with local anesthetic using a small gauge needle (e.g., 27G), a 19-gauge, 10 cm needle, designed to allow the introduction of a catheter through the needle and connected to a peripheral nerve stimulator, is advanced to obtain stimulation of the lumbar plexus. When a transverse process is encountered, the needle is then partially withdrawn and advanced slightly cephalad until it slides past the transverse process of the lumbar vertebra.

When the needle tip is in the psoas compartment and in the proper location, stimulation of the lumbar plexus is recognized by observing the rise of patella, contraction of the quadriceps and sartorius muscles. Generally current of 0.6 to 0.8 mA indicate stimulation of the femoral nerve when the needle is correctly positioned. Ultrasound imaging may be useful in this needle placement. When performed, ultrasound guidance is separately reported.

At this point careful aspiration for blood and CSF is performed. A test dose of local anesthetic (3 ml of 2% lidocaine with epinephrine 1:200,000) is administered to rule out IV or intrathecal injection. Between 15 and 30 ml of dilute local anesthetic (e.g., 0.25% bupivacaine, 0.2% ropivacaine) is slowly injected through the needle, followed by insertion of an infusion catheter through the needle (about 5 cm past the tip of the needle). The patient is observed for

signs of undesired epidural spread and associated hemodynamic changes, and for analgesia of the left leg and hip. The catheter is checked for intravascular and intrathecal placement and secured in place. Once correct function of the catheter is confirmed, a bacterial filter is attached and a continuous infusion of dilute concentration of local anesthetic (e.g., 0.2% ropivacaine, 0.25 % bupivacaine) is started at 8-10 ml/hour. Alternatively, a patient controlled infusion may be started at 5 ml/hr with a bolus of 10 ml/30-60 minutes. Assistance at the time of ambulation is essential.

Description of Post-Service Work: A note is written in the patient's record that documents the nature of the nerve block, the patient's analgesia self-rating, mobility, and vital signs. The complications of a lumbar plexus block include: intravascular injection, intrathecal injection with high level of the resultant spinal block, infection, ureteral, venous, or renal puncture; intraperitoneal injection; hematoma of the psoas muscle with nerve compression; and extension of anesthesia into the epidural space.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):		Tripti Kataria, MD, MPH				
Specialty(s):		American Society of Anesthesiologists				
CPT Code:		64449				
Sample Size: 137		Resp N: 36		Response: 26.2 %		
Sample Type: Panel						
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.00	0.00	6.25	46.00
Survey RVW:		1.50	1.90	2.22	2.86	16.00
Pre-Service Evaluation Time:				20.00		
Pre-Service Positioning Time:				9.00		
Pre-Service Scrub, Dress, Wait Time:				10.00		
Intra-Service Time:		5.00	15.00	20.00	26.25	180.00
Immediate Post Service-Time:		11.00				
Post Operative Visits		Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):		0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):		0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:		0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):		0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:		0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	64449	Recommended Physician Work RVU: 1.90		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		19.00	19.00	0.00
Pre-Service Positioning Time:		5.00	1.00	4.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		20.00		
Immediate Post Service-Time:	<u>11.00</u>			
Post Operative Visits	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62319	000	1.87	RUC Time

CPT Descriptor Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, ipioid, steroid, other solution), epidural or subarachnoid; lumbar sacral (caudal)

KEY MPC COMPARISON CODES:

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
62270	000	1.37	RUC Time	81,700

CPT Descriptor 1 Spinal puncture, lumbar, diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36556	000	2.50	RUC Time	614,232

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 17 % of respondents: 47.2 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 64449	<u>Key Reference CPT Code:</u> 62319	<u>Source of Time</u> RUC Time
Median Pre-Service Time	29.00	48.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	11.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	60.00	108.00	

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	3.00	3.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.06	3.18
Urgency of medical decision making	2.76	2.82

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.47
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Physical effort required	3.35	3.00
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.59	3.35
Outcome depends on the skill and judgment of physician	4.00	3.65
Estimated risk of malpractice suit with poor outcome	3.35	3.29

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

Pre-Service intensity/complexity	2.94	3.00
Intra-Service intensity/complexity	3.59	3.29
Post-Service intensity/complexity	2.94	2.88

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 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) These procedures are often performed on patients who are undergoing a surgical procedure that requires a general anesthetic. They may be placed pre- intra- or post-operatively. When this occurs, they are separate, distinct and independent from the anesthesia service described by codes 00100-01999.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 00100-01999

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64449

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? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Anesthesiology Frequency 9360 Percentage 93.60 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
3,421 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Anesthesiology Frequency 3202 Percentage 93.59 %

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

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 Committee
Summary of Recommendations

April 2008

Intermetatarsal Neuroma Injection(s) and Destruction by a Neurolytic Agent

In February 2008, the CPT Editorial Panel created two new codes to report injection(s) of an anesthetic agent and destruction by neurolytic agent of the plantar common digital nerve.

64455, *Injection(s), anesthetic agent and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)*

The specialty society presenters articulated for the RUC that the physician work involved in the injection of an anesthetic agent and/or steroid and distinguished the work from other injection services. Based on this explanation, the RUC agreed that the survey median intra-service time of three minutes was inappropriate and inaccurate. They agreed with the specialty societies' expert panel consensus of 5 minutes of intra-service time. The RUC concluded that the survey respondents most likely included within the pre-service time, two additional minutes of intra-service time involved for the actual injection. This was supported by several reference services that the specialty societies agreed were very similar, but none had intra-service times less than five minutes. To account for this shift in intra-service time, the RUC agreed that the pre-service time should be reduced. The RUC did so by reducing the survey median pre-time from 19 minutes to 10 minutes. These 10 minutes consist of pre-service time package #5 (7 minutes) plus 3 additional minutes. These additional 3 minutes include 1 minute to account for communication with other healthcare professionals; 1 minute for check/set-up room; and 1 minute for preparing for the procedure.

The RUC agreed that the survey median work RVU of 0.80 was too high. The specialty society and the RUC agreed that the survey 25th work RVU of 0.75 appropriately values the physician work required for this service and places it in the correct order with other injection services. The physician work required for code 64455 was compared to the work of code 20550, *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU = 0.75, intra-service time = 5 minutes), the key reference service. Code 20550 involves injection into a muscle, which the RUC determined is less difficult than the work involved in injecting anesthetic directly into a nerve. When injecting a nerve, the physician must first find the nerve and second, be very aware not to damage it. Neither of these concerns is present in the injection into muscle, making a nerve injection more difficult and more intense. Code 20550 was valued by the RUC in 2002 along with several other injection services. The RUC extensively reviewed the injection services and took significant steps to ensure that there were no rank order anomalies. Code 64455, which previously was reported using 20550, was created to account for the additional work involved in injecting a nerve rather than muscle. The committee agreed that to recommend a work RVU of any less than 0.75 would create a rank order anomaly.

To further support a work RVU of 0.75 for code 64455, the committee reviewed the respective IWPUTs of several injection services: 64614, 20550, 20553, 20551 and 20526. With a work RVU of 0.75, the IWPUT for code 64455 (0.083) falls right in the middle of the IWPUT for the injection services indicated.

Code	Short Descriptor	wRVU	Pre	Intra	Post	IWPUT
64614	Destroy nerve	2.20	15	20	15	0.076
20550	Inj. tendon, sheath/lig	0.75	10	5	5	0.083
64455	Inj digital nerve	0.75	10	5	5	0.083
20553	Inj. trigger point	0.75	7	10	5	0.094
20551	Inj. tendon, sheath/lig	0.75	10	5	5	0.098
20526	Ther. inj.; carp. tun.	0.94	6	5	5	0.139

Thus, the RUC determined that the appropriate work RVU for 64455 is 0.75 with an adjusted intra-service time of 5 minutes, which results in an IWPUT directly in line with other injection services and maintain proper rank order.

The RUC recommends a work RVU of 0.75, amended pre-service package #5 with an additional three minutes (10 minutes pre-service time) and intra-service time of 5 minutes for 64455.

64632, Injection, anesthetic agent; other peripheral nerve or branch

The specialty society presenters articulated for the RUC that the physician work involved in the injection of an anesthetic agent and/or steroid and distinguished the physician work required for other injection services. Based on this explanation, the RUC agreed that the survey median intra-service time of five minutes was appropriate. Additionally, the RUC determined that the survey respondents overstated the pre-service time. As such, the RUC agreed that the pre-service time is only 10 minutes. These 10 minutes consist of pre-service time package #5 (7 minutes) plus 3 additional minutes. The additional 3 minutes include 1 minute to account for communication with other healthcare professionals; 1 minute for check/set-up room; and 1 minute for preparing for the procedure. The RUC determined that the specialty society recommended post-service office of a single 99212 was appropriate.

The RUC determined that the survey median work RVU of 1.80 was too high, but that the survey 25th percentile work RVU of 0.95 was too low. The work of this service is nearly identical to that of the 64455, but includes a single 99212 office visit within its 010 day global period. As such, the committee based its recommendation on the recommended valuation of 64455 and added the work of a 99212 ($0.75 + 0.45 = 1.20$). The RUC noted that the resulting IWPUT is 0.083, identical to 64455 and in line with the range of the CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

key 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, intra-service time = 20 minutes) and the entire family. The survey code requires greater mental effort and judgment, technical skill, and physical effort, but requires less intra-service time. As such, the IWPUT for 64632 (0.083) is incrementally higher than those services: 64612 (IWPUT=0.059), 64613 (IWPUT=0.056) and 64614 (IWPUT=0.076).

Code	Short Descriptor	wRVU	Pre	Intra	Post	IWPUT
64612	Chemodenervation, face muscle	1.98	10	20	6	0.059
64613	Chemodenervation, neck muscle	1.98	10	21	16	0.056
64614	Chemodenervation, extremity muscle	2.20	15	20	15	0.076
64632	Destroy digital nerve	1.20	10	5	5	0.083

The RUC recommends a work RVU of 1.20 for 64632.

Practice Expense

The RUC recommends the direct practice expense inputs for the non-facility setting as modified by the Practice Expense Subcommittee.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
20500		Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia") (For injection of Morton's neuroma, see 64455, 64632)	010	1.25 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Nervous System Extracranial Nerves, Peripheral Nerves and Automatic Nervous System Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic				
●64455	BB1	Injection(s), anesthetic agent and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma) (Do not report 64455 with 64632)	000	0.75
64450		Injection, anesthetic agent; other peripheral nerve or branch	000	1.27 (No Change)
Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency)				
●64632	BB2	Destruction by neurolytic agent; plantar common digital nerve (Do not report 64632 with 64455)	010	1.20

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

CPT Code: 64455 Tracking Number BB1

Specialty Society Recommended RVU: **0.75**

Global Period: 000

RUC Recommended RVU: **0.75**

CPT Descriptor: Injection(s), anesthetic agent and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 46-year-old female presents with a painful neuroma in the third intermetatarsal space of her right foot. The decision is made to proceed with a therapeutic intermetatarsal neuroma injection.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

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

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

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

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

Description of Pre-Service Work: Communicate with other professionals; review of treatment options; review x-rays; review procedure with patient; discuss possible complications; obtain patient consent; and communicate with patient's family. Prepare injection by mixing local anesthetic with steroid. The patient's involved foot is placed on a sterile barrier and prepped. The physician gloves.

Description of Intra-Service Work: The intermetatarsal space is palpated and the point of maximal tenderness is identified. A dorsal approach is utilized and the needle is inserted top to bottom without penetrating the plantar skin. A portion of the injectable is deposited. The needle is redirected distally and medially without exiting the dorsal site and a portion of the injectable is deposited. The needle is again redirected distally and laterally without exiting the dorsal site and the final portion of the injectable is deposited.

Description of Post-Service Work: The injection area is cleansed and a bandage is applied. The patient is monitored for any potential complications from the injection. Instruct patient and/or care giver on appropriate activities and home care. Discuss future management of the condition. Dictate notes for medical chart. Dictate procedure note and a letter to the PCP and/or insurance company.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):	Frank Spinosa, DPM; Robb Mothershed,DPM; R. Dale Blasier, MD; Tye Ouzounian, MD					
Specialty(s):	podiatry; orthopaedic surgery					
CPT Code:	64455					
Sample Size:	100	Resp N:	30	Response: 30.0 %		
Sample Type: Random						
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	20.00	55.00	150.00	500.00
Survey RVW:		0.68	0.75	0.80	0.85	1.27
Pre-Service Evaluation Time:				15.00		
Pre-Service Positioning Time:				2.00		
Pre-Service Scrub, Dress, Wait Time:				2.00		
Intra-Service Time:		1.00	2.00	3.00	5.00	20.00
Immediate Post Service-Time:	<u>5.00</u>					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00				
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00				
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00				
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00				
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	64455	Recommended Physician Work RVU: 0.75		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		10.00	7.00	3.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		5.00		
Immediate Post Service-Time:	5.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0		
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20550	000	0.75	RUC Time

CPT Descriptor Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 17 % of respondents: 56.6 %

TIME ESTIMATES (Median)

	CPT Code: 64455	Key Reference CPT Code: 20550	Source of Time RUC Time
Median Pre-Service Time	10.00	10.00	
Median Intra-Service Time	5.00	5.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	20.00	20.00	
Other time if appropriate			

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

The number of possible diagnosis and/or the number of management options that must be considered	2.88	2.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.41	2.24
Urgency of medical decision making	2.00	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.12	2.88
Physical effort required	1.88	1.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.29	2.12
Outcome depends on the skill and judgment of physician	2.88	2.53
Estimated risk of malpractice suit with poor outcome	2.00	1.88

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

Pre-Service intensity/complexity	2.35	2.29
Intra-Service intensity/complexity	2.71	2.47
Post-Service intensity/complexity	2.00	1.94

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.*

New code 64455 and key reference code 20550 are essentially the same service. We recommend the survey 25th percentile work RVU of 0.75.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64450, 20550, 28899

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? Commonly

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 150000

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

Please explain the rationale for this estimate. specialty opinion

Specialty podiatry Frequency 145000 Percentage 96.66 %

Specialty orthopaedic surgery Frequency 5000 Percentage 3.33 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 92,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. According to the 2005 Medicare data, code 64450 was reported approximately 217,000 times. It is estimated that approximately 58,000 of those services involved an injection of an intermetatarsal neuroma. Code 20550 was reported approximately 828,000 times. It is estimated that approximately 32,000 of those services involved an injection of an intermetatarsal neuroma. Code 28899 was reported approximately 3,000 times and it is estimated that 1,580 of those services involved an injection of an intermetatarsal neuroma. The overall incidence is estimated to be higher when non-Medicare patients are taken into consideration.

Specialty podiatry	Frequency 91000	Percentage 98.91 %
Specialty orthopaedic surgery	Frequency 1000	Percentage 1.08 %
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: 64632 Tracking Number BB2

Specialty Society Recommended RVU: **1.20**

Global Period: 010

RUC Recommended RVU: **1.20**

CPT Descriptor: Destruction by neurolytic agent; plantar common digital nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old male presents with a painful neuroma in the 2nd intermetatarsal space of his left foot, which has failed typical conservative measures. The decision is made to proceed with neurolytic injection of the intermetatarsal neuroma.

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

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

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

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

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

Description of Pre-Service Work: Communicate with other professionals; review of treatment options; review x-rays; review procedure with patient; discuss possible complications; obtain patient consent; and communicate with patient's family. Prepare injection by mixing local anesthetic with alcohol. The patient's involved foot is placed on a sterile barrier and prepped. The physician gloves.

Description of Intra-Service Work: The intermetatarsal space is palpated and the point of maximal tenderness is identified. A dorsal approach is utilized and the needle is inserted top to bottom without penetrating the plantar skin. A portion of injectable is deposited. The needle is redirected distally and medially without exiting the dorsal site and a portion of the injectable is deposited. The needle is again redirected distally and laterally without exiting the dorsal site and the final portion of the injectable is deposited.

Description of Post-Service Work: The injection area is cleansed and a bandage is applied. The patient is monitored for any potential complications from the injection. Instruct patient and/or care giver on appropriate activities and home care. Discuss future management of the condition. Dictate notes for medical chart. Dictate procedure note and a letter to the PCP and/or insurance company. At follow-up office visit, physician will examine patient and discuss treatment success or adverse reactions that may have occurred after the visit. Revise treatment plan(s) Dictate notes for medical chart. Dictate procedure note and a letter to the PCP and/or insurance company.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Frank Spinosa, DPM; Robb Mothershed, DPM; R. Dale Blasier, MD; Tye Ouzounian, MD				
Specialty(s):	podiatry; orthopaedic surgery				
CPT Code:	64632				
Sample Size:	100	Resp N:	35	Response: 35.0 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	11.00	33.00	200.00
Survey RVW:	0.60	0.95	1.80	2.33	5.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			3.00		
Pre-Service Scrub, Dress, Wait Time:			3.00		
Intra-Service Time:	1.00	3.00	5.00	9.00	40.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>55.00</u>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	64632	Recommended Physician Work RVU: 1.20		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		10.00	7.00	3.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		5.00		
Immediate Post Service-Time:	<u>5.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>16.00</u>	99211x 0.00 12x 1.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64614	010	2.20	RUC Time

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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 5 % of respondents: 14.2 %

TIME ESTIMATES (Median)

	CPT Code: 64632	Key Reference CPT Code: 64614	Source of Time RUC Time
Median Pre-Service Time	10.00	15.00	
Median Intra-Service Time	5.00	20.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	36.00	50.00	
Other time if appropriate			

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

The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	2.75
Urgency of medical decision making	2.00	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.75	3.00
Physical effort required	2.00	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.50
Outcome depends on the skill and judgment of physician	3.75	3.00
Estimated risk of malpractice suit with poor outcome	3.00	2.50

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

Pre-Service intensity/complexity	2.75	3.00
Intra-Service intensity/complexity	3.00	2.50
Post-Service intensity/complexity	2.50	2.25

Additional Rationale

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

It is difficult to compare new code 64632 to key reference code 64614, which is a more extensive procedure. Our consensus panel believes new code 64632 which has a 10-day global period is similar in total work to 20550 (0-day global) plus one 99212 office visit. We recommend 1.20 work RVUs, which is equal to 0.75 + 0.45. This value is between the survey 25th and median RVW.

With respect to the pre-service time, we recommend package 6 with the following modifications:

- Evaluation: Subtract 4 minutes (total 13 min) because some percent of the time an E/M will occur and 9 min is allotted for H&E in package 6.
- Positioning: Add 1 minute (total = 2 min) to position foot in a stable fashion and prep for injection.
- Scrub/Dress/Wait: Subtract 4 minutes (total 1 min). Local anesthesia is mixed with drug. Physician scrubs and dons gloves.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64640

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? Commonly

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 75000

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

Please explain the rationale for this estimate. specialty estimate

Specialty podiatry	Frequency 60000	Percentage 80.00 %
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Specialty orthopaedic surgery	Frequency 500	Percentage 0.66 %
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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? 45,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 50% of 64640 in Medicare 2006 data

Specialty podiatry	Frequency 35000	Percentage 77.77 %
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Specialty orthopaedic surgery	Frequency 250	Percentage 0.55 %
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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 Update Process
Practice Expense Summary of Recommendation
000 Day Global Periods
Facility and Non-Facility Direct Inputs**

CPT Long Descriptor: 64455 Injection(s), anesthetic agent and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)

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

A consensus panel of experts representing Orthopaedics and Podiatry reviewed the practice expense details for the survey codes relative to other 0-day global codes specifically 20550 and 64450. Our specific allocation of time is found in the attached excel spreadsheet.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No pre-service time for the procedure when performed in the office. For the facility, we assigned 19 total pre-time clinical labor minutes (5 for pre-service diagnostic and referral forms, 3 for coordinating pre-surgery services, 3 to schedule space and equipment in the facility, 5 minutes to provide pre-service education and obtain consent, and 3 minutes for miscellaneous clinical activities)

Intra-Service Clinical Labor Activities:

Office

2 minutes for meeting and greeting patient
1 minutes to provide pre-service education and obtain consent
2 minutes to prepare room, equipment and supplies
2 minutes to assist MD in preparing and positioning of patient for procedure (and imaging).
3 minutes to assist physician in performing the procedure
3 minutes to monitor patient following services (includes checking tubes, monitors, and drains). Patient has been lying on back with leg positioned for 20 minutes and as a result, staff need to be certain of vestibular stability and physical stability.
3 minutes to clean room and equipment used by surgeon
3 minutes to check patient's dressings and provide wound care instructions, coordinate future office visits and write prescriptions.

Facility - none

Post-Service Clinical Labor Activities:

none

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

CPT Long Descriptor:64632: Destruction by neurolytic agent; plantar common digital nerve

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

A consensus panel of experts representing Orthopaedics and Podiatry reviewed the practice expense details for the survey codes relative to other similar neurolytic agent destruction codes, specifically 20550 and 64450. Our specific allocation of time is found in the attached excel spreadsheet.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No pre-service time for the procedure when performed in the office. For the facility, we assigned 19 total pre-time clinical labor minutes (5 for pre-service diagnostic and referral forms, 3 for coordinating pre-surgery services, 3 to schedule space and equipment in the facility, 5 minutes to provide pre-service education and obtain consent, and 3 minutes for miscellaneous clinical activities)

Intra-Service Clinical Labor Activities:

Office

2 minutes for meeting and greeting patient

1 minutes to provide pre-service education and obtain consent

2 minutes to prepare room, equipment and supplies

2 minutes to assist MD in preparing and positioning of patient for procedure (and imaging).

3 minutes to assist physician in performing the procedure

3 minutes to monitor patient following services (includes checking tubes, monitors, and drains). Patient has been lying on back with leg positioned for 20 minutes and as a result, staff need to be certain of vestibular stability and physical stability.

3 minutes to clean room and equipment used by surgeon

3 minutes to check patient's dressings and provide wound care instructions, coordinate future office visits and write prescriptions.

Facility

None

Post-Service Clinical Labor Activities:

1-99212 (27 minutes) assigned to reflect the recommended post-operative visits.

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			64455		64632	
	Meeting Date: April 2008			Injection(s), anesthetic agent and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)		Destruction by neurolytic agent; plantar common digital nerve	
2							
3	LOCATION	Code	Staff Type	Office	Facility	Office	Facility
4	GLOBAL PERIOD			0	0	10	10
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	19	0	46	27
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	19	0	19	0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	27	27
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure made						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA				
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA				
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA				
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA				
16	Other Clinical Activity (please specify)	L037D	RN/LPN/MTA				
17	End: When patient enters office/facility for surgery/procedure						
18	SERVICE PERIOD						
19	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure						
20	Review charts	L037D	RN/LPN/MTA				
21	Greet patient and provide gowning	L037D	RN/LPN/MTA	2		2	
22	Obtain vital signs	L037D	RN/LPN/MTA				
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	1		1	
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA				
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2	
27	Sedate/apply anesthesia	L037D	RN/LPN/MTA				
28	Intra-service						
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	3		3	
30	Post-Service						
31	Monitor pt following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	3		3	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
33	Clean Scope	L037D	RN/LPN/MTA				
34	Clean Surgical Instrument Package	L037D	RN/LPN/MTA				
35	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
36	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3	
38	Discharge day management 99238 --12 minutes, 99239 --15 minutes	L037D	RN/LPN/MTA				
39	Other Clinical Activity (please specify)	L037D	RN/LPN/MTA				
40	End: Patient leaves office						
41	POST-SERVICE Period						
42	Start: Patient leaves office/facility						
43	Conduct phone calls/call in prescriptions						
45	List Number and Level of Office Visits						
46	99211 16 minutes		16				
47	99212 27 minutes		27			1	1
48	99213 36 minutes		36				
49	99214 53 minutes		53				
50	99215 63 minutes		63				
51	Other						
52	Total Office Visit Time	L037D	RN/LPN/MTA	0	0	27	27
53	Other						
54	End: with last office visit before end of global period						

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			64455		64632	
2	Meeting Date: April 2008			Injection(s), anesthetic agent and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)		Destruction by neurolytic agent; plantar common digital nerve	
3	LOCATION	Code	Staff Type	Office	Facility	Office	Facility
55	MEDICAL SUPPLIES	Code	Unit				
56	pack, minimum multi-specialty visit	SA048	pack	0	0	1	1
57	drape, sterile barrier 16in x 29in	SB007	item	1		1	
58	gloves, sterile	SB024	pair	1		1	
59	needle, 18-27g	SC029	item	2		2	
60	synnqe 10-12ml	SC051	item	1		1	
61	swab-pad, alcohol	SJ053	item	2		2	
62	povidone soln (Betadine)	SJ041	ml	10		10	
63	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	2		2	
64	bandage, strp 0.75in x 3in (Bandaid)	SG021	item	1		1	
65	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1	
66	sclerosing solution inj	SH062	ml			1	
67							
68	Equipment	Code					
69	table, exam	EF023		19		46	27
70	light, exam	EQ168		19		46	27
71							
72	NOTES:						
73	Tnamicinolone injection for code 644XX is separately reportable with HCPCS J3301-J3303						
74	Item SH062 sclerosing inj is proxy for 4% ethyl alcohol inj						

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Endothelial Keratoplasty

In February 2008, the CPT Editorial Panel created two CPT codes to describe the physician service of endothelial keratoplasty, which is a new surgical method of repairing some diseased corneas that in the past would have required a full thickness corneal transplant (also called penetrating keratoplasty). Rather than perform a classical transplant with donor tissue replacing the full-thickness of the cornea, the surgeon replaces only the innermost layer of the cornea containing the corneal endothelium. The surgical procedure is radically different from the full-thickness procedure and requires different surgical skills.

65756 Keratoplasty (corneal transplant); endothelial

The RUC reviewed specialty society surveyed physician work data from 51 corneal surgeons. The survey respondents chose its key reference service code 65750 *Keratoplasty (corneal transplant); penetrating (in aphakia)* (work RVU = 16.60), which was compared to new code 65756. The RUC recognized that the largest mean differences were in the areas of technical skill required, outcome depending on the skill and judgment of the physician, and the intensity of the intra-service time.

The RUC agreed that the technical skill required for this procedure was significantly greater than that for the standard full-thickness keratoplasty because the procedure requires extensive manipulation of the transplanted material in the anterior chamber through small incisions. The reduced intra-service time when compared with the reference code is due to the fact that an endothelial graft does not have to be sutured in place. This suturing process in the reference procedure requires more time, but less physician effort and technical skill. Post operatively, code 65756 and 65750 include six post operative visits within the global period, although the level of some of the visits for 65756 are lower than for the reference code. Considering the higher intra service intensity of 65756 and the lower post operative visit levels compared to 65750, the RUC and specialty society agreed that the overall physician work values were quite similar.

The RUC also compared the physician work of codes 44310 *Ileostomy or jejunostomy, non-tube* (work RVU = 17.49) and 49002 *Reopening of recent laparotomy* (work RVU = 17.55) to new code 65756. The RUC and specialty concurred that the physician work for new code 65756 is not as high as these services, however it is highly intense and complex. The RUC agreed with the specialty society that a reasonable physician work RVU for code 65756 is below the survey median of 18.00 and more in line with its key

reference service code. The specialty and RUC agreed that the 25th percentile survey work RVU of 16.60 provides an accurate value for code 65756. **The RUC recommends a work relative value of 16.60 for CPT code 65756.**

65757 - Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure) (Use 65757 in conjunction with 65756)

The specialty society provided a description of the work and effort involved in preparing a corneal endothelial allograft. The RUC believed that the survey respondents valued the service too high at 2.75 work RVUs and an intensity of 0.183. The RUC reviewed backbench work service 50327 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each* (work RVU=4.00, intra-service time = 44 minutes, IWPUT = .091, XXX global), and the dermal autograph work of 15136 *Dermal autograph, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.50, intra-service time = 15 minutes, IWPUT = 0.010, ZZZ global). The RUC agreed that the intensity of new code 65757 should be between these two services. The RUC also compared 65757 to 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 1.44, intra-service time = 23 minutes, global period = ZZZ) and understood the intensity per minute of 6577X2 exceeded that of 13122. The RUC agreed with the physician time of 15 minutes from the survey results. Although the RUC concurred that this service has a high level of intensity, the committee believed that the intra-service work intensity should be about half of what was originally proposed by the specialty. The committee believed the physician work was lower than code 50327 and 15136 yet its intensity was between the two at approximately 0.096. The RUC calculated a work RVU for new code 65757 based on the agreed upon intensity of 0.096 and the 15 minutes of survey intra service time. **The RUC recommends a work relative value of 1.44 for 65757.**

Practice Expense: The RUC recommends the standard 090 day global direct practice expense inputs for new code 65757 as they apply to the facility setting only, as these procedures will typically be performed in the hospital setting. New code 65757 does not require direct practice expense inputs and the RUC recommends none.

New Technology:

The RUC recommends that 65756 and 65757 be added to the new technology list as this procedure utilizes new techniques.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Corneal transplant includes use of fresh or preserved grafts, and. <u>The preparation of donor material is included for penetrating or anterior lamellar keratoplasty, but reported separately for endothelial keratoplasty. Do not report 65710-65757 in conjunction with 92025.</u></p> <p><i>(Keratoplasty excludes refractive keratoplasty procedures, 65760, 65765, and 65767)</i></p>				
▲65710	DD1	Keratoplasty (corneal transplant); <u>anterior</u> lamellar	090	14.09 (No Change)
▲65730	DD2	penetrating (except in aphakia <u>or pseudophakia</u>)	090	15.99 (No Change)
65750	DD3	penetrating (in aphakia)	090	16.60 (No Change)
65755	DD4	penetrating (in pseudophakia)	090	16.49 (No Change)
●65756	DD5	endothelial	090	16.60
●+65757	DD6	<p>Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)</p> <p><u>(Use 65757 in conjunction with 65756)</u></p>	ZZZ	1.44

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

CPT Code: 65756 Tracking Number DD5

Specialty Society Recommended RVU: **16.60**

Global Period: 090

RUC Recommended RVU: **16.60**

CPT Descriptor: Keratoplasty (corneal transplant); endothelial

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year-old male develops pseudophakic corneal edema in his left eye 7 years after cataract surgery. Visual acuity is reduced to 20/80 and there is significant glare disability due to the edema, limiting his ability to drive, read, and watch television. A well-positioned posterior chamber intraocular lens is present, and the posterior segment examination is unremarkable.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 54%

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

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

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Review patient record. Obtain consent. Write preoperative orders for medications. Select appropriate anesthesia. Discuss surgery again with patient and family. Scrub and gown. Perform surgical *time out* with the OR team After appropriate anesthesia is administered povidone-iodine 5% solution is placed in the conjunctival sac and used for preparing the lashes and periocular skin. Draping of the surgical field is performed.

Description of Intra-Service Work: Acular and lidocaine are applied topically to the recipient. White-to-white is measured with a caliper and a trephine size is selected. Superior and inferior 4-0 silk bridge sutures are placed and clamped. The epithelium of the recipient cornea is marked with the trephine.

The donor graft is punched with the same trephine used to mark the recipient. The lamellar disc is inspected and trimmed if full-thickness in areas. The donor graft is covered with preservation media.

The temporal cornea is marked with 5.5 mm calipers painted with gentian violet. A conjunctival peritomy is performed temporally. Bleeding is controlled with cautery. A 5.5 mm wide scleral tunnel is made temporally and carried forward to clear cornea with a crescent blade. A paracentesis is made to the right of the scleral tunnel, inside the trephine mark. Preservative-free lidocaine is placed in the anterior chamber. A 23-gauge needle attached to irrigation is passed through clear cornea inside the trephine mark to the left of the scleral tunnel and used to maintain the anterior chamber and stabilize eye position throughout the case. Anterior chamber air is removed with a cannula through the paracentesis. Descemet's membrane is lightly scored with a reverse Sinskey hook inside the epithelial trephine mark. Irrigation is turned off. Trypan blue dye is placed in the anterior chamber to stain the endothelium. A small incision is made through the scleral tunnel into the anterior chamber with a 15 degree blade. Irrigation is turned on and excess trypan blue is irrigated from the eye. A Descemet's membrane scraper is placed through the tunnel incision and used to scrape/detach Descemet's membrane, avoiding the central cornea. Descemet's membrane is removed with forceps and unfolded on the surface of the cornea to check for complete removal. Additional trypan blue is placed and additional scraping is performed in cases of incomplete removal. The periphery of the recipient stroma is gently roughened with

the scraper. The incision is opened to the full width of the 5.5mm tunnel with a 15 degree blade. The 23-gauge infusion needle is removed.

The donor is removed from the punch block with a spatula and transferred to the surface of the recipient cornea, endothelial side up. A small amount of cohesive viscoelastic is placed on the left side of the donor endothelium. The epithelial lamella of the donor is fixed with forceps while the endothelial lamella is folded to the left with additional forceps so that the top half overlaps the bottom in a taco fashion. The folded posterior lamella is grasped with special insertion forceps and is inserted into the anterior chamber. The forceps are opened and removed without pulling out the donor. The anterior chamber is filled with balanced salt solution through the right-sided paracentesis without dislodging the donor. The scleral tunnel is sutured with 3 radial 10-O nylon sutures, which are tied and trimmed. A 30-gauge needle is placed through a limbal stab incision peripheral to the donor on the left, and air is slowly injected between the posterior and anterior halves of the folded donor. If the donor moves out of position prior to unfolding, a backhanded 10-O nylon suture is placed through the limbus on the left, through the anterior edge of the folded donor, out through the recipient cornea and tied. Air is added slowly to unfold the donor. If the donor does not unfold, a bent needle-tip is placed through a limbal paracentesis on the right and used to engage the stromal side of the inferior portion of the donor.

The 10-O nylon donor suture is removed once the donor is unfolded and in position. Air is added until the eye is firm and left in place for 10 minutes. During this time, the surface is compressed with a Lindstrom or other roller to remove interface fluid and secure proper donor position. A mid-peripheral incision is placed in each of the four quadrants of the recipient cornea and used to release interface fluid. The conjunctiva is closed with cautery. A subconjunctival injection of dexamethasone is administered inferonasally. A final paracentesis is made at the limbus, peripheral to the donor, with a 15 degree blade. Balanced salt solution is injected and air is removed, leaving a deep chamber and a 4-5mm air bubble. The final paracentesis incision is hydrated with balanced salt solution. Homatropine 5%, moxifloxacin 0.3%, and ketorolac 0.5% are applied topically. The lid speculum and drapes are removed.

Description of Post-Service Work: The patient is instructed to lie flat in postoperative care area for 45 minutes and the position of the graft is re-checked prior to discharge.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Stephen A. Kamenetzky, M.D. and David B. Glasser, M.D.				
Specialty(s):	Ophthalmology				
CPT Code:	65756				
Sample Size:	200	Resp N:	51	Response: 25.5 %	
Sample Type: Convenience					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	10.00	25.00	37.50	300.00
Survey RVW:	13.20	16.60	18.00	20.00	29.00
Pre-Service Evaluation Time:			10.0		
Pre-Service Positioning Time:			10.0		
Pre-Service Scrub, Dress, Wait Time:			10.0		
Intra-Service Time:	30.00	60.00	60.00	80.00	120.00
Immediate Post Service-Time:	<u>20.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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 0.50 99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0 12x 3.0 13x 3.0 14x 0.0 15x 0.0			
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	65756	Recommended Physician Work RVU: 16.60		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.0	0.0
Pre-Service Positioning Time:		1.00	1.0	0.0
Pre-Service Scrub, Dress, Wait Time:		5.00	5.0	0.0
Intra-Service Time:		60.00		
Immediate Post Service-Time:	<u>20.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
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>19.0</u>	99238x 0.5 99239x 0.0		
Office time/visit(s):	<u>117.0</u>	99211x 0.0 12x 3.0 13x 3.0 14x 0.0 15x 0.0		
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
65750	090	16.60	RUC Time

CPT Descriptor Keratoplasty (corneal transplant); penetrating (in aphakia)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
49002	090	17.55	RUC Time	5,460

CPT Descriptor 1 Reopening of recent laparotomy

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
44310	090	17.49	RUC Time

CPT Descriptor Ileostomy or jejunostomy, non-tube**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 80.3 %

TIME ESTIMATES (Median)

	CPT Code: 65756	Key Reference CPT Code: 65750	Source of Time RUC Time
Median Pre-Service Time	39.00	40.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	117.0	138.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	255.00	288.00	
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	4.37	4.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	4.02
Urgency of medical decision making	3.54	3.63

Technical Skill/Physical Effort (Mean)

Technical skill required	4.88	4.37
Physical effort required	4.44	4.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.46	4.39
Outcome depends on the skill and judgment of physician	4.93	4.56
Estimated risk of malpractice suit with poor outcome	4.02	3.93

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

Pre-Service intensity/complexity	4.32	4.10
Intra-Service intensity/complexity	4.71	4.34
Post-Service intensity/complexity	4.20	3.98

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 AAO is presenting this code for a new technique for treatment of loss of vision from corneal edema caused by corneal endothelial failure. Previously, this condition required excision of a full thickness corneal button and replacement with a full thickness graft. These grafts were secured by multiple sutures which needed to remain in place for 12 to 18 months which prolonged healing and induced significant corneal astigmatism. These factors delayed return of visual function and the patient's return to normal daily function. The new technique involves selectively transplanting the

endothelial layer of the cornea. Although technically more difficult, this procedure avoids the need for a full thickness graft, minimizes corneal astigmatism and speeds visual rehabilitation.

The AAO surveyed 200 corneal surgeons and got 51 responses (25.5%). The vignette was felt to be typical by 78% of those surveyed. The 25th percentile WRVU was 16.6 with a median value of 18.00. The median intraservice time was 60 minutes. Service package 3 was chosen for the preservice time. Respondents felt that the mental effort and judgment, technical skill and physical effort and stress required were higher for all but one measure than the reference code 65750 (penetrating keratoplasty in aphakia). The largest mean differences were in the areas of technical skill required, outcome depending on the skill and judgment of the physician, and the intensity of the intraservice time. Six post operative visits during the global period were recognized, although the level of some of the visits was less than for the reference code. The survey findings were reviewed by the consensus panel which included a member of the Cornea Society who has ample experience with the endothelial keratoplasty procedure. It was felt that the technical skill required for this procedure was significantly greater than that for the standard full-thickness keratoplasty because the procedure requires extensive manipulation of the transplanted material in the anterior chamber through small incisions. The reduced intraservice time when compared with the reference code is due to the fact that an endothelial graft does not have to be sutured in place. This suturing process in the reference procedure requires more time, but less physician effort and technical skill.

The panel also considered the fact that corneal topography is bundled with all of the current corneal transplant codes, but is not mentioned in the new code descriptor. It would be the recommendation of the panel that corneal topography (92025) be bundled in the new code as well for all measurements during the 90-day global period.

The final step in preparing donor corneal tissue for transplantation is a part of the current corneal transplant codes. It involves punching a full-thickness central corneal button from a piece of donor tissue obtained from an eye bank. For endothelial keratoplasty, the graft material is still obtained from the eye bank, but it is available in two forms: precut (anterior and posterior lamellae separated) or not prepared (a full thickness corneal button which the operating surgeon will separate into anterior and posterior lamellae in the operating room). When the precut graft is used, the work for the final step to prepare the endothelial material is included in the intraservice work of the new code, just as it is in the old keratoplasty codes. However, the graft preparation is technically more difficult than for a standard keratoplasty because the precut lamellae, which are less than 1mm thick, must first be carefully aligned under the operating microscope in order to obtain a suitable graft. The button is then punched from the donor tissue, the lamellae are again separated and only the endothelial layer is used for the surgery.

The separate scenario when the operating surgeon prepares the anterior and posterior lamellae by dissection from intact eye bank material is discussed as an add-on code -- 65757

After reviewing the data, the panel recommends that the **25th percentile WRVU of 16.6** be accepted by the RUC for this procedure. This happens to be the same wRVU value as the reference code. The consensus panel felt that this was quite appropriate in that the increased technical skill required for both preparing the graft material, then positioning and anchoring it in the eye was balanced by the shorter intraservice time and lower intensity overall of the postoperative visits. For comparison, the panel noted that CPT code 44310 *Ileostomy or jejunostomy, non-tube* has an RUV of 17.49 with 62.5 minutes of IST. It has more hospital care, but only 2 postoperative visits.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Will be reported with 6575X2 in some instances where the surgeon prepares his own graft tissue in the back bench area of the OR.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Unlisted code, 65710, 65730, 65750, 65755. Primarily as the unlisted code since most carriers were not allowing use of the other codes for this new procedure in 2006 or 2007.

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? 4500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is an estimate based on historical trends for keratoplasty with consideration of additional patients who may not have been previous candidates for other keratoplasty procedures but who may now be eligible.

Specialty	Frequency	Percentage 0.00 %
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Specialty	Frequency	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? 900

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Same as above

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
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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? 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: 65757 Tracking Number DD6

Specialty Society Recommended RVU: **2.75**

Global Period: ZZZ

RUC Recommended RVU: **1.44**

CPT Descriptor: Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)
(Use 6575X2 in conjunction with 6575X1)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: n endothelial graft is required for an endothelial keratoplasty. The surgeon prepares this in the operating room prior to performing the intraocular surgery.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

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

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The endothelial graft is prepared in the operating room. The temperature of the artificial anterior chamber (AAC) on which the donor cornea will be mounted is checked, an infusion system is attached, and all air bubbles are removed. The donor cornea is secured to the AAC with a screw-top mechanism while preventing reintroduction of air into the system. Alignment of the donor material is then checked under the operating microscope and the tissue repositioned if necessary. The pressure in the system is measured. The corneal epithelium is removed under the scope and a reference mark applied to the donor cornea to allow alignment of the segments after the cornea has been cut. The central corneal thickness (pachymetry) is measured after the material has been hydrated and the microkeratome, which splits the donor button into two pieces, is set for the appropriate depth to cut based on the pachymetry measurement. After rechecking the pressure settings of the AAC and rewetting the cornea, the microscope is used to inspect the microkeratome and then the corneal cap is cut from the donor material. Under the scope, the cap is retrieved from the microkeratome, realigned on the donor bed using the previously placed marker, and the cap measured to be sure that the endothelial graft is of sufficient diameter to be used. The screw top of the AAC is then removed, the infusion restarted and the donor material carefully removed from the AAC making certain that there is no collapse of the chamber (which would damage the graft) during the process.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Stephen A. Kamenetzky, M.D. and David B. Glasser, M.D.				
Specialty(s):	Ophthalmology				
CPT Code:	65757				
Sample Size:	200	Resp N:	28	Response: 14.0 %	
Sample Type: Convenience					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5 00	21.50	41.00	300.00
Survey RVW:	2.50	5.00	6.00	8.00	16.50
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	0.00	15.00	15.00	20.00	30.00
Immediate Post Service-Time:	<u>0.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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			
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23), 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	65757	Recommended Physician Work RVU: 4.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.0	0.0
Pre-Service Positioning Time:		0.00	0.0	0.0
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0
Intra-Service Time:		15.00		
Immediate Post Service-Time:	<u>0.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
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 0.0 99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0		
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
65750	090	16.60	RUC Time

CPT Descriptor**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
12052	010	2.81	RUC Time	73448

CPT Descriptor 1 Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15151	ZZZ		RUC Time

CPT Descriptor Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (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: 25.0 %

TIME ESTIMATES (Median)

	CPT Code: 65757	Key Reference CPT Code: 65750	Source of Time Harvard Time
Median Pre-Service Time	0.00	40.00	
Median Intra-Service Time	15.00	90.00	
Median Immediate Post-service Time	0.00	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	138.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	15.00	288.00	

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	3.71	3.57
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	3.43
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Urgency of medical decision making	3.14	3.00
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.86	3.86
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Physical effort required	4.43	3.86
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.57	3.86
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	4.71	4.14
--------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	3.71	3.86
------------------------------------------------------	------	------

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

Pre-Service intensity/complexity	3.71	3.29
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Intra-Service intensity/complexity	4.29	3.57
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Post-Service intensity/complexity	3.00	3.29
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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 code is submitted as an add-on code for 65756 to prepare the graft material in cases where completely processed tissue from an eye bank is not being used. The work involved is greater than that for preparing a standard full thickness corneal button. It is expected that this technique will be used in 50% of 65756 procedures.

The survey was submitted to 200 ophthalmologists with a response rate of 28 (14%). This low response rate was thought to be due to the fact that many ophthalmologists use prepared tissue. The 25th percentile WRVU was 5 with a median IST of 15 minutes. No preservice time was submitted. The reference code chosen most frequently was 65750 which is the penetrating keratoplasty code with a WRVU of 16.6 followed by 66682 with a value of 7.15. Both of these codes are 90-day global services with pre and post procedure components.

The consensus panel reviewed the survey data and felt that the findings were going to be of little use in determining a reasonable WRVU for 65756. There was obviously some confusion regarding exactly what was being asked and the responses reflected that. The preparation of the graft material is a complex process (described in detail below), but does not approach the intensity determined by the survey.

The following steps are performed by the surgeon to prepare the donor material. For 65756, all of these will have been done by the eye bank that supplied the corneal button. The temperature of the artificial anterior chamber (AAC) on which the donor cornea will be mounted is checked, an infusion system is attached, and all air bubbles are removed. The donor material is secured to the AAC with a screw-top mechanism while preventing reintroduction of air into the system. Alignment of the donor material is then checked under the operating microscope and the tissue repositioned if necessary. The pressure in the system is measured. The corneal epithelium is removed under the scope and a reference mark applied to the donor material to allow alignment of the segments after the cornea has been cut. The central corneal thickness (pachymetry) is measured after the material has been hydrated and the microkeratome, which splits the donor button into two pieces, is set for the appropriate depth based on the pachymetry measurement. After rechecking the pressure settings of the AAC and rewetting the cornea, the microscope is used to inspect the microkeratome and then the corneal cap is cut from the donor material. Under the scope, the cap is retrieved from the microkeratome, realigned on the donor bed using the previously placed marker, and the cap measured to be sure that the endothelial graft is of sufficient diameter to be used. The screw top of the AAC is then removed, the infusion restarted and the donor material carefully removed from the AAC making certain that there is no collapse of the chamber (which would damage the graft) during the process. The donor corneal material is then at the stage where it would be if it had been provided by the eye bank and the remainder of the donor tissue preparation is included in the work of the base code.

The survey findings were reviewed by the consensus panel which included a member of the Cornea Society who has ample experience with the work required to obtain material for the transplant. The panel reviewed the RUC database for 000, XXX, backbench and ZZZ codes with similar intraservice times. The ZZZ group was felt to be the most reasonable set of codes with which to compare 65757. CPT 15151 *Tissue cultured epidermal autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)* has a WRVU of 2.00 and an IST of 20 minutes. CPT 15152 (a similar procedure with a larger graft) has a WRVU of 2.5 with the same IST as 15151. It was felt that the 65757 code has a higher level of intensity than either of these codes (which have ISTs of 20 min) because the technical skill of cutting the graft is greater than attaching pre-cut material to a denuded area. In addition, there is significant psychological stress caused by the fact that if there is a problem with harvesting the graft, the case will likely have to be cancelled as additional donor material is rarely available.

Upon considering these issues, **the consensus committee recommends a WRVU of 2.75 for 65757.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

your scenario. 657X1. This new add-on code would be performed by the operating surgeon at the back bench area of the OR prior to starting the primary code, 65X71.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This work was likely not reported separately except perhaps with an unlisted code since the other keratoplasty codes contain the tissue prep work within the 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 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? 2250

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

Please explain the rationale for this estimate. It is 50% of the frequency we estimated for its primary code overall as we believe that approximately half of ophthalmologists performing the primary procedure will be preparing their own graft material.

Specialty	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? 450

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Same rationale as above

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

Professional Liability Insurance Information (PLI)

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

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

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

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			65756		65757	
2	Meeting Date: RUC April 25-26, 2008			Keratoplasty (corneal transplant); endothelial		Backbench preparation of corneal endothelial allograft prior to transplantation	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			N/A	90	N/A	ZZZ
5	TOTAL CLINICAL LABOR TIME			0.0	249.0	0.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	60.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	189.0	0.0	0.0
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure						
11	Complete pre-service diagnostic & referral forms	L038A			5		
12	Coordinate pre-surgery services	L038A			20		
13	Schedule space and equipment in facility	L038A			8		
14	Provide pre-service education/obtain consent	L038A			20		
15	Follow-up phone calls & prescriptions	L038A			7		
16	End: When patient enters office/facility for surgery/procedure						
17	SERVICE PERIOD						
18	Start: When patient enters office/facility for surgery/procedure						
19	Pre-service services						
20	Review charts						
21	Greet patient and provide gowning						
22	Obtain vital signs						
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies						
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	Intra-service						
29	Assist physician in performing procedure						
30	Post-Service						
31	Monitor pt following service/check tubes, monitors, drains						
32	Clean room/equipment by physician staff						
33	Clean Scope						
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms, lab & X-ray requisitions						
36	Review/read X-ray, lab, and pathology reports						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
38	Discharge day management 99238 --12 minutes						
39	End: Patient leaves office						
40	POST-SERVICE Period						
41	Start: Patient leaves office/facility						
42	Conduct phone calls/call in prescriptions						
43	Office visits						
44	List Number and Level of Office Visits						
45	99211 16 minutes		16				
46	99212 27 minutes		27		3		
47	99213 36 minutes		36		3		
48	99214 53 minutes		53				
49	99215 63 minutes		63				
50	Total Office Visit Time			0	189	0	0
51	Other Activity (please specify)						
52	End: with last office visit before end of global period						
53	MEDICAL SUPPLIES	CMS Code	Unit				
54	Ophthalmic visit package	SA082			3		
55	Ophthalmic visit package	SA050			3		
56	Exam Lane	EL005			3		
57	Screening Lane	EL006			3		
58	Equipment	Code					
59							

**RUC Recommendations for
CPT 2009
Volume 2**

**RUC Meetings
September 2007, February 2008 and
April 2008**

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2009**

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AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

High Dose Rate Brachytherapy

In February 2008, the CPT Editorial Panel met and agreed that the existing CPT codes for High Dose Rate (HDR) brachytherapy no longer reflect the most current practice. The process of care for HDR brachytherapy has evolved over the past decade and they believed the present descriptors did not optimally discriminate physician work. The number of dwell positions as described in the current codes is a poor surrogate for physician work and changing the code to reflect the number of channels used better describes the physician work. In addition the existing codes were originally valued as 090 day global service codes, but in 2007 were converted to XXX global codes. Thus a more up to date evaluation of the entire work process was required and the CPT Editorial Panel deleted four existing and created three new brachytherapy procedure codes that more accurately described the services provided. The three new procedure codes are:

The RUC reviewed the specialty society's survey results for each of the three new procedure codes and obtained a better understanding of the physician work, intensity, risk factors, and rank order of high dose rate brachytherapy services. The RUC and the specialty agreed that it was difficult for the specialty and survey respondents to select reference services for these procedures while deleting similar procedure codes, however the survey results did provide a good starting point at obtaining the relative work values. The RUC and specialty society agreed to use a building block approach to establish the values for each code.

77785 - Remote afterloading high dose rate radionuclide brachytherapy; 1 channel

RUC members reviewed the key reference service, 77315 *Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)* (work RVU = 1.56), in relation to new code 77785. The RUC determined that the intra service work intensity for code 77785 was too high. They agreed that the intensity of code 77785 was equivalent to the intensity of an established patient level two evaluation and management office code (99212, IWPUR= 0.0316) and that its value be equivalent to a E/M code 99214 (work RVU=1.42), by using a building block approach using the specialty society's recommended physician time components (shown below). In addition, the RUC agreed the relative work value lies between two multi-specialty points of comparison codes 11755 *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)* (work RVU=1.31), and 29445

Application of rigid total contact leg cast (work RVU=1.78). The RUC recommends a work relative value of 1.42 for new code 77785.

77786 - Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels

RUC members reviewed the key reference service, 19296 *Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy* (work RVU = 3.63) and its intra service work intensity to the survey results and specialty recommendation for code 77786. The RUC determined that the recommended value of 3.10 was too low for the service provided in relation to code 77785. They agreed that the intensity of code 77786 was equivalent to the intensity of an established patient level four evaluation and management office code (99214, IWPOT= 0.0434). It was understood that the surveyed typical number of catheter placements for the code is eight each placement escalates the physician work and risk of error. If any of the catheters are misplaced, significant patient harm would result. The committee also agreed that key reference code 19296 *Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy* (work RVU=3.63), is more intensive and more work than 777X2, and that the relative work value also lies between codes 79101 *Radiopharmaceutical therapy, by intravenous administration* (work RVU=1.96), 45380 *Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple* (work RVU=4.43). The RUC used a building block approach using the specialty society's recommended physician time components (as shown below) to establish a work value of 3.25 for code 77785. **The RUC recommends a work relative value of 3.25 for new code 77786.**

77787 - Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels

RUC members reviewed the key reference service, 19298 *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance* (work RVU = 6.00) in relation to code 77787. The RUC determined that with the specialty recommended value of 5.60 the intra service work intensity is too high for the service provided. They agreed that the intensity of code 77786 was equivalent to the intensity of an established patient level five evaluation and management office code (99215, IWPOT= 0.0443). It was understood that with each catheter placement the physician work and risk of error escalates as the physician is repeating the procedures steps and if any of the catheters are misplaced, significant patient harm would result. The committee also agreed that key reference code 19298 *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance* (work RVU=6.00), is more intensive and more work than 777X3, and that the relative work value lies between codes 43260 *Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU=5.96) and 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU=3.52). The RUC used a building block approach using the intra service work intensity

of a 99213 to establish a work relative value of 4.89 for code 77787 (as shown below). **The RUC recommends a work relative value of 4.89 for new code 77787.**

Building Block Methodology using Evaluation and Management Code Intensities

CPT Code	Pre Time	Pre Service IWPUR	Pre Serv RVU	Intra Time	Intra Service IWPUR	Intra Serv RVU	Post Time	Post IWPUR	Post Serv RVU	Total Building Block Values
777X1	11	0.0224	0.246	30	0.0316	0.947	10	0.0224	0.224	1.42
777X2	14	0.0224	0.310	60	0.0434	2.602	15	0.0224	0.336	3.25
777X3	20	0.0224	0.448	90	0.0443	3.991	20	0.0224	0.269	4.89

Practice Expense: The RUC reviewed the direct practice expense inputs for each new code and made minimal edits from the specialty recommendation as they were similar to the deleted codes they replaced. In addition, since conscious sedation was not inherent in procedure code 777X3, although frequently used, the Registered Nurse clinical labor time, medical supplies, and equipment associated with conscious sedation was eliminated.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●77785	EE1	Remote afterloading high dose rate radionuclide brachytherapy; 1 channel	XXX	1.42
●77786	EE2	2-12 channels	XXX	3.25
●77787	EE3	over 12 channels	XXX	4.89
D 77781		Remote afterloading high intensity brachytherapy, 1-4 source positions or catheters (77781 has been deleted. To report, see 77785, 77786)	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 77782		5-8 source positions or catheters (77782-77784 have been deleted. To report, see 77785-77787)	XXX	N/A
D 77783		9-12 source positions or catheters (77782-77784 have been deleted. To report, see 77785-77787)	XXX	N/A
D 77784		over 12 source positions or catheters (77782-77784 have been deleted. To report, see 77785-77787)	XXX	N/A

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

CPT Code: 77785 Tracking Number EE1

Specialty Society Recommended RVU: **1.66**

Global Period: XXX

RUC Recommended RVU: **1.42**

CPT Descriptor: Remote afterloading high dose rate radionuclide brachytherapy, 1 channel

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female status post hysterectomy, pelvic lymph node dissection and periaortic lymph node sampling is found to have stage I C endometrial carcinoma, grade 2, 0/15 pelvic nodes and 0/4 periaortic lymph node positive. Vaginal cuff radiation is prescribed. A vaginal cylinder is inserted, and simulation, computer planning and medical physics preparation are performed (reported separately). HDR brachytherapy is then delivered.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 26%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 25%

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

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

Description of Pre-Service Work:

1. Review of (records, dose prescription and dosimetry plan)
2. Obtain (or verify) consent
3. Vaginal applicator exposed
4. Patient educated on procedure and radiation safety
5. Position patient
6. Time out performed

Description of Intra-Service Work:

1. Applicator inspected for size, position and stability following transport.
2. Adjust as needed
3. Channel length measured with physicist and notated
4. Transfer tube selected and connected to channel applicator
5. HDR afterloader device positioned and locked
6. Transfer tube connected to indexer ring and locked in place
7. Afterloader device position adjusted to minimize kinking
8. Emergency source retraction handle exposed on afterloader
9. Examine patient comfort, transfer tube and applicator stability
10. Leave the treatment vault (ensure patient, applicator and afterloader emergency panel are visible on remote camera monitor)
11. Review of computer control console parameters.. Correlate with approved computer plan. Approve fraction size, dose, source strength (additional decay calculation for afternoon treatments), retractions, channel number and dwell time / total time
12. Run check cable through all source positions (adjust connection in room to transfer tubes etc as needed)

13. Radioactive source deployed. Monitor dwell position and times. Monitor patient maintaining visual and verbal contact with patient for full duration of treatment, acting promptly on variances and computer prompts and error messages, monitoring patients condition , vitals and any interruptions till end of treatment.
14. Confirm source retraction into safe (room radiation detector, first in room with Geiger counter and survey patient)
15. Disconnect from afterloader
16. Reconfirm applicator position
17. Remove applicator, foley catheter from patient
18. Examine treatment site

Description of Post-Service Work:

1. Procedure note
2. Communication with primary physician, other oncologist
3. Coordination for subsequent treatments (if any)
4. Discharge instructions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	David Beyer, M.D.; Micheal Kuettel, M.D., Ph.D.; Najeeb Mohideen, M.D.				
Specialty(s):	American Society for Therapeutic Radiology and Oncology (ASTRO)				
CPT Code:	77785				
Sample Size:	337	Resp N:	68	Response: 20.1 %	
Sample Type: Random					
	<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate	1.00	15.00	30.00	50.00	810.00
Survey RVW:	0.80	1.70	2.01	3.00	6.00
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	28.75	30.00	40.00	60.00
Immediate Post Service-Time:	<u>10.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30), 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	77785	Recommended Physician Work RVU: 1.66		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		10.00	13.00	-3.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	6.00	-6.00
Intra-Service Time:		30.00		
Immediate Post Service-Time:	<u>10.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
77315	XXX	1.56	RUC Time

CPT Descriptor Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11755	000	1.31	RUC Time	23,198

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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
29445	000	1.78	RUC Time	11,090

CPT Descriptor 2 Application of rigid total contact leg cast

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 26.4 %

TIME ESTIMATES (Median)

	CPT Code: 77785	Key Reference CPT Code: 77315	Source of Time RUC Time
Median Pre-Service Time	11 00	0.00	
Median Intra-Service Time	30.00	45.00	
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	
Prolonged Services Time	0.0	0.00	
Median Total Time	51.00	45.00	

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	3.67	3.72
--------------------------------------------------------------------------------------------------	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.28
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Urgency of medical decision making	3.17	2.94
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.44	3.06
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Physical effort required	3.39	2.83
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.06	3.06
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	3.78	3.06
--------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	3.94	2.78
------------------------------------------------------	------	------

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

Pre-Service intensity/complexity	3.50	2.50
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Intra-Service intensity/complexity	3.61	3.17
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Post-Service intensity/complexity	2.83	2.56
-----------------------------------	------	------

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.*

Background

This new family of HDR codes will replace the existing HDR codes. In the CMS Proposed PFS for 2007 all four (4) CPT® codes in the family of remote afterloading high intensity brachytherapy services (CPT codes

77781–77784) CMS proposed to remove the 90-day global period and assign the CPT codes a global period of “XXX”. The work RVUs of each of the four (4) CPT codes was proposed to be reduced by 0.45 work RVUs corresponding to the elimination of a level II E/M service (CPT code 99212) from the post-operative period. ASTRO supported the CMS proposal to change the global period from 90 days to “XXX.” However, we strongly objected to the arbitrary reduction in work RVUs that were not supported by any data. During the first two years of the fee schedule, these CPT® codes had global periods of “XXX.” In 1994, the global period was changed to 90 days, but there was no corresponding increase in work RVUs or physician time. In fact, ironically, the work RVUs decreased slightly because in that year CMS (formerly HCFA) made a budget neutrality adjustment across all the RVUs. In 1998, the work RVUs were increased slightly (as were all services with global periods of 90 days) to be consistent with the increases in work RVUs for E/M services that had been granted in 1997 after completion of the first 5-year review.

CPT® Code	1992 Work RVU (global period = xxx)¹	1994 Work RVU (global period changed to 90)²	1998 Work RVUs (all global services increased to be consistent with 1997 E/M work RVU changes)³	2006 Work RVUs
77781	1.64	1.59	1.66	1.66
77782	2.46	2.39	2.49	2.49
77783	3.68	3.58	3.73	3.72
77784	5.52	5.37	5.61	5.60

We argued that if any adjustment were to be made, it should be to return the work RVUs to their level in 1992 when the global period was “XXX.” CMS implemented their original proposal in the Final PFS Rule, effective January 2007. The CMS comments suggested the issue be brought up at the RUC.

Since the codes were under review by CMS ASTRO decided to bring the codes to CPT to update the descriptors.

We felt the number of dwell positions was a poor surrogate for physician work and changing the code to reflect the number of channels used better described the physician work.

RECOMMENDATIONS

We received over 65 completed surveys from our membership. ASTRO’s consensus panel carefully considered surveyed data, IWPUT, work neutrality, site of service and the history of these codes and recommends 77785 be valued at 1.66 RVUs.

The lowest code in the current HDR family (77781) was valued at 1.66 RVUs for over a decade. The survey data has a 25th percentile of 1.70, similar to the longstanding RVUs for the current family of HDR codes. The IWPUT with our recommended times:

PRE: 11 minutes (straightforward patient/straightforward procedure (no sedation/anesthesia care) (Facility Package 1A)) REDUCED by 3 minutes for eval time and REDUCED by all the scrub/dress/and wait time

INTRA: 30 minutes and

POST: 10 minutes

yields an IWPUT of 0.03965. This IWPUT seems reasonable and fits within the family of radiation oncology codes. For example, our reference code (77315 – recently RUC’ed) has an IWPUT of 0.0347. This code has a slightly higher IWPUT which is supported by the consensus panel and the survey data.

Further, we would request that the work unit pool for this family be considered the pool of RVUs resulting in the original RVUs for these codes and not the RVUs that resulted in an adjustment by CMS for 2007. Our recommendations for these codes would redistribute the existing units among the family resulting in no increase in aggregate work units for this family.

Site of Service Note:

¹ Federal Register. Monday, November 25, 1991. page 59502.

² Federal Register. Thursday, December 2, 1993. page 63626.

³ Federal Register. Friday, October 31, 1997. page 59048.

It is important to note that these codes have both a PC and a TC. At first glance it may appear that the RUC database indicates that these procedures are done greater than 99% in the office setting. However, if you go to the subsequent records under the Medicare Claims Data tab, there are additional calculations.

When the PC for these codes is submitted it is, for the overwhelming majority of the time, because the technical side of the code (i.e. delivery) was performed in the hospital setting (outpatient or inpatient). For example, 15,084 of the 22,180 procedures for CPT code 77781 were for the PC. The hospital outpatient prospective payment file for the same data year (2006) reports 11,843 claims. The remainder of the professional code procedures would be for inpatients, ASCs, other sites or when one physician performs just the PC only and the TC is done by another physician (there are 649 TC only claims in the Part B file).

So, this code is done the majority of the time in the facility setting (>65%). That is why we selected a Facility Setting pre-service time package.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Multiple codes are typically reported because of the number of steps involved. There is currently no companion insertion code for this procedure. Also, depending on the implant, there may be a simulation code performed on the same day (77280-77290). Physics and dosimetry may be required (77300, 77326-77328).
-

FREQUENCY INFORMATION

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

- 77781 Remote afterloading high intensity brachytherapy, 1-4 source positions or catheters
- 77782 Remote afterloading high intensity brachytherapy, 5-8 source positions or catheters
- 77783 Remote afterloading high intensity brachytherapy, 9-12 source positions or catheters
- 77784 Remote afterloading high intensity brachytherapy, over 12 source positions or catheters

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

Specialty Radiation Oncology

How often? Sometimes

Specialty

How often?

Specialty How often?

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

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

Please explain the rationale for this estimate. Due to patient population we would estimate that the Medicare population represents approximately 50% of the total number of procedures.

Specialty	Frequency 0	Percentage 0.00 %
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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?

22,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. please see above

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?

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: 77786 Tracking Number EE2

Specialty Society Recommended RVU: **3.10**

Global Period: XXX

RUC Recommended RVU: **3.25**

CPT Descriptor: Remote afterloading high dose rate radionuclide brachytherapy, 2-12 channels

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old man with a history of heavy tobacco use presents with a 2.5 cm squamous cell cancer in the floor of mouth, T2 N0. The tumor and regional lymph nodes are treated with external beam irradiation. An interstitial implant boost of the oral tongue and floor of mouth is performed (reported separately). Following simulation, computer planning and medical physics preparation (reported separately), and HDR boost is administered.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 35%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 33%

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

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

Description of Pre-Service Work:

1. Review of records, dose prescription, dosimetry plan, and external beam radiation records
2. Patient comfort and safety evaluated (i.e. bleeding, pain, airway)
3. Obtain consent
4. Patient educated on procedure and radiation safety
5. Position Patient
6. Time out performed

Description of Intra-Service Work:

1. Catheters / applicator inspected for number, position, and integrity. Verify no change in anatomy since insertion (ie edema), position and stability following transport, adjust as needed and number & diagram.
2. Channel stabilizers removed from each catheter.
3. Catheter lengths measured (with source ruler), confirmed with physicist and notated
4. Individually numbered transfer tubes selected and connected to similarly numbered catheter in patient
5. HDR afterloader device positioned and locked
6. Transfer tubes connected to similarly numbered indexer ring and locked in place
7. Consistent numbering verified
8. Afterloader device position adjusted to minimize kinking, traction or pressure on patient, etc
9. Emergency source retraction handle exposed on afterloader
10. Assure patient comfort, airway, transfer tube and applicator stability
11. Leave the treatment vault. Ensure patient, monitoring equipment, applicator and afterloader emergency panel are visible on remote camera monitor.
12. Review of computer control console parameters. Correlate with approved computer plan. Approve same (name, fraction, dose, source strength, retractions, channel numbers and dwell times / total time).

13. Run check cable through all channels and source positions. Adjust connection in room to transfer tubes etc as identified by faults.
14. Radioactive source deployed. Monitor active channel, dwell positions, & times.
15. Monitor patient maintaining visual and verbal contact with patient for full duration of treatment, acting promptly on variances and computer prompts and error messages, monitoring patients condition , vitals and any interruptions till end of treatment.
16. Confirm source retraction into safe. Room radiation detector, first in room with Geiger counter, and survey patient.
17. Repeat steps 4-15 for second hook up if needed
18. Disconnect from afterloader
19. Examine treatment site
20. Remove applicator from patient. Pain management, bimanual direct pressure to control bleeding, and clean & dress.

Description of Post-Service Work:

1. Procedure note
2. Communication with primary physician, other oncologist
3. Coordination for subsequent treatments (if any)
4. Examine patient prior to discharge
5. Discharge instructions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	David Beyer, M.D.; Micheal Kuettel, M.D., Ph.D.; Najeeb Mohideen, M.D.				
Specialty(s):	American Society for Therapeutic Radiology and Oncology (ASTRO)				
CPT Code:	77786				
Sample Size:	336	Resp N:	66	Response: 19.6 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	12.00	35.00	200.00
Survey RVW:	1.50	3.75	4.10	6.40	10.00
Pre-Service Evaluation Time:			20.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	15.00	50.00	60.00	70.00	150.00
Immediate Post Service-Time:	<u>15.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	77786	Recommended Physician Work RVU: 3.10		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		13.00	13.00	0.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	6.00	-6.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	<u>15.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
19296	000	3.63	RUC Time

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

KEY MPC COMPARISON CODES:

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
79101	XXX	1.96	RUC Time	4,619

CPT Descriptor 1 Radiopharmaceutical therapy, by intravenous administration

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
45380	000	4.43	RUC Time	737,302

CPT Descriptor 2 Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 25 % of respondents: 37.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 77786	<u>Key Reference CPT Code:</u> 19296	<u>Source of Time</u> RUC Time
Median Pre-Service Time	14.00	55.00	
Median Intra-Service Time	60.00	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	19.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	89.00	119.00	
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	3.84	3.16
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.96	3.60
Urgency of medical decision making	3.96	3.64

Technical Skill/Physical Effort (Mean)

Technical skill required	4.24	3.64
Physical effort required	3.68	3.40
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.20	3.36
Outcome depends on the skill and judgment of physician	4.32	3.68
Estimated risk of malpractice suit with poor outcome	4.12	3.12

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

Pre-Service intensity/complexity	3.72	3.28
Intra-Service intensity/complexity	4.16	3.68
Post-Service intensity/complexity	3.60	3.12

Additional Rationale

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

Background

This new family of HDR codes will replace the existing HDR codes. In the CMS Proposed PFS for 2007 all four (4) CPT® codes in the family of remote afterloading high intensity brachytherapy services (CPT codes 77781–77784) CMS proposed to remove the 90-day global period and assign the CPT codes a global period of

“XXX”. The work RVUs of each of the four (4) CPT codes was proposed to be reduced by 0.45 work RVUs corresponding to the elimination of a level II E/M service (CPT code 99212) from the post-operative period.

ASTRO supported the CMS proposal to change the global period from 90 days to “XXX.” However, we strongly objected to the arbitrary reduction in work RVUs that were not supported by any data. During the first two years of the fee schedule, these CPT® codes had global periods of “XXX.” In 1994, the global period was changed to 90 days, but there was no corresponding increase in work RVUs or physician time. In fact, ironically, the work RVUs decreased slightly because in that year CMS (formerly HCFA) made a budget neutrality adjustment across all the RVUs. In 1998, the work RVUs were increased slightly (as were all services with global periods of 90 days) to be consistent with the increases in work RVUs for E/M services that had been granted in 1997 after completion of the first 5-year review.

CPT® Code	1992 Work RVU (global period = xxx) ¹	1994 Work RVU (global period changed to 90) ²	1998 Work RVUs (all global services increased to be consistent with 1997 E/M work RVU changes) ³	2006 Work RVUs
77781	1.64	1.59	1.66	1.66
77782	2.46	2.39	2.49	2.49
77783	3.68	3.58	3.73	3.72
77784	5.52	5.37	5.61	5.60

We argued that if any adjustment were to be made, it should be to return the work RVUs to their level in 1992 when the global period was “XXX.” CMS implemented their original proposal in the Final PFS Rule, effective January 2007. The CMS comments suggested the issue be brought up at the RUC.

Since the codes were under review by CMS ASTRO decided to bring the codes to CPT to update the descriptors.

We felt the number of dwell positions was a poor surrogate for physician work and changing the code to reflect the number of channels used better described the physician work.

RECOMMENDATIONS

We received over 65 completed surveys from our membership. ASTRO’s consensus panel carefully considered surveyed data, IWPUT, work neutrality, site of service and the history of these codes and recommends 77786 be valued at 3.10 RVUs.

The two “middle” codes in the current HDR family (77782 & 77783) were valued at 2.49 & 3.72 respectively for over a decade. The survey data has a 25th percentile of 3.75, similar to the longstanding RVUs for the current family of HDR codes. The IWPUT with our recommended times:

PRE: 14 minutes (straightforward patient/straightforward procedure (no sedation/anesthesia care) (Facility Package 1A)) REDUCED by 6 minutes for scrub/dress/ and wait time (all)

INTRA: 60 minutes

POST: 15 minutes

yields an IWPUT of 0.04084. This IWPUT seems reasonable and fits within the family of radiation oncology codes. For example, our reference code (19296 – RUC’ed in 04) has an IWPUT of 0.05455. The surveyed code has a lower IWPUT which is supported by the consensus panel.

Further, we would request that the work unit pool for this family be considered the pool of RVUs resulting in the original RVUs for these codes and not the RVUs that resulted in an adjustment by CMS for 2007. Our recommendations for these codes would redistribute the existing units among the family resulting in no increase in aggregate work units for this family.

¹ Federal Register. Monday, November 25, 1991. page 59502.

² Federal Register. Thursday, December 2, 1993. page 63626.

³ Federal Register. Friday, October 31, 1997. page 59048.

Site of Service Note:

It is important to note that these codes have both a PC and a TC. At first glance it may appear that the RUC database indicates that these procedures are done greater than 99% in the office setting. However, if you go to the subsequent records under the Medicare Claims Data tab, there are additional calculations.

When the PC for these codes is submitted it is, for the overwhelming majority of the time, because the technical side of the code (i.e. delivery) was performed in the hospital setting (outpatient or inpatient). More specifically, 3,656 of the 5,613 procedures for CPT code 77782 and 3,984 of the 5,214 procedures for CPT code 77783 were for the PC. The hospital outpatient prospective payment file for the same data year (2006) reports 3,327 and 3,681 claims for 77782 and 77783 respectively. The remainder of the professional code procedures would be for inpatients, ASCs, other sites or when one physician performs just the PC only and the TC is done by another physician (there are 72 TC only claims in the Part B file for 77782 and 206 for 77783).

So, this code is done the majority of the time in the facility setting (>71%). That is why we selected a Facility Setting pre-service time package.

Number of Channels

The AMA requested that we add an additional question to our x2 and x3 surveys to query our survey respondents regarding the typical number of catheters used. The median number of channels for x2 was 8 and the mean was 7.86.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Multiple codes are typically reported because of the number of steps involved. For example, a companion insertion code, which describes the surgical placement of the applicator, such as 31643, 57155, and 55875 may be billed on the same day in advance of the HDR brachytherapy treatment by the same or a different physician. There is currently no companion insertion code for this procedure. Also, depending on the implant, there may be a simulation code performed on the same day (77280 - 77290). Physics and dosimetry may be required (77300, 77326-77328).

FREQUENCY INFORMATION

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

- 77781 Remote afterloading high intensity brachytherapy, 1-4 source positions or catheters
- 77782 Remote afterloading high intensity brachytherapy, 5-8 source positions or catheters
- 77783 Remote afterloading high intensity brachytherapy, 9-12 source positions or catheters
- 77784 Remote afterloading high intensity brachytherapy, over 12 source positions or catheters

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

Specialty Radiation Oncology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 20000

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

Please explain the rationale for this estimate. Due to patient population we would estimate that the Medicare population represents approximately 50% of the total number of procedures.

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

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see above

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

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

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

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Code: 77787 Tracking Number EE3

Specialty Society Recommended RVU: **5.60**

Global Period: XXX

RUC Recommended RVU: **4.89**

CPT Descriptor: Remote afterloading high dose rate radionuclide brachytherapy, over 12 channels

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old man presents with a T2c Gleason 7, PSA 11 prostate cancer. He receives external beam irradiation to the prostate and periprostatic lymph nodes. An interstitial implant boost of prostate is performed (reported separately). Following simulation, computer planning and medical physics preparation (reported separately), and HDR boost is administered.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 58%

Is moderate sedation inherent to this procedure in the office setting? Yes Percent of survey respondents who stated it is typical in the office setting? 56%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work:

1. Review of records, dose prescription, dosimetry plan and external beam radiation records
2. Patient comfort and safety evaluated (bleeding and pain)
3. Obtain consent
7. Patient educated on procedure and radiation safety
8. Patient positioned to display the implanted catheters appropriately
9. Time out performed

Description of Intra-Service Work:

1. Catheters / applicator inspected for: Number, position, integrity. Verify no change in anatomy since insertion (ie edema). Position and stability following transport. Adjust as needed. Number and diagram
2. Channel stabilizers removed from each catheter
3. Catheter lengths measured (with source ruler), confirmed with physicist and notated
4. Individually numbered transfer tubes selected and connected to similarly numbered catheter in patient
5. HDR afterloader device positioned and locked
6. Transfer tubes connected to similarly numbered indexer ring and locked in place
7. Consistent numbering verified
8. Afterloader device position adjusted to minimize kinking, traction or pressure on patient, etc
9. Emergency source retraction handle exposed on afterloader
10. Assure patient comfort, transfer tube and applicator stability
11. Leave the treatment vault. Ensure patient, monitoring equipment, applicator and afterloader emergency panel are visible on remote camera monitor
12. Review of computer control console parameters. Correlate with approved computer plan. Approve same (name, fraction, dose, source strength, retractions, channel numbers and dwell times / total time).

13. Run check cable through all channels and source positions. Adjust connection in room to transfer tubes etc as identified by faults
14. Radioactive source deployed. Monitor active channel, dwell positions, and times.
15. Monitor patient maintaining visual and verbal contact with patient for full duration of treatment, acting promptly on variances and computer prompts and error messages, monitoring patients condition , vitals and any interruptions
till end of treatment.
15. Confirm source retraction into safe. Room radiation detector. First in room with Geiger counter. Survey patient
16. Repeat steps 4-15 for second hook up
17. Disconnect from afterloader
18. Examine treatment site
19. Remove applicator from patient. Pain management, bimanual direct pressure to control bleeding, irrigate foley catheter for bleeding and clean & dress

Description of Post-Service Work:

1. Procedure note
2. Communication with primary physician, other oncologist
3. Coordination for subsequent treatments (if any)
4. Examine patient prior to discharge
5. Discharge instructions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	David Beyer, M.D.; Micheal Kuettel, M.D., Ph.D.; Najeeb Mohideen, M.D.				
Specialty(s):	American Society for Therapeutic Radiology and Oncology (ASTRO)				
CPT Code:	77787				
Sample Size:	336	Resp N:	59	Response: 17.5 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.50	15.00	97.50	750.00
Survey RVW:	2.25	6.00	6.25	10.00	15.00
Pre-Service Evaluation Time:			30.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	20.00	75.00	90.00	120.00	180.00
Immediate Post Service-Time:	<u>20.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	77787	Recommended Physician Work RVU: 5.60		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		19.00	19.00	0.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	5.00	-5.00
Intra-Service Time:		90.00		
Immediate Post Service-Time:	<u>20.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
19298	000	6.00	RUC Time

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

KEY MPC COMPARISON CODES:

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
43260	000	5.95	RUC Time	19,159

CPT Descriptor 1 Endoscopic retrograde cholangiopancreatography (ERCP); 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95810	XXX	3.52	RUC Time	271,044

CPT Descriptor 2 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 21 % of respondents: 35.5 %

TIME ESTIMATES (Median)

	CPT Code: 77787	Key Reference CPT Code: 19298	Source of Time RUC Time
Median Pre-Service Time	20.00	60.00	
Median Intra-Service Time	90.00	60.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	19.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	130.00	169.00
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	3.95	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	3.90
Urgency of medical decision making	3.86	3.62

Technical Skill/Physical Effort (Mean)

Technical skill required	4.62	4.48
Physical effort required	4.33	4.38
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.48	3.90
Outcome depends on the skill and judgment of physician	4.62	4.10
Estimated risk of malpractice suit with poor outcome	4.57	4.24

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

Pre-Service intensity/complexity	4.19	3.81
Intra-Service intensity/complexity	4.38	4.33
Post-Service intensity/complexity	3.90	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.*

Background

This new family of HDR codes will replace the existing HDR codes. In the CMS Proposed PFS for 2007 all four (4) CPT® codes in the family of remote afterloading high intensity brachytherapy services (CPT codes 77781–77784) CMS proposed to remove the 90-day global period and assign the CPT codes a global period of “XXX”. The work RVUs of each of the four (4) CPT codes was proposed to be reduced by 0.45 work RVUs corresponding to the elimination of a level II E/M service (CPT code 99212) from the post-operative period.

ASTRO supported the CMS proposal to change the global period from 90 days to “XXX.” However, we strongly objected to the arbitrary reduction in work RVUs that were not supported by any data. During the first two years of the fee schedule, these CPT® codes had global periods of “XXX.” In 1994, the global period was changed to 90 days, but there was no corresponding increase in work RVUs or physician time. In fact, ironically, the work RVUs decreased slightly because in that year CMS (formerly HCFA) made a budget neutrality adjustment across all the RVUs. In 1998, the work RVUs were increased slightly (as were all services with global periods of 90 days) to be consistent with the increases in work RVUs for E/M services that had been granted in 1997 after completion of the first 5-year review.

CPT® Code	1992 Work RVU (global period = xxx)¹	1994 Work RVU (global period changed to 90)²	1998 Work RVUs (all global services increased to be consistent with 1997 E/M work RVU changes)³	2006 Work RVUs
77781	1.64	1.59	1.66	1.66
77782	2.46	2.39	2.49	2.49
77783	3.68	3.58	3.73	3.72
77784	5.52	5.37	5.61	5.60

We argued that if any adjustment were to be made, it should be to return the work RVUs to their level in 1992 when the global period was “XXX.” CMS implemented their original proposal in the Final PFS Rule, effective January 2007. The CMS comments suggested the issue be brought up at the RUC.

Since the codes were under review by CMS ASTRO decided to bring the codes to CPT to update the descriptors.

We felt the number of dwell positions was a poor surrogate for physician work and changing the code to reflect the number of channels used better described the physician work.

RECOMMENDATIONS

We received almost 60 completed surveys from our membership. ASTRO’s consensus panel carefully considered surveyed data, IWPUT, work neutrality, site of service and the history of these codes and recommends 77787 be valued at 5.60 RVUs.

The “top” code in the current HDR family (77784) was valued at 5.60 for over a decade. The survey data has a 25th percentile of 6.00, similar to the longstanding RVUs for the current family of HDR codes. The IWPUT with our recommended times:

PRE: 20 minutes (straightforward patient/straightforward procedure (With sedation/anesthesia care) (Facility Package 1B)) REDUCED by 5 minutes for scrub/dress/ and wait time (all)

INTRA: 90 minutes

POST: 20 minutes

yields an IWPUT of 0.05227. This IWPUT seems reasonable and fits within the family of radiation oncology codes. For example, our reference code (19298 – RUC’ed in 04) has an IWPUT of 0.05931. The surveyed code has a lower IWPUT which is supported by the consensus panel.

Further, we would request that the work unit pool for this family be considered the pool of RVUs resulting in the original RVUs for these codes and not the RVUs that resulted in an adjustment by CMS for 2007. Our

¹ Federal Register. Monday, November 25, 1991. page 59502.

² Federal Register. Thursday, December 2, 1993. page 63626.

³ Federal Register. Friday, October 31, 1997. page 59048.

recommendations for these codes would redistribute the existing units among the family resulting in no increase in aggregate work units for this family.

Site of Service Note:

It is important to note that these codes have both a PC and a TC. At first glance it may appear that the RUC database indicates that these procedures are done greater than 99% in the office setting. However, if you go to the subsequent records under the Medicare Claims Data tab, there are additional calculations.

When the PC for these codes is submitted it is, for the overwhelming majority of the time, because the technical side of the code (i.e. delivery) was performed in the hospital setting (outpatient or inpatient). More specifically, 9,559 of the 14,654 procedures for CPT code 77784 were for the PC. The hospital outpatient prospective payment file for the same data year (2006) reports 6,239 claims for 77784. The remainder of the professional code procedures would be for inpatients, ASCs, other sites or when one physician performs just the PC only and the TC is done by another physician (there are 541 TC only claims in the Part B file for 77784).

So, this code is done the majority of the time in the facility setting (>65%). That is why we selected a Facility Setting pre-service time package.

Number of Channels

The AMA requested that we add an additional question to our x2 and x3 surveys to query our survey respondents regarding the typical number of catheters used. The median number of channels for x3 was 18 and the mean was 17.97.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Multiple codes are typically reported because of the number of steps involved. For example, a companion insertion code, which describes the surgical placement of the applicator, such as 31643, 57155, and 55875 may be billed on the same day in advance of the HDR brachytherapy treatment by the same or a different physician. There is currently no companion insertion code for this procedure. Also, depending on the implant, there may be a simulation code performed on the same day (77280 - 77290). Physics and dosimetry may be required (77300, 77326-77328).

FREQUENCY INFORMATION

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

- 77781 Remote afterloading high intensity brachytherapy, 1-4 source positions or catheters
- 77782 Remote afterloading high intensity brachytherapy, 5-8 source positions or catheters
- 77783 Remote afterloading high intensity brachytherapy, 9-12 source positions or catheters
- 77784 Remote afterloading high intensity brachytherapy, over 12 source positions or catheters

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

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

Specialty radiation oncology

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 30000

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

Please explain the rationale for this estimate. Due to patient population we would estimate that the Medicare population represents approximately 50% of the total number of procedures.

Specialty

Frequency

Percentage

%

Specialty

Frequency

Percentage

%

Specialty

Frequency

Percentage

%

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

15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see above

Specialty

Frequency

Percentage

%

Specialty

Frequency

Percentage

%

Specialty

Frequency

Percentage

%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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

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

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

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs**

CPT Long Descriptor: Remote afterloading high dose rate radionuclide brachytherapy, 1 channel

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 and physicists who perform HDR. The group used submitted practice expense data and existing HDR codes data as the basis to initiate the consensus process. The recommendations represent the consensus opinion of the ASTRO RVS Committee and experts in HDR.

Please describe the clinical activities of your staff:

Please note that the description of the clinical activities is for CPT code 77785.

The most common procedure associated with this code is a vaginal cuff intracavitary treatment after hysterectomy for endometrial cancer, and it was the procedure selected to describe the typical patient encounter. During this procedure, the patient has a vaginal applicator inserted. She is then taken to the simulator suite for the initial data acquisition for planning target volume determination. Aside from the pre service labor, the HDR procedure begins when the patient leaves the simulator room and is taken to the HDR holding area.

Pre-Service Clinical Labor Activities:

The pre-service diagnostic forms, the coordination of the pre-surgery services and scheduling of the equipment in the facility are done by the Radiation Therapist (RTT) and the Medical Physicist) MP. The service requires the involvement of the Oncology Registered Nurse (ORN), the Radiation Therapist (RTT), the Certified Medical Dosimetrist (CMD) and the Medical Physicist (MP), in addition to the Doctor. All of them must have their schedules clear, as they are continuously involved in the procedure once it starts.

Intra-Service Clinical Labor Activities:

The patient is taken into the HDR treatment room, a shielded vault comparable to a linear accelerator room. The HDR machine has been tested and validated by the dosimetrist. The implant channel is cleaned and by the physicist/dosimetrist. The source transfer cable is attached to the applicator and the HDR afterloader. The radiation prescription is verified and the treatment time and dwell positions are checked by the physicist. The test cable run is performed to assure an unobstructed transfer. While the physicist is performing these steps and procedures, the ORN is present and immediately available, connecting the patient to the remote monitors, assessing pain, and tracking vital signs. After the system has been connected, checked, and the dwell times and doses verified, and the patient has been positioned for remote monitoring, the

staff leave the treatment room and the vault is closed. The HDR machine is then armed and the source released. The HDR treatment lasts approximately fifteen minutes as the source moves in and out of the transfer cable into the indwelling applicator channel. Supervision is personal for the physician, physicist, oncology nurse, and radiation therapist. The RTT monitors the dwell position times and verifies the overall treatment time. The nurse is monitoring the patient's vital signs and general condition, the physicist monitors the source exchange and is immediately available to assist the physician to troubleshoot any treatment console system error codes, and the physician is present for the entire treatment delivery. After the HDR treatment, the radiation source is secured and the room is entered. The room and patient are surveyed and the source transfer tube is disconnected from the patient and the HDR afterloader. The patient is then transferred from the shielded vault and taken to the holding area where the physician removes the cylinder.

Post-Service Clinical Labor Activities:

Nurse cleans the perineum, applies a dressing, assists the patient out of bed, monitors vital signs, provides post treatment education, and schedules the follow up appointments.

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs**

CPT Long Descriptor: Remote afterloading high dose rate radionuclide brachytherapy, 2-12 channels

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 and physicists who perform HDR. The group used submitted practice expense data and existing HDR codes data as the basis to initiate the consensus process. The recommendations represent the consensus opinion of the ASTRO RVS Committee and experts in HDR.

Please describe the clinical activities of your staff:

Please note that the description of the clinical activities is for CPT code 77786.

The most common procedure associated with this code is a head and neck implant, and this was the procedure selected to describe the typical patient encounter. During this procedure, the HDR brachytherapy catheters are placed in the operating room. After the patient leaves the recovery room, he is transported to the doctor's office where the HDR treatment will be delivered. The patient has a PCA pump in place for pain control, and he is in the doctor's office for about four hours. After he arrives in the office, he is taken to the simulator room for the initial data acquisition for planning target volume determination. Aside from the pre-service labor, the HDR procedure actually begins when the patient leaves the simulator room and is taken to the HDR holding area.

Pre-Service Clinical Labor Activities:

The pre-service diagnostic forms, the coordination of the pre-surgery services and scheduling of the equipment in the facility are done by the Radiation Therapist (RTT) and the Medical Physicist (MP). The service requires the involvement of the Oncology Registered Nurse (ORN), the Radiation Therapist (RTT), the Certified Medical Dosimetrist (CMD) and the Medical Physicist (MP), in addition to the Doctor. All of them must have their schedules clear, as they are continuously involved in the procedure once it starts. The brachytherapy catheter placement must be scheduled for the Operating Room and the OR time must be coordinated with the Head and Neck Surgeon.

Once the patient arrives in the doctor's office, the ORN must take report from the recovery room and review the chart. As the patient has and is actively using a PCA pump outside of the hospital, the ORN must be present and immediately available throughout the HDR procedure.

Intra-Service Clinical Labor Activities:

The patient is taken into the HDR treatment room, a shielded vault comparable to a linear accelerator room. The HDR machine has been tested and validated by the dosimetrist. The brachytherapy channels are cleaned and the catheters are trimmed to their final length by the physicist/ dosimetrist. The source transfer cables, each individually numbered and cross referenced to the computerized treatment plan, are attached one at a time and double checked. The radiation prescription is verified and the treatment time and dwell positions are checked by the physicist. The test cable run is performed, as each catheter must be checked to assure an unobstructed transfer. While the physicist is performing these procedures, the Oncology Registered Nurse (ORN) is present and immediately available, connecting the patient to the remote monitors, assessing pain, and tracking vital signs. After the system has been connected, checked, and the dwell times and doses verified, and the patient has been positioned for remote monitoring, the staff leave the treatment room and the vault is closed. The HDR machine is then armed and the source released. The HDR treatment lasts approximately twenty five minutes as the source moves in and out of the transfer cables into the matrix of brachytherapy channel dwell positions for precisely prescribed periods of time. Supervision is personal for the physician, MP, ORN, and RTT. The RTT monitors the dwell position times and verifies the total treatment time, the nurse is monitoring the patient's vital signs and oxygen saturation status, the physicist monitors the source exchange and is immediately available to assist the physician to troubleshoot any error codes, and the physician is present for the entire exposure. After the last transfer, the radiation source is secured and the room is entered. The room and patient are surveyed and the source transfer tubes are disconnected from the patient and the HDR afterloader. The patient is then removed from the shielded vault and taken to the holding area, where the implant is removed. The nurse assists the physician with the implant removal, which takes about fifteen minutes, including the time to apply direct pressure to the implant catheter sites to obtain hemostasis and to manage the patient's airway. After the bleeding has been controlled and airway is deemed stable, the nurse monitors the patient's vital signs, and ensures complete recovery after the procedure.

Post-Service Clinical Labor Activities:

Nurse removes the IV, cleans the implant site, applies a dressing, assists the patient out of bed, monitors vital signs, and provides post treatment education and schedules the follow up appointments. Phone calls are made by the nurse to follow up and phone in prescriptions.

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs**

CPT Long Descriptor: Remote afterloading high dose rate radionuclide brachytherapy, over 12 channels

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 and physicists who perform HDR. The group used submitted practice expense data and existing HDR codes data as the basis to initiate the consensus process. The recommendations represent the consensus opinion of the ASTRO RVS Committee and experts in HDR. .

Please describe the clinical activities of your staff:

Please note that the description of the clinical activities is for CPT code 77787.

The most common procedure associated with this code is a prostate implant, and it was the procedure selected to describe the typical patient encounter. During this procedure, the HDR template and brachytherapy catheters are placed in the operating room. After the patient leaves the recovery room, he is transported to the doctor's office where the HDR treatment will be delivered. After he arrives in the office, he is taken to the simulator suite for the initial data acquisition for planning target volume determination. Aside from the pre-service labor, the HDR procedure actually begins when the patient leaves the simulator room and is taken to the HDR holding area.

Pre-Service Clinical Labor Activities:

The pre-service diagnostic forms, the coordination of the pre-surgery services and scheduling of the equipment in the facility are done by the RTT and the MP. The service requires the involvement of the Oncology Registered Nurse (ORN), the Radiation Therapist (RTT), the Medical Dosimetrist and the Medical Physicist, in addition to the Doctor. All must have their schedules clear, as they are continuously involved in the procedure once it starts. The template placement must be scheduled for the Operating Room and the OR time must be coordinated with the Urologist.

Once the patient arrives in the doctor's office, the ORN must take report from the recovery room and review the chart.

Intra-Service Clinical Labor Activities:

The patient is taken into the HDR treatment room, a shielded vault comparable to a linear accelerator room. The HDR machine has been tested and validated by the dosimetrist. The brachytherapy channels are cleaned and the catheters are trimmed to their final length by the physicist/ dosimetrist. The source transfer cables, each individually numbered and cross referenced to the computerized treatment plan, are attached one at a time and double checked. The radiation prescription is verified and the treatment time and dwell positions are checked by the physicist. The test cable run is performed, as each catheter must be checked to assure an unobstructed transfer. While the physicist is performing these procedures, the ORN is present and immediately available, connecting the patient to the remote monitors, assessing pain, and tracking vital signs. ~~The nurse and physician administer conscious sedation.~~ After the system has been connected, checked, and the dwell times and doses verified, and the patient has been positioned for remote monitoring, the staff leave the treatment room and the vault closed. The HDR machine is then armed and the source released. The HDR treatment lasts approximately forty minutes as the source moves in and out of the transfer cables into the matrix of brachytherapy channel dwell positions for precisely prescribed periods of time. Supervision is personal for the physician, MP, ORN, and RTT. The RTT monitors the dwell times and verifies the treatment times, the nurse is monitoring the patient's vital signs and oxygen saturation status, the physicist monitors the source exchange and is immediately available to assist the physician to troubleshoot any error codes, and the physician is present for the entire exposure. After the last radiation transfer, the source is secured and the room is entered. The room and patient are surveyed and the source transfer tubes are disconnected from the patient and the HDR afterloader. The patient is then removed from the shielded vault and taken to the holding area, where the implant is removed. The nurse assists the physician with the implant removal, which takes about fifteen minutes, including the time to apply direct pressure on the perineum to obtain hemostasis. After the implant site and urinary bleeding have been controlled, the nurse removes the foley catheter, monitors the patient's vital signs, and ensures complete recovery after the procedure.

Post-Service Clinical Labor Activities:

Nurse removes the IV, cleans the perineum implant site, applies a dressing, assists the patient out of bed, monitors vital signs, and provides post treatment education and schedules the follow up appointments. Phone calls are made by the nurse to follow up and phone in prescriptions.

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee			77785		77786		77787	
2	Meeting Date: April 2008			Remote afterloading high dose rate radionuclide brachytherapy, 1 channel		Remote afterloading high dose rate radionuclide brachytherapy, 2-12 channels		Remote afterloading high dose rate radionuclide brachytherapy, over 12 channels	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD: XXX								
5	TOTAL CLINICAL LABOR TIME			56.0	12.0	134.0	12.0	245.0	12.0
6		L037D	RN/LPN/MTA	18 0	12 0	41 0	12 0	24 0	12 0
7		L050C	Radiation Therapist	22 0		53 0		91 0	
8		L051A	RN	0 0		0 0		50 0	
9		L107A	Med Dos/Med Phys	6 0		20 0		40 0	
10		L152A	Medical Physicist	10 0		20 0		40 0	
11	TOTAL PRE-SERV CLINICAL LABOR TIME			6.0	12.0	9.0	12.0	9.0	12.0
12		L037D	RN/LPN/MTA	6 0	12 0	9 0	12 0	9 0	12 0
13	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			50.0	0.0	125.0	0.0	236.0	0.0
14		L107A	Med Dos/Med Phys	6 0	0 0	20 0	0 0	40 0	0 0
15		L152A	Medical Physicist	10 0	0 0	20 0	0 0	40 0	0 0
16		L050C	Radiation Therapist	22 0	0 0	53 0	0 0	91 0	0 0
17		L051A	RN	0 0	0 0	0 0	0 0	50 0	0 0
18		L037D	RN/LPN/MTA	12 0	0 0	32 0	0 0	15 0	0 0
19	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0
20	PRE-SERVICE								
21	Start: Following visit when decision for surgery or procedure made								
22	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	2	3	3	3	3	3
23	Nurse-to-nurse coordination of patient transfer								
24	Coordinate pre-surgery services	L037D	RN/LPN/MTA	2	3	3	3	3	3
25	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
26	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	2	3	3	3	3	3
27	Follow-up phone calls & prescriptions								
28	End: When patient enters office/facility for surgery/procedure								
29	SERVICE PERIOD								
30	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure								
31	Review charts	L037D	RN/LPN/MTA	1		3		3	
32	Greet patient and provide gowning	L037D	RN/LPN/MTA	1		3		3	
33	Obtain vital signs	L037D	RN/LPN/MTA	3		5		5	
34	Provide pre-service education/obtain consent								
35	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2	
36	Setup scope, remote monitoring and radiation protection equipment (non facility setting only)	L050C	Radiation Therapist	2		5		5	
37	Prepare-position patient/monitor patient/set up IV	L037D	RN/LPN/MTA	2		2		2	
38	Intra-service								
39	Assist physician in performing procedure								
40	Enter Treatment Plan	L050C	Rad Therapist	2		4		5	
41	Prepare and measure channels, attach transfer cables	L050C	Rad Therapist	1		7		15	
42	Treatment "Dry Run"	L050C	Rad Therapist	1		3		5	
43	Treatment	L050C	Rad Therapist	10		20		40	
44	Detach cables and complete treatment documentation	L050C	Rad Therapist	2		6		8	
45	Assist physician in performing procedure								
46	Enter source coordinates and import computer plan	L107A	Med Dos/Med Phy	2		6		15	
47	Confirm patient connections match diagram and plan	L107A	Med Dos/Med Phy	2		7		15	
48	Verify HDR prescription, doses, treatment parameters	L107A	Med Dos/Med Phy	2		7		10	
49	Treatment	L152A	Medical Physicist	10		20		40	
50	Assist physician in performing procedure								
51	Treatment (for x3)	L051A	RN					40	
52	Treatment (for x2)	L037D	RN/LPN/MTA			5			
53	Assist w/implant removal (for x3)	L051A	RN					10	
54	Assist w/implant removal (for x1 and x2)	L037D	RN/LPN/MTA	1		5			
55									
56	Post-Service								
58	Monitor pt following service/check tubes, monitors, drains (For x1 and X2)	L037D	RN/LPN/MTA	2		7			
59	Clean room/equipment by physician staff	L050C	Radiation Therapist	2		3		3	
60	Clean Scope (transfer tube, connection device)	L050C	Radiation Therapist	2		5		10	
61	Clean Surgical Instrument Package								
62	Complete diagnostic forms, lab & X-ray requisitions								
63	End: Patient leaves office								

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee			77785		77786		77787	
2	Meeting Date: April 2008			Remote afterloading high dose rate radionuclide brachytherapy, 1 channel		Remote afterloading high dose rate radionuclide brachytherapy, 2-12 channels		Remote afterloading high dose rate radionuclide brachytherapy, over 12 channels	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
64	POST-SERVICE Period								
65	Start: Patient leaves office/facility								
66	Conduct phone calls/call in prescriptions								
67	Office visits								
68	List Number and Level of Office Visits								
69	99211 16 minutes		16						
70	99212 27 minutes		27						
71	99213 36 minutes		36						
72	99214 53 minutes		53						
73	99215 63 minutes		63						
74	Other								
75	Total Office Visit Time			0	0	0	0	0	0
76	Other Activity (please specify)								
77	End: with last office visit before end of global period								
78	MEDICAL SUPPLIES	Code	Unit						
79	gloves, non-sterile	SB022	6	3		6		6	
80	gloves, sterile	SB024	4			4		3	
81	gown, patient	SB026	1	1		1		1	
82	towel, non-sterile	SB042	6	1		6		6	
83	glutaraldehyde 3.4% (Cidex, Maxide, Wavicide)	SM018	13	13		13		13	
84	kit, scissors and clamp	SA027	1	1		1		1	
85	tincture of benzoin, liquid	SJ059	5	5		5		5	
86	sodium chloride 0.9% inj (250-1000ml uou)	SH067	1			1		1	
87	gauze, sterile 4in x 4in	SG055	10			5		6	
88	Equipment	Code							
89	stretcher	EF018		50		125		236	
90	table, exam	EF023		50		125		236	
91	HDR Afterloader System, Nucletron	ER003		50		125		236	
92	electrometer, PC-based, dual cha	ER028		50		125		236	
93	radiation survey meter	ER054		50		125		236	
94	source, 10 Ci Ir 192	ER060		50		125		236	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Radiopharmaceutical Localization Injection

Non-imaging gamma probe procedures are now commonly performed, for which a radiopharmaceutical must be prepared, injected, and handled in accordance with acceptable regulatory and safety requirements. Those gamma probe procedures are performed during surgery as part of and during neck exploration for parathyroid tumors or for sentinel nodes in cancer patients (usually breast and melanoma).

The CPT Editorial Panel developed a diagnostic radiopharmaceutical injection procedure code in order to reflect the resources used for the procedure in February 2008. Previously, there had been no codes specifically for provision of those radioactive drugs when unaccompanied by a procedure performed in nuclear medicine. New code 78808 *Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (eg, parathyroid adenoma)* reflects the resources required to provide required for the handling and provision of radioactive drugs by intravenous routes prior to gamma probe localization (eg. parathyroid tumors).

The American College of Nuclear Physicians, American College of Radiology and the Society of Nuclear Medicine conducted a joint survey with 38 respondents. The survey results indicated a procedure that lasted 20 minutes with a median physician work RVU of 0.40. The specialty concluded that the survey median data overestimated the physician work of the procedure, and recommended an RVU of 0.18 which was the 25th percentile. That value is consistent with the key reference service that was most frequently selected by the survey participants, which was CPT code 90774 *Therapeutic, prophylactic or diagnostic injection (specify substance or drug), intravenous push, single or initial substance/drug* (work RVU = 0.18). The society noted that the descriptions of the physician work for both codes are similar in that both require that the physicians provide and confirm orders, interact and review plan with staff, assure that the injection/dose is correctly administered and provide direct physician supervision. The physician work is dissimilar in that it is unlikely that the physician will need to assess the patient during the radiopharmaceutical injection procedure, however the physician provides nuclear regulatory oversight and control, dictates and signs a report of the procedure and coordinates the procedure with the surgeon for whom the radiopharmaceutical is being given. The intra-service time of CPT code 90774 is 5 minutes and the RUC agreed that this would also be the typical time for new code 78808. The RUC agreed with the 25th percentile survey estimate for intra-service time of 5 minutes, and total time of 13 minutes. **The RUC recommends a work relative value of 0.18 for CPT code 78808.**

Practice Expense: The RUC reviewed the direct practice expense inputs for new code 78808 and made minor edits to the specialty recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●78808	FF1	Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (eg, parathyroid adenoma) (For sentinel lymph node identification, use 38792)	XXX	0.18

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

CPT Code: 78808 Tracking Number FF1

Specialty Society Recommended RVU: **0.18**

Global Period: XXX

RUC Recommended RVU: **0.18**

CPT Descriptor: Injection procedure for radiopharmaceutical localization by non-imaging probe study; intravenous (eg. parathyroid adenoma)

(For sentinel lymph node identification, use 38792)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old male presents with a history of tumor. The patient now presents for surgical resection and the referring surgeon requests injection of radiopharmaceutical so that the lesion can be intra-operatively localized with a gamma probe

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 82%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 89%

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

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

Description of Pre-Service Work: Physician reviews the clinical request, the history and images from prior studies, and may interview patient. Physician determines the appropriateness of the request, and orders the radiopharmaceutical and dose for injection.

Description of Intra-Service Work: Physician provides supervision of handling of radioisotope, the preparation and injection of the radiopharmaceutical, interpretation and report of the examination and is available.

Description of Post-Service Work: Physician supervises handling and disposal of radioactive materials. Physician reviews and signs the dictated report of the injection of the radioactive drug. Regulatory review and oversight is provided by the physician throughout the procedure..

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Kenneth McKusick, Gary Dillehay, Geraldine McGinty, Jonathan Berlin				
Specialty(s):	SNM Advancing Molecular Imaging and Therapy (formerly Society of Nuclear Medicine), ACNP American College of Nuclear Physicians, ACR American College of Radiology				
CPT Code:	78808				
Sample Size:	508	Resp N:	38	Response: 7.4 %	
Sample Type: Random					
	<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate	2.00	5.00	15.00	40.00	200.00
Survey RVW:	0.01	0.18	0.40	1.13	3.20
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	1.00	5.00	10.00	15.00	60.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70), 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	78808	Recommended Physician Work RVU: 0.18		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	13.00	-8.00
Pre-Service Positioning Time:		0.00	1.00	-1.00
Pre-Service Scrub, Dress, Wait Time:		0.00	6.00	-6.00
Intra-Service Time:		5.00		
Immediate Post Service-Time:	<u>3.00</u>			
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90774	XXX	0.18	RUC Time

CPT Descriptor Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78006	XXX	0.49	Harvard Time	29,372

CPT Descriptor 1 Thyroid imaging, with uptake; single determination

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78707	XXX	0.96	RUC Time	32,439

CPT Descriptor 2 Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
38792	000	0.52	RUC Time

CPT Descriptor Injection procedure; for identification of sentinel node

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 26.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 78808	<u>Key Reference CPT Code:</u> 90774	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	2.00	
Median Intra-Service Time	5.00	5.00	
Median Immediate Post-service Time	3.00	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	
Prolonged Services Time	0.0	0.00	
Median Total Time	13.00	9.00	

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	2.45	2.20
--------------------------------------------------------------------------------------------------	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.71	1.60
--------------------------------------------------------------------------------------------------------------------------------	------	------

Urgency of medical decision making	2.16	1.80
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.47	2.00
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Physical effort required	2.79	2.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.55	1.80
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	2.68	1.90
--------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	2.18	1.70
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INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.95	1.30
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Intra-Service intensity/complexity	2.68	1.90
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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.*

The American College of Nuclear Physicians, American College of Radiology and the Society of Nuclear Medicine conducted a joint on-line Survey. The physician advisors and staff (the Committee) met by conference call to review and evaluate the survey data, and to develop the practice expense recommendations.

The Committee concluded that the Survey median data overestimated the work of the procedure, and recommends an RVU of 0.18 which was the 25th percentile. That value is consistent with the Reference Code that was most frequently selected by the Survey participants, which was CPT 90774 (*Therapeutic, prophylactic or diagnostic injection (specify substance or drug), intravenous push, single or initial substance/drug*). The Committee noted that the descriptions of the Physician Work for both codes are similar in that both require that the physicians provide and confirm orders, interact and review plan with staff, assure that the injection/dose is correctly administered, and provide direct physician supervision. The physician work is dissimilar in that it is unlikely that the physician will need to assess the patient during the radiopharmaceutical injection procedure, but the physician provides nuclear regulatory oversight and control, will dictate and sign a report of the procedure, and coordinate the procedure with the surgeon for whom the radiopharmaceutical is being given.

The Committee agreed with the 25th percentile Survey estimate for intra-service time of 5 minutes, and total time of 13 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90774, 90779, 78099, 78999

Source: Medicare Physicians Supplier Procedure Summary 2003-2006, Part B Non-Managed Care Beneficiaries

Totals	2006	2005	2004	2003
2% of 90774	n/a new code	n/a	n/a	n/a
1% of 90779	n/a new code	n/a	n/a	n/a
10% of 78999	450	807	1082	96
100% of 78099	13	19	11	10
78070 parathyroid	28,602	28,025	27,661	25,646

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 Nucler Medicine

How often? Commonly

Specialty Radiology

How often? Sometimes

Specialty How often?

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

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A slightly higher frequency of a subspecialty of nuclear medicine than for radiologists.

Specialty Nuclear Medicine	Frequency 600	Percentage 60.00 %
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Specialty Radiology	Frequency 400	Percentage 40.00 %
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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? 1,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. A slightly higher frequency of a subspecialty of nuclear medicine than for radiologists.

Specialty Nuclear Medicine	Frequency 600	Percentage 60.00 %
----------------------------	---------------	--------------------

Specialty Radiology	Frequency 400	Percentage 40.00 %
---------------------	---------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
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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? Yes

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

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

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Facility & Non Facility Direct Inputs**

CPT Long Descriptor: Injection procedure for radiopharmaceutical localization by non-imaging probe study; intravenous (eg. parathyroid adenoma)

Sample Size: Consensus Panel Response Rate: (%):N/A Global Period: _XXX

Geographic Practice Setting percentage: Does not apply, see description below.

Rural _____ Suburban _____ Urban _____

Type of Practice %: _0__ Solo Practice
 _30__ Single Specialty Group
 _35__ Multispecialty Group
 _35__ 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 College of Nuclear Physicians (ACNP), the Society of Nuclear Medicine (SNM) and the American College of Radiology (ACR) utilized consensus panel, to develop the direct practice expense recommendations. For the consensus panel, attention was paid to the geographic distribution, practice type (academic, private practice) and practice size of the representatives. A joint consensus between ACNP, SNM and the ACR was reached for the final practice expense recommendation for this new code.

Pre-Service:

Nuclear Medicine Technologist (Nuc Med Tech) reviews request, pulls prior parathyroid imaging study; confirms the order and appropriateness with the physician (who must order radionuclide administration); confirms radiopharmaceutical to be used; obtains physician written directive; and orders radiopharmaceutical from the central commercial nuclear pharmacy. Nuc Med Tech receives and then prepares radiopharmaceutical for administration.

Intra-Service:

Nuclear Medicine Technologist (Nuc Med Tech) prepares the area for the patient arrival, obtains the dose from the pharmacy area, reassays patient dose, and ensures dose would be appropriate for the patient as per the written directive. The Nuc Med Tech interviews the patient (pregnancy, recent contrast and meds) and gives routine pre-radiopharmaceutical injection education and instructions. The Nuc Med Tech greets patient and escorts to the injection area; starts IV; flushes to confirm IV position; injects dose and flushes; reassays for residual, records the site, date, and time of injection in the medical record and radiopharmaceutical dosage computer; and stores the radioactive syringe and IV materials, cleans up of injection area, defacing labels and storing or returning to the nuclear pharmacy as required by the NRC.

Post-Service:

When injection is complete, the Nuclear Medicine Technologist contacts the appropriate operating room or ambulatory surgery center staff, and instructs or arranges for patient transfer. Nuc Med Tech completes Nuclear Regulatory Commission (NRC) regulatory compliance process of the radiopharmaceutical injection and storage areas.

	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation			78808	
2	Apr-08			Injection procedure for radiopharmaceutical localization by non-imaging probe study; intravenous (eg parathyroid adenoma)	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD				
5	TOTAL CLINICAL LABOR TIME	L049A	NMT	46.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L049A	NMT	6.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L049A	NMT	37.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L049A	NMT	3.0	0.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms				
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	(*) Review X-ray, scan, lab, and past tests to confirm appropriateness of procedure with physician; confirm technique to be used and any special views required, obtain physician written directive, confirm radiopharmaceutical dose, and order the radiopharmaceutical from the commercial central pharmacy	L049A	NMT	6	
17	End:When patient enters office/facility for surgery/procedure				
18	SERVICE PERIOD				
19	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
20	(*) Prepare radiopharmaceutical delivered by central pharmacy with NRC and DOT required check-in of RP, QC dose calibrator ad survey equipment, survey package, wipe test of package and recording all. Ready dose for potential infusion/injection with in-house labels and records, and resurvey verifying measured dose with perscribed dose in 16.	L049A	NMT	13	
21	Review charts				
22	Greet patient and provide gowning	L049A	NMT	3	
23	Obtain vital signs				
24	Provide pre-service education/obtain consent emphasis on radiation risk	L049A	NMT	3	
25	Prepare room, equipment, supplies	L049A	NMT	2	
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV	L049A	NMT	2	
28	Sedate/apply anesthesia				
29	Intra-service				
30	Perform procedure	L049A	NMT	5	
31	Post-Service				
32	Monitor pt. following service/check tubes, monitors, drains				
33	Clean room/equipment by physician staff			3	
34	(*) Specific room clean up of injection areas with defacement of ladels, and required NRC and Monitoring tasks including measurement of residual RP dose in syringe.	L049A	NMT	3	
35	Clean Scope				
36	Clean Surgical Instrument Package				
37	(*) Complete diagnostic forms, lab & X-ray requisitions, enter RP dispensed in computer systems for NRC decay and tracking	L049A	NMT	3	
38	Review/read X-ray, lab, and pathology reports				
39	End: Patient leaves office				
40	POST-SERVICE/Period				
41	Start: Patient leaves office/facility				
42	Coordinate pre-surgery communication	L049A	NMT	2	
43	(*) Regulatory compliance –NRC required wipe tests and surveys of areas used, and documentation.	L049A	NMT	3	

	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation			78808	
2	Apr-08			Injection procedure for radiopharmaceutical localization by non-imaging probe study; intravenous (eg parathyroid adenoma)	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
44	MEDICAL SUPPLIES	CMS Code	Unit		
45	RADIOPHARMACEUTICAL - STORAGE AND RECEIVING AREA				
46	Sanitizing cloth-wipe (surface, instruments, equipment)	SM022		4	
47					
48	INJECTION AREA				
49	Alcohol Swabs	SJ053		2	
50	Angiocatheter 14g-24g	SC001		1	
51	Stop cock, 3 way	SC049		1	
52	Band aid	SG021		1	
53	Chux	SB044		2	
54	Gauze, 2x2	SG050		2	
55	Gloves, non-sterile	SB022		2	
56	Syringe, 10-12cc	SC051		1	
57	Needles, 18-27 g	SC029		1	
58					
59	Equipment				
60	Radiopharmaceutical Receiving Area				
61	(This is a fixed room for future codes)				
62	Dose Calibrator \$6,000	ER027		1	
63	Dedicated nuclear pharmacy software	ED020		0	
64	Calibration Source Vial Set & Check Sleeves	ER026		1	
65	Survey meter	ER054		1	
66	L-Block Table Shield	ER053		1	
67	Lead-lined radioactive waste and lead lined Sharps box	ER058		1	
68	Injection Room				
69	(This is a fixed room for future codes)				
70	Chair, medical recliner	EF009		1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2008

End Stage Renal Disease (ESRD) Services

In early 2007, the RUC received a request from CMS to evaluate the End Stage Renal Disease services. CMS states, "As you know, in the physician fee schedule Final Rule for 2007, we did not implement the RUC recommendation to apply the increases in the E/M codes to the G-codes for ESRD physician services. As we stated in the rule, we did not have the information to know what assumptions to make regarding the level of E/M visits to use as part of the building blocks for each of these services. At that time, we also indicated that we would like for the renal physicians to take these G-codes to the RUC, so that we could receive more specific recommendations on the appropriate RVUs for these services. We, therefore, request formally that the RUC review any of the ESRD G-codes that the renal physicians wish to present."

In September 2007, the RUC's Research Subcommittee recommended that the Renal Physicians of America (RPA) review the existing language associated with the temporary ESRD G-codes and submit a coding proposal to the CPT Editorial Panel defining these services and typical patients. Further, the Research Subcommittee reviewed vignettes, proposed educational materials, proposed survey instruments and summary of recommendation forms. As these services are performed over the course of a month, the Research Subcommittee and the RUC determined that a building block approach using work and time proxies of the evaluation and management services should be utilized to evaluate these services. This approach was reflected on the specialty's survey instruments and their summary of recommendation forms.

RPA submitted a coding proposal to the CPT Editorial Panel for review at its October 2007 meeting, which was very similar in structure to the existing G-codes. This proposal was approved and therefore was forwarded to the RUC for review. The specialty society did utilize the RUC approved modified survey instruments and summary of recommendation forms into their recommendations. As these services are bundled services, the RUC recommended to the society that a building block methodology would be the best manner to evaluate these codes. The RUC recommended that the building block methodology be incorporated into the survey instrument by utilizing a grid that would allow survey respondents to record what services they provide to the typical patient on a daily basis over a month. This grid would allow the respondent to indicate the days in which the patient received dialysis, the additional services performed

by the physician (broken down into E/M visit proxies and actual time), additional services performed by the physician extender, i.e. a nurse practitioner or physician assistant (broken down into E/M visit proxies and actual time) and other services not included in these E/M visit proxies such as record review. On the grid, all of the visits and times would be added by the survey respondent. Then, the visits would be multiplied by the associated E/M work RVU proxies. It was determined that the intra-service times for evaluation and management proxies were appropriate as all time in these services are conducted face-to-face with the patient. Finally, all work RVUs were totaled for a recommended work RVU for the particular service being surveyed. This building block methodology utilizing evaluation and management work proxies was deemed to be appropriate because the same approach was utilized to develop RUC recommendations for the adult ESRD services when they were first reviewed in April 1995.

As part of these modified survey instruments and summary of recommendation forms, the RUC had presumed that there was physician extender time associated with these services. Accordingly, the survey instruments and the summary of recommendation forms were modified to try to capture this time. However, in all of the ESRD services, the survey respondents indicated that it was not typical for them to utilize physician extenders i.e. less than 25% of survey respondents indicated that they used physician extenders. Therefore, all of the service time and work discussed in this recommendation are provided by the physician. The RUC in its review of these services assumed the RPA survey times were relatively correct however, made adjustments in the assumed visit intensity.

Adult End Stage Renal Dialysis Services

As the review of these services are considered to be part of the Five-Year Review and the RUC operates with the initial presumption that the current values of existing services is correct, compelling evidence that the existing values for a service(s) are no longer rational or appropriate must be presented to the RUC. The societies did present this compelling evidence stating that as the existing ESRD G-codes and valuation for these codes were established without the input of organized medicine specifically the nephrologist community, the current methodology used in establishing the valuation for these services was flawed. The RUC agreed with this compelling evidence and continued with their evaluation of these services.

90960 End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 4 or more face-to-face physician visits per month

The RUC reviewed survey data from 55 renal physicians for 90960 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has four face-to-face physician visits per month associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99213 Office/Outpt Visit, Est	0.92	15 minutes
3 – 99214 Office/Outpt Visit, Est	(1.42 x 3) 4.26	75 minutes
90960	5.18 RVUs	90 minutes

The RUC recommends 5.18 work RVUs and 90 minutes for 90960.

90961 End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 2-3 face-to-face physician visits per month

The RUC reviewed survey data from 44 renal physicians for 90961 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has three face-to-face physician visits per month associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

3 – 99214 Office/Outpt Visit, Est	(1.42 x 3) 4.26	75 minutes
90961	4.26 RVUs	75 minutes

The RUC recommends 4.26 work RVUs and 75 minutes for 90961.

90962 End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 1 face-to-face physician visit per month

The RUC reviewed survey data from 44 renal physicians for 90962 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has one face-to-face physician visit per month associated with it however, because it is only one visit, there is significant care plan oversight associated with this service to promote continuity of care. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – G0182 Care Plan Oversight	1.73	38 minutes
1 – 99214 Office/Outpt Visit, Est	1.42	25 minutes
90962	3.15 RVUs	63 minutes

The RUC recommends 3.15 work RVUs and 63 minutes for 90962.

90966 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over

The RUC noted that CMS when valuing the associated G-codes determined that the work of 90966 and 90961 *End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 2-3 face-to-face physician visits per month* was equivalent. Therefore, the RUC recommends that the value and the times for 90966 be directly crosswalked from 90961.

3 – 99214 Office/Outpt Visit, Est	(1.42 x 3) 4.26	75 minutes
90966	4.26 RVUs	75 minutes

The RUC recommends 4.26 work RVUs and 75 minutes for 90966.

The RUC believes that the previous valuations for the adult end stage renal dialysis services are correct. Although these services have had compelling evidence presented that indicates that the existing valuation of the services is flawed because organized medicine specifically the nephrologist community had not been consulted in the existing valuation of these services, the RUC believes that the recommendations for the adult end stage renal dialysis services are essentially work neutral as the RUC recommendations for these services result in only an overall 1% increase in the work RVUs allocated to this family of services.

Pediatric End Stage Renal Disease Services

As the review of these services are considered to be part of the Five-Year Review and the RUC operates with the initial presumption that the current values of existing services is correct, compelling evidence that the existing values for a service(s) are no longer rational or appropriate must be presented to the RUC. The societies did present this compelling evidence stating that as the existing pediatric ESRD G-codes and valuation for these codes were established without the input of organized medicine, specifically the pediatric nephrologist community, who would be the providers of these services, the current methodology used in establishing the valuation for these services was flawed. The RUC agreed with this compelling evidence and continued with their evaluation of these services.

90951 End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month

The RUC reviewed the survey data provided by the specialty and were concerned about the low survey response rate, 3 survey respondents. The specialty society explained that the survey response rate was so low because these services are rarely performed, less than 10-15 infants in the country require this service. The specialty society also indicated that the typical number of face-to-face

physician visits for this service is at least 13-17 visits. The pediatric nephrologists typically attend each of the dialysis sessions. Therefore, the specialty society recommends that this service be crosswalked to 99295 *Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less* (Work RVU=18.46, 274 minutes) as this service requires extensive and intensive physician work. Furthermore, the RUC noted that this value is further supported by a building block approach. Assuming 13 visits is typical of this service and that they all were at a 99214 Office/Outpt Visit, Est visits level of service, the physician work from that building block approach is the same as crosswalking 90951 to 99295. **Therefore, the RUC recommends 18.46 work RVUs and 274 minutes for 90951.**

90952 *End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month* and 90953 *End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month*

The specialty society stated that there were zero survey respondents for these services because these services are so infrequently performed. It is rare that these patients with this chronic illness at this age would be seen 2-3 times per month or once per month as again the pediatric nephrologist would typically attend all dialysis sessions. Therefore, because of the rareness of these services and the zero response rate, the RUC recommends that these service be carrier priced. **The RUC recommends that 90952 and 90953 are carrier priced.**

90954 *End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month*

The RUC reviewed the survey data provided by the specialty and were concerned about the low survey response rate, 7 survey respondents. The specialty society explained that the survey response rate was so low because these services are rarely performed, less than 10-15 patients in the country require this service. The specialty society also indicated that the typical number of face-to-face physician visits for this service is at least 13-17 visits. The pediatric nephrologist typically attends each dialysis session. Therefore, the specialty society recommends that this service be crosswalked to 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* (Work RVU=15.98, 240 minutes) as this service requires extensive and intensive physician work and properly reflects the relativity between 90954 and 90951 *End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month* (RUC recommended RVU=18.46). **Therefore, the RUC recommends 15.98 work RVUs and 240 minutes for 90954.**

90955 End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month

The RUC reviewed 90955 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has three visits, of which one visit is a prolonged visit and significant care plan oversight, which includes assessing nutritional needs associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
2 – 99214 Office/Outpt Visit, Est	(1.42 x 2) 2.84	50 minutes
1 – 99354 Prolonged Service, Office	1.77	60 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
1 – 97802 Medical Nutrition, Indiv	0.45	15 minutes
90955	8.79 RVUs	198 minutes

The RUC recommends 8.79 work RVUs and 198 minutes for 90955.

90956 End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month

The RUC reviewed 90956 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has one prolonged service visit and significant care plan oversight, which includes assessing nutritional needs associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
1 – 99354 Prolonged Service, Office	1.77	60 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
1 – 97802 Medical Nutrition, Indiv	0.45	15 minutes
90956	5.95 RVUs	148 minutes

The RUC recommends 5.95 work RVUs and 148 minutes for 90956.

90957 End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month

The RUC reviewed 90957 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed with the specialty society that this procedure typically has seven visits of which one is a prolonged visit and significant care plan oversight associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
3 – 99214 Office/Outpt Visit, Est	(1.42 x 3) 4.26	75 minutes
3 – 99213 Office/Outpt Visit, Est	(0.92 x 3) 2.76	45 minutes
1 – 99354 Prolonged Service, Office	1.77	60 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
90957	12.52 RVUs	253 minutes

The RUC recommends 12.52 work RVUs and 253 minutes for 90957.

90958 End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month

The RUC reviewed 90958 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has three visits of which one visit is a prolonged visit and significant care plan oversight associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
2 – 99214 Office/Outpt Visit, Est	(1.42 x 2) 2.84	50 minutes
1 – 99354 Prolonged Service, Office	1.77	60 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
90958	8.34 RVUs	183 minutes

The RUC recommends 8.34 work RVUs and 183 minutes for 90958.

90959 End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month

The RUC reviewed 90959 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has one prolonged service visit and significant care plan oversight associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
1 – 99354 Prolonged Service, Office	1.77	60 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
90959	5.50 RVUs	133 minutes

The RUC recommends 5.50 work RVUs and 133 minutes for 90959.

Pediatric Home Dialysis

90963 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents

The RUC noted that they could not apply the methodology used in 90964 or 90965 because the RUC recommended that 90952 *End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month* be carrier priced as the volume of this procedure is very low (Medicare Utilization=19 for 2006). Therefore, the RUC tried to determine the relativity in work and time between 90963 and 90964 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents* (RUC Recommended Value=9.14). The RUC determined that for the under two patient population there would be more time required to manage fluids and nutritional concerns as well as make changes to their dialysis programs and prescriptions as compared to the two to eleven patient population. Therefore, to account for this increased amount of time, the RUC recommends to begin with the recommended value/building block of 90964 and add the equivalent of a 99214 Office Visit (Work RVU=1.42) as demonstrated below:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
2 – 99214 Office/Outpt Visit, Est	(1.42 x 2) 2.84	50 minutes

2 – 99354 Prolonged Service, Office	(1.77 x 2) 3.54	120 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
1 – 97802 Medical Nutrition, Indiv	0.45	15 minutes
90963	10.56 RVUs	258 minutes

The RUC recommends 10.56 work RVUs and 258 minutes for 90963.

90964 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents

The RUC noted that when the RUC reviewed the adult ESRD codes, 90961 *End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 2-3 face-to-face physician visits per month* was recommended to be crosswalked to 90966 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over* due to the fact when valuing the associated G-codes, CMS determined that the work of these two codes was equivalent. However, the RUC determined that the pediatric patient population requires additional time and work as compared to 90955 *End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month*. Therefore, the RUC recommends modifying the building block associated with 90955 to account for the additional time and physician work associated with 90964, as follows:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
1 – 99214 Office/Outpt Visit, Est	1.42	25 minutes
2 – 99354 Prolonged Service, Office	(1.77 x 2) 3.54	120 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
1 – 97802 Medical Nutrition, Indiv	0.45	15 minutes
90964	9.14 RVUs	233 minutes

The RUC recommends 9.14 Work RVUs and 233 minutes for 90964.

90965 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

The RUC noted that when the RUC reviewed the adult ESRD codes, 90961 *End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 2-3 face-to-face physician visits per month* was recommended to be crosswalked to 90966 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over* due to the fact when valuing the associated G-codes, CMS determined that the work of these two codes was equivalent. However, the RUC determined that the pediatric patient population requires additional time and work as compared to 90958 *End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month*. Therefore, the RUC recommends modifying the building block associated with 90958 to account for the additional time and physician work associated with 90965, as follows:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
1 – 99214 Office/Outpt Visit, Est	1.42	25 minutes
2 – 99354 Prolonged Service, Office	(1.77 x 2) 3.54	120 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
90965	8.69 RVUs	218 minutes

The RUC recommends 8.69 Work RVUs and 218 minutes for 90965.

Per Day Services

90967 *End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients under two years of age*

The current methodology for how the G0324 *End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients under two years of age* is valued is by taking the current G0320 *End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients under two years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents* and dividing it by 30 as these services are valued on a per day basis. Therefore, the RUC recommends that 90967 be valued using the same methodology as follows taking 90963 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents* (RUC Recommended Value=10.56) and dividing it by 30 resulting in a value of 0.35 RVUs. **The RUC recommends 0.35 work RVUs for 90967.**

90968 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients two to eleven years of age

The current methodology for how the G0325 *End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between two and eleven years of age* is valued is by taking the current G0321 *End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients for patients between two and eleven years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents* and dividing it by 30 as these services are valued on a per day basis. Therefore, the RUC recommends that 90968 be valued using the same methodology as follows taking 90964 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents* (RUC Recommended Value=9.14) and dividing it by 30 resulting in a value of 0.30 RVUs. **The RUC recommends 0.30 work RVUs for 90968.**

90969 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients twelve to nineteen years of age

The current methodology for how the G0326 *End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between twelve and nineteen years of age* is valued is by taking the current G0322 *End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients for patients between twelve and nineteen years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents* and dividing it by 30 as these services are valued on a per day basis. Therefore, the RUC recommends that 90969 be valued using the same methodology as follows taking 90965 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents* (RUC Recommended Value=8.69) and dividing it by 30 resulting in a value of 0.29 RVUs. **The RUC recommends 0.29 work RVUs for 90969.**

90970 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients twenty years of age and over

The current methodology for how the G0327 *End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients twenty years of age and over* is valued is by taking the current G0323 *End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients for patients twenty years of age and over* and dividing it by 30 as these services are valued on a per day basis. Therefore, the RUC recommends that 90970 be valued using the same methodology as follows taking 90966

End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and older (RUC Recommended Value=4.26) and dividing it by 30 resulting in a value of 0.14 RVUs. **The RUC recommends 0.14 work RVUs for 90970.**

The RUC recommends that all of the ESRD services be flagged in the RUC database to state that these services should not be used to validate the work or times of other services.

Practice Expense

The RUC reviewed the practice expense inputs for the adult ESRD services and determined that the inputs recommended by the specialty societies was appropriate – a direct practice expense input crosswalk from 99375 *Care Plan Oversight*, 36 minutes of RN/LPN/MTA time and two follow-up phone calls, 6 minutes of RN/LPN/MTA time to account for the complete assessment which is performed in the office for the adult ESRD services. Further, the RUC reviewed the practice expense inputs for the pediatric ESRD services and determined that the inputs recommended by the specialty societies was appropriate – a direct practice expense input crosswalk from 99375 *Care Plan Oversight*, 36 minutes of RN/LPN/MTA time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 90918		End stage renal disease (ESRD) related services per full month; for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	XXX	N/A
D 90919		for patients between two and eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	XXX	N/A
D 90920		for patients between twelve and nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	XXX	N/A
D 90921		for patients twenty years of age and older	XXX	N/A
D 90922		End stage renal disease (ESRD) related services (less than full month), per day;	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		for patients under two years of age		
D 90923		for patients between two and eleven years of age	XXX	N/A
D 90924		for patients between twelve and nineteen years of age	XXX	N/A
D 90925		y years of age and older (90918, 90922 have been deleted. To report ESRD-related services for patients under two years of age, see 90951-90953, 90963, 90967 (90919, 90923 have been deleted. To report ESRD-related services for patients between two and eleven years of age, see 90954-90956, 90964, 90968) (90920, 90924 have been deleted. To report ESRD-related services for patients between twelve and nineteen years of age, see 90957- 90959, 90965, 90969) (90921, 90925 have been deleted. To report ESRD-related services for patients twenty years of age and older, see 90960-90962, 90966, 90970)	XXX	N/A
Miscellaneous Dialysis Procedures				
90947		<i>Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated physician evaluations, with or without substantial revision of dialysis prescription</i>	000	2.16 (No Change)
Disease Services				
Codes 90951-90962 are reported once per month to distinguish age-specific services for End-Stage Renal Disease (ESRD) Services performed in an outpatient setting with three levels of service based on the number of face-to-face visits. ESRD-related physician services include establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls, and patient management during the dialysis, provided during a full month. In the circumstances where the patient has had a complete assessment visit during the month and services are provided over a period of less than a month, 90951-90962				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>may be used according to the number of visits performed.</p> <p>Codes 90963-90966 are reported once per month for a full month of service to distinguish age-specific services for End-Stage Renal Disease (ESRD) Services for home dialysis patients.</p> <p>Evaluation and management services unrelated to ESRD services that cannot be performed during the dialysis session may be reported separately.</p> <p>Codes 90967-90970 are reported to distinguish age-specific services for End-Stage Renal Disease (ESRD) Services for less than a full month of service, per day, for services provided under the following circumstances: home dialysis patients less than a full month, transient patients, partial month where there was one or more face-to-face visits without the complete assessment and either the patient was hospitalized before a complete assessment was furnished, dialysis was stopped due to recovery or death, or the patient received a kidney transplant.</p> <p>Example: Home ESRD-related services are initiated on July 1 for a 57 year old male. On July 11, he is admitted to the hospital as an inpatient and is discharged on July 27. In this example code 909X70 should be reported for each day outside of the inpatient hospitalization (30 days/month less 17 days/hospitalization = 13 days) Report inpatient E/M services as appropriate. Dialysis procedures rendered during the hospitalization (July 11-27) should be reported as appropriate (90935-90937, 90945-90947)</p>				
●90951	K1	End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	XXX	18.46
●90952	K2	with 2-3 face-to-face physician visits per month	XXX	Carrier Priced
●90953	K3	with 1 face-to-face physician visit per month	XXX	Carrier Priced
●90954	K4	End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	XXX	15.98

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●90955	K5	with 2-3 face-to-face physician visits per month	XXX	8.79
●90956	K6	with 1 face-to-face physician visit per month	XXX	5.95
●90957	K7	End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	XXX	12.52
●90958	K8	with 2-3 face-to-face physician visits per month	XXX	8.34
●90959	K9	with 1 face-to-face physician visit per month	XXX	5.50
●90960	K10	End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 4 or more face-to-face physician visits per month	XXX	5.18
●90961	K11	with 2-3 face-to-face physician visits per month	XXX	4.26
●90962	K12	with 1 face-to-face physician visit per month	XXX	3.15
●90963	K13	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	XXX	10.56
●90964	K14	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	XXX	9.14
●90965	K15	End-stage renal disease (ESRD) related services for home dialysis per full month,	XXX	8.69

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents		
●90966	K16	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over	XXX	4.26
●90967	K17	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients under two years of age	XXX	0.35
●90968	K18	for patients two to eleven years of age	XXX	0.30
●90969	K19	for patients twelve to nineteen years of age	XXX	0.29
●90970	K20	for patients twenty years of age and over	XXX	0.14
90989		<i>Dialysis training, patient, including helper where applicable, any mode, completed course</i>	XXX	N/A (No Change)
D G0308		End stage renal disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	XXX	N/A
D G0309		End stage renal disease (ESRD) related services during the course of treatment for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month	XXX	N/A
D G0310		End stage renal disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month		
D G0311		End-stage renal disease (ESRD) related services during the course of treatment, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	XXX	N/A
D G0312		End-stage renal disease (ESRD) related services during the course of treatment, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month	XXX	N/A
D G0313		End-stage renal disease (ESRD) related services during the course of treatment, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month	XXX	N/A
D G0314		End-stage renal disease (ESRD) related services, during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	XXX	N/A
D G0315		End-stage renal disease (ESRD) related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month	XXX	N/A
D G0316		End-stage renal disease (ESRD) related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month	XXX	N/A
D G0317		End-stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 4 or more face-to-face physician visits	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		per month		
D G0318		End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 2 or 3 face to face physician visits per month	XXX	N/A
D G0319		End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 1 face to face physician visit per month	XXX	N/A
D G0320		End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients under two years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents	XXX	N/A
D G0321		End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients two to eleven years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents	XXX	N/A
D G0322		End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twelve to nineteen years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents	XXX	N/A
D G0323		End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twenty years of age and older	XXX	N/A
D G0324		End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients under two years of age	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D G0325		End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between two and eleven years of age	XXX	N/A
D G0326		End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between twelve and nineteen years of age	XXX	N/A
D G0327		End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients twenty years of age and over	XXX	N/A

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

CPT Code: 90960

Tracking Number: K10

Specialty Society Recommended RVU: 5.76

RUC Recommended RVU: 5.18

Global Period: XXX

CPT Descriptor: End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year old man receives hemodialysis at a dialysis facility. His disease burden includes Type II diabetes mellitus, vascular disease, multiple access problems, hypertension, secondary hyperparathyroidism, anemia, and polypharmacy (> 7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: His nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition including post hospitalization (the typical patient has 2.0 admissions per year or 14 hospitalization days per year); evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription; scheduled review of routinely collected laboratory data including intravenous ESA's and iron and vitamin D or its surrogates; episodic adjustments of home medications including antihypertensives and phosphate binders; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, transplantation centers, and other medical specialists; and overall care coordination. The nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient or his caregiver. He will see the patient during dialysis sessions four or more times during the month in order to accomplish this care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008			
Presenter(s):	Robert J. Kossmann, M.D.F.A.C.P., F.A.S.N.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.				
Specialty(s):	Renal Physicians Association (RPA)				
CPT Code:	90960				
Sample Size:	145	Resp N:	55	Response: 37.9 %	
Sample Type:	Convenience				
	<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate	12.00	214.00	480.00	697.50	1219.00
Number of Visits	3	4	5	6.25	18
Number of Days of Dialysis	N/A	N/A	N/A	N/A	N/A
Physician Work	2.05	4.19	5.36	6.70	11.94
Physician Time	35.00	70.00	95.00	115.00	239.00
Extender Work *	0.00	0.00	0.00	0.10	8.64
Extender Time	0.00	0.00	0.00	3.00	180.00

BREAK-OUT OF SURVEY DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU *	Estimated Time
99213	0.92	15	99441	0.21	10
99213	0.92	15			
99214	1.42	25			
99215	2.00	40			
99441	0.25	10			
Sum	5.51	105		0.21	10

* The resulting work RVUs for the physician extender have been multiplied by 0.85 to reflect the Medicare payment policy of these professionals.

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	4
Number of Days of Dialysis	13
Work	5.18
Time	90

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
1-99213	0.92	15			
3-99214	4.26	75			
Sum	5.18	90			

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

<u>CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90921	XXX	4.46	RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services per full month; for patients twenty years of age and older

KEY MPC COMPARISON CODES:

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

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

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.*

2008 RVW value for G0317 (current code for service): 5.09

RPA Recommendation for 9096X0: 5.76

The Renal Physicians Association (RPA) surveyed:

- 9096X0, End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month

Code 9096X0 represents a bundle of medical management services provided to an adult ESRD patient. This patient has 4 or more face-to-face encounters with the physician within the month.

BACKGROUND

The society was requested to survey this service by the Centers for Medicare and Medicaid Services (CMS).

UNIQUE SURVEY INSTRUMENT

These services are provided by a physician in conjunction with a physician extender. The survey instrument allowed survey respondents to record what services were typically provided to a patient over a month period. The respondent was requested to estimate both physician and extender work and time.

RPA ANALYSIS

A panel of RPA physicians reviewed the survey data.

Days of Dialysis

None of the survey respondents reported on the number of days of dialysis (column 2). The panel attributed this to lack of familiarity with the survey instrument. The medical standard which is consistent with the panel's professional experience is 13 days per month. The panel unanimously agreed to recommend 13 days of dialysis per month.

Physician Extender

The striking characteristic of the data was that only 25% of the respondents reported extender services in addition to physician services. The panel of physicians concluded that this reflected the varying practice patterns across the US.

Because of the low number of responses with physician extender data, the work RVU and time data for physician extenders was 0.00 up to and including the median value. When the responses that included physician extender data were extracted and reviewed separately, it was found that the median RVU for the physician extender was 2.48 (RVU discounted by 15%) and the median time was 50 minutes. These respondents also tended to have lower physician time and RVU. This indicated to the panel that for the practices that used extenders these professionals were an important component of providing the service.

Blended Data

The panel concluded that the most accurate method to capture the work and the time of both the physician and extender that reflects all types of practices providing these services is to recommend a weighted analysis (75%/25%) that blended physician and extender RVU and time data. This resulted in a median RVU of 5.76 and a median time of 107 minutes. The panel concluded that these values were consistent with the CPT codes or "surrogate services" reported by survey respondents.

The 2008 work RVU for code G0317 which is currently being reported to provide this service is 5.09. The panel concluded that this increase of 0.67 RVUs was appropriate.

In view of the above, RPA recommends 5.76 RVU for code 9096X0 and a time of 107 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0317, End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month

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 Nephrology 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? 1816342

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The estimate represents the 2005 Medicare utilization for G0317. We believe this reflects the national utilization for this service.

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? 1,816,342 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization for code G0317

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

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. G0317 which is the G-code that is being replaced with this new CPT code

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

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

CPT Code: 90961 Tracking Number: K11

Specialty Society Recommended RVU: 4.26
RUC Recommended RVU: 4.26

Global Period: XXX

CPT Descriptor: End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 2-3 face-to-face physician visits per month

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year old man receives hemodialysis at a dialysis facility. His disease burden includes Type II diabetes mellitus, vascular disease, multiple access problems, hypertension, secondary hyperparathyroidism, anemia, and polypharmacy (> 7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: His nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition including post hospitalization (the typical patient has 2.0 admissions per year or 14 hospitalization days per year); evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription; scheduled review of routinely collected laboratory data including intravenous ESA's and iron and vitamin D or its surrogates; episodic adjustments of home medications including antihypertensives and phosphate binders; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, transplantation centers, and other medical specialists; and overall care coordination. The nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient or his caregiver. He will see the patient during dialysis sessions two to three times during the month in order to accomplish this care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008			
Presenter(s):	Robert J. Kossmann, M.D., F.A.C.P.;Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.				
Specialty(s):	Renal Physicians Association (RPA)				
CPT Code:	90961				
Sample Size:	145	Resp N:	44	Response: 30.3 %	
Sample Type:	Convenience				
	<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate	5.00	48.00	82.00	130.00	563.00
Number of Visits	3	3	3	4	8
Number of Days of Dialysis	N/A	N/A	N/A	N/A	N/A
Physician Work	1.90	3.75	4.59	5.50	10.25
Physician Time	25.00	61.00	75.00	93.00	188.00
Extender Work *	0.00	0.00	0.00	0.00	3.56
Extender Time	0.00	0.00	0.00	0.00	70.00

BREAK-OUT OF SURVEY DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
99213	0.92	15	99213	0.92	15
99214	1.42	25			
99215	2.00	40			
99441	0.25	10			
Sum	4.59	90.00		0.92	15

* The resulting work RVUs for the physician extender have been multiplied by 0.85 to reflect the Medicare payment policy of these professionals.

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	3
Number of Days of Dialysis	13
Work	4.26
Time	75

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
3-99214	4.26	75			
Sum	4.26	75			

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

CPT Code Global Work RVU Time Source
 90921 XXX 4.46 RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services per full month; for patients twenty years of age and older

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 1

MPC CPT Code 2 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 2

Other Reference CPT Code Global Work RVU Time Source

CPT Descriptor

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.*

2008 RVW value for G0318 (current code for service): 4.24

RPA Recommendation for 9096X1: 4.94

The Renal Physicians Association (RPA) surveyed:

- 9096X1, End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 2-3 face-to-face physician visits per month

Code 9096X1 represents a bundle of medical management services provided to an adult ESRD patient. This patient has 2-3 or more face-to-face encounters with the physician within the month.

BACKGROUND

The society was requested to survey this service by the Centers for Medicare and Medicaid Services (CMS).

UNIQUE SURVEY INSTRUMENT

These services are provided by a physician in conjunction with a physician extender. The survey instrument allowed survey respondents to record what services were typically provided to a patient over a month period. The respondent was requested to estimate both physician and extender time.

RPA ANALYSIS

A panel of RPA physicians reviewed the survey data.

Days of Dialysis

None of the survey respondents reported on the number of days of dialysis (column 2). The panel attributed this to lack of familiarity with the survey instrument. The medical standard which is consistent with the panel's professional experience is 13 days per month. The panel unanimously agreed to recommend 13 days of dialysis per month.

Physician Extender

The striking characteristic of the data was that only 25% of the respondents reported extender services in addition to physician services. The panel of physicians concluded that this reflected the varying practice patterns across the US.

Because of the low number of responses with physician extender data the work RVU and time data for physician extenders was 0.00 up to and including the 75th percentile value. When the responses that included physician extender data were extracted and reviewed separately, it was found that the median RVU for a physician extender was 1.17 (RVU discounted by 15%) and the median time was 22.5 minutes. These respondents also tended to have lower physician time and RVU. This indicated to the panel that for the practices that used extenders these professionals were an important component of providing the service.

Blended Data

The panel concluded that the most accurate method to capture the work and the time of both the physician and extender that reflects all types of practices providing these services is to recommend a weighted analysis that blended (75%/25%) physician and extender RVU and time data. This resulted in a median RVU of 4.94 and a median time of 88 minutes. The panel concluded that these values were consistent with the CPT codes or "surrogate services" reported by survey respondents.

The 2008 work RVU for code G0318 which is currently being reported to provide this service is 4.24. The panel concluded that this increase of 0.70 RVUs was appropriate.

In view of the above, RPA recommends 4.94 RVU for code 9096X1 and a time of 88 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0318, End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 2 or 3 face-to-face physician visits per month

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 Nephrology 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? 593308
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. 2005 Medicare utilization for G0318 (593,308) reflects national utilization for this service.

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? 593,308
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization for code G0318

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

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. G0318 which is the G-code that is being replaced with this new CPT code

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

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

CPT Code: 90962

Tracking Number: K12

Specialty Society Recommended RVU: 3.47

RUC Recommended RVU: 3.15

Global Period: XXX

CPT Descriptor: End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 1 face-to-face physician visits per month

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year old man receives hemodialysis at a dialysis facility. His disease burden includes Type II diabetes mellitus, vascular disease, multiple access problems, hypertension, secondary hyperparathyroidism, anemia, and polypharmacy (> 7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: His nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition including post hospitalization (the typical patient has 2.0 admissions per year or 14 hospitalization days per year); evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription; scheduled review of routinely collected laboratory data including intravenous ESA's and iron and vitamin D or its surrogates; episodic adjustments of home medications including antihypertensives and phosphate binders; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, transplantation centers, and other medical specialists; and overall care coordination. The nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient or his caregiver. He will see the patient during dialysis sessions once during the month in order to accomplish this care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008			
Presenter(s):	Robert J. Kossmann, M.D, F.A.C.P., F.A.S.N.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.				
Specialty(s):	Renal Physicians Association (RPA)				
CPT Code:	90962				
Sample Size:	145	Resp N:	44	Response: 30.3 %	
Sample Type:	Convenience				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	7.00	12.00	16.75	120.00
Number of Visits	1	1	1	3	6
Number of Days of Dialysis	N/A	N/A	N/A	N/A	N/A
Physician Work	1.50	2.51	3.43	4.34	13.5
Physician Time	20.00	40.00	60.00	81.00	170.00
Extender Work *	0.00	0.00	0.00	0.00	1.99
Extender Time	0.00	0.00	0.00	0.00	60.00

BREAK-OUT OF SURVEY DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
99215	2.00	40.00	99213	0.92	15.00
99441	0.25	10.00			
Sum	2.25	50.00		0.92	15.00

* The resulting work RVUs for the physician extender have been multiplied by 0.85 to reflect the Medicare payment policy of these professionals.

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	1
Number of Days of Dialysis	13
Work	3.15
Time	63

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
1-G0182	1.73	38			
1-99214	1.42	25			
Sum	3.15	63			

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

CPT Code Global Work RVU Time Source
 90921 XXX 4.46 RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services per full month; for patients twenty years of age and older

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 1

MPC CPT Code 2 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 2

Other Reference CPT Code Global Work RVU Time Source

CPT Descriptor

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.*

2008 RVW value for G0319 (current code for service): 3.39

RPA Recommendation for 9096X2: 3.75

The Renal Physicians Association (RPA) surveyed:

- 9096X2, End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 1 face-to-face physician visits per month

Code 9096X2 represents a bundle of medical management services provided to an adult ESRD patient. This patient has 1 face-to-face encounter with the physician within the month.

BACKGROUND

The society was requested to survey this service by the Centers for Medicare and Medicaid Services (CMS).

UNIQUE SURVEY INSTRUMENT

These services are provided by a physician in conjunction with a physician extender. The survey instrument allowed survey respondents to record what services were typically provided to a patient over a month period. The respondent was requested to estimate both physician and extender work and time.

RPA ANALYSIS

A panel of RPA physicians reviewed the survey data.

Days of Dialysis

None of the survey respondents reported on the number of days of dialysis (column 2). The panel attributed this to lack of familiarity with the survey instrument. The medical standard which is consistent with the panel's professional experience is 13 days per month. The panel unanimously agreed to recommend 13 days of dialysis per month.

Physician Extender

The striking characteristic of the data was that only 25% of the respondents reported extender services in addition to physician services. The panel of physicians concluded that this reflected the varying practice patterns across the US.

Because of the low number of responses with physician extender data the work RVU and time data for physician extenders was 0.00 up to and including the 75th percentile value. When the responses that included physician extender data were extracted and reviewed separately, it was found that the median RVU for the physician extender was 0.68 (RVU discounted by 15%) and the median time was 20 minutes. These respondents also tended to have lower physician time and RVU. This indicated to the panel that for the practices that used extenders these professionals were an important component of providing the service.

Blended Data

The panel concluded that the most accurate method to capture the work and the time of both the physician and extender that reflects all types of practices providing these services is to recommend a weighted analysis (75%/25%) that blended physician and extender RVU and time data. This resulted in a median RVU of 3.75 and a median time of 64 minutes. The panel concluded that these values were consistent with the CPT codes or "surrogate services" reported by survey respondents.

The 2008 work RVU for code G0319 which is currently being reported to provide this service is 3.39. The panel concluded that this increase of 0.36 RVUs was appropriate.

In view of the above, RPA recommends 3.75 RVU for code 9096X2 and a time of 64 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0319, End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 1 face-to-face physician visit per month

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 Nephrology 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? 202340

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for G0319 reflect national utilization for this service

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? 202,340 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for G0319

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

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. G0319 which is the G-code that is being replaced with this new CPT code

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

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

CPT Code: 90963 Tracking Number: K13 Specialty Society Recommended RVU: 11.00
RUC Recommended RVU: 10.56

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services for home dialysis per full month, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10-month-old boy with ESRD from prune belly syndrome with renal dysplasia receives nightly home continuous cycling peritoneal dialysis (CCPD) by parent caregivers. His disease burden includes catheter access problems, renal osteodystrophy, anemia, acidosis, growth failure, developmental delay, anorexia and feeding problems, family dysfunction related to a technologically dependent infant, modified childhood immunizations and polypharmacy (> 7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition; evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription; frequent adjustment of target weight for growth and fluid intake; scheduled review of routinely collected laboratory data; episodic adjustment of home medications including oral iron supplements, vitamin D metabolites or surrogates, potassium supplements or exchange resins, calcium supplements, phosphate supplements or binders, and ESA and growth hormone injections; growth and nutritional monitoring with frequent adjustments of gastrostomy or nasogastric tube feedings of a special infant formula with added protein, carbohydrate and/or oil for adequate caloric intake for growth; monitoring of developmental progress and initiation and coordination of intervention for delayed milestones; coordination and appropriate dosing of childhood immunizations; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, transplantation centers, and other medical specialists; and overall care coordination with regular counseling and support of the parents/caregivers and siblings for the care of a technologically dependent infant with chronic kidney disease using high-tech home therapy. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers. He/she will see the patient one or more times during the month in order to accomplish his care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008			
Presenter(s):	Eileen Brewer, M D , F A A.P.; Richard J Hamburger, M.D., F.A C P , F A S N., Robert J Kossmann, M.D.				
Specialty(s):	American Soceity of Pediatric Nephrology (ASPEN)				
CPT Code:	90963				
Sample Size:	30	Resp N:	5	Response: 16.6 %	
Sample Type:	Convenience				
	<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate	1.00	4.00	7.00	10.00	12.00

Number of Visits	1	2	2	2	4
Number of Days of Dialysis	30	30	30	30	30
Physician Work	7.30	8.02	8.21	10.11	10.44
Physician Time	195	200	210	255	255
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR PHYSICIAN SERVICES (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/code	Total Est Time	Total Est Time divided by #surveys
99215	6	2.00	12.00	2.40	40	240	48
99339	2	1.25	2.50	0.50	20	40	8
99441	6	0.25	1.50	0.30	10	60	12
99367	9	1.10	9.90	1.98	30	270	54
99442	12	0.50	6.00	1.20	15	180	36
99443	2	0.75	1.50	0.30	25	50	10
99214	5	1.42	7.10	1.42	25	125	25
99283	1	1.34	1.34	0.27	60	60	12
SUM	43	8.61	41.84	8.37	225	1025	205

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	3
Number of Days of Dialysis	30
Physician Work	10.56
Physician Time	258
Extender Work	0
Extender Time	0

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU*	Estimated Time
1-99215	2.00	35			
2-99354	3.54	120			
1-G0182	1.73	38			
1-97802	0.45	15			
2-99214	2.84	50			
Sum	10.56	258			

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

CPT Code Global Work RVU Time Source
 90918 XXX 11.16 RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services for home dialysis per full month, for patients less than two years of age.

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 1

MPC CPT Code 2 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 2

Other Reference CPT Code Global Work RVU Time Source

CPT Descriptor

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 had only 5 survey respondents for this rarely billed code, because 2 other pediatric survey respondents had not personally reported this MCP in the last year. Almost all of the 5 respondents thought they were restricted in picking from the office E&M 99211-99215 categories for patient visits to the dialysis clinic, which did not accurately reflect the work effort, specialized pediatric nephrology expertise and the usual 60 min face-to-face visit with these infants and their home caregiver parents at peritoneal dialysis clinic visits. For this reason, the survey median artificially undervalued the work effort. Almost all the respondents reported the infants needed to be seen at least twice monthly, if not weekly at face-to-face visits. The less than 2 year old, who is rapidly growing and developing, requires frequent formula changes and laboratory assessment, and has frequent intercurrent illnesses, is the most difficult home dialysis patient for the pediatric nephrologist to manage. The 75th percentile was chosen as more reflective of the amount of effort to care for these infants and more consistent with the current G-code 320, which is 10.61.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0320, End-stage renal disease (ESRD) related services for home dialysis per full month, for patients less than two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

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 ped nephrology

How often? Sometimes

Specialty

How often?

Specialty

How often?

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

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency 0	Percentage 0.00 %
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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? 203

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization for code G0320

Specialty ped nephrology	Frequency 203	Percentage 100.00 %
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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? 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. G0320 which is the G-code that is being replaced with this new CPT code

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

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

CPT Code: 90964 Tracking Number: K14 Specialty Society Recommended RVU: 9.63
RUC Recommended RVU: 9.14

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 6-year-old boy with posterior urethral valves and obstructive uropathy receives home continuous cycling peritoneal dialysis (CCPD) by parent caregivers. His disease burden includes catheter access problems, renal osteodystrophy, anemia, acidosis, growth failure, behavior problems, family stress related to a technologically dependent child and polypharmacy (> 7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition; evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription; frequent adjustment of target weight for growth and fluid intake; scheduled review of routinely collected laboratory data; episodic adjustment of home medications including oral iron supplements, vitamin D metabolites or surrogates, potassium supplements or exchange resins, calcium supplements, phosphate supplements or binders, and ESA and growth hormone injections; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, transplantation centers, and other medical specialists; and overall care coordination. Growth and nutritional monitoring and intervention with special renal supplemental formula plus monitoring of developmental, behavioral and school problems and initiation of intervention will be accomplished along with counseling of the parents or caregivers for coping with a technologically dependent child with chronic kidney disease receiving high-tech home therapy. The pediatric nephrologist will also likely have multiple unscheduled telephone interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers, and may see the patient one or more times during the month in order to accomplish his care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008			
Presenter(s):	Eileen Brewer, M D., F.A A P ; Richard J. Hamburger, M D., F A C P , F A S N.; Robert J. Kossmann, M.D.				
Specialty(s):	American Soceity of Pediatric Nephrology (ASPN)				
CPT Code:	90964				
Sample Size:	30	Resp N:	7	Response: 23.3 %	
Sample Type:	Convenience				
	<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate	2.00	6.50	20.00	73.00	79.00
Number of Visits	1	1	1	1	2
Number of Days of Dialysis	30	30	30	30	30

Physician Work	4.35	6.66	7.85	8.21	10.34
Physician Time	195	200	210	210	255
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR PHYSICIAN SERVICES (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by	Estimated Time/code	Total Est Time
				#surveys		
99215	6	2.00	12.00	1.71	40	240
99442	17	0.50	8.50	1.27	15	255
99339	7	1.25	8.75	1.25	25	175
99441	5	0.25	1.25	0.18	10	50
99443	4	0.75	3.00	0.43	25	100
99214	2	1.42	2.84	0.18	25	175
99367	12	1.10	13.20	1.90	30	360
SUM	53	7.27	49.54	6.92	170	1355

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	2
Number of Days of Dialysis	30
Physician Work	9.14
Physician Time	233
Extender Work	0
Extender Time	0

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU*	Estimated Time
1-99215	2.00	35			
1-99214	1.42	25			
2-99354	3.54	120			
1-G0182	1.73	38			
1-97802	0.45	15			
Sum	9.14	233			

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

<u>CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90919	XXX	8.53	RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

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

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.*

Almost all of the 7 respondents were uncertain about work description codes and thought they were restricted in picking from the office E&M 99211-99215 categories for patient visits to the dialysis clinic, which did not accurately reflect the work effort, specialized pediatric nephrology expertise and the usual 60 min face-to-face visit with young children 2-11 years old and their parent caregivers at peritoneal dialysis clinic visits. Two respondents were particularly low in their assessment of work effort at 4.35 and 5.95, which significantly affected the total estimate of work associated with these services. For this reason, the survey median artificially undervalued the work effort. The 75th percentile was chosen as more reflective of the amount of effort to care for these young children and more consistent with the current G-code 321, which is 8.11.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0321, End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

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 ped nephrology 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? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty	Frequency 0	Percentage 0.00 %
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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?
1,105 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. 2005 Medicare utilization for code G0321

Specialty ped nephrology	Frequency 1105	Percentage 100.00 %
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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? 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. G0321 which is the G-code that is being replaced with this new CPT code

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

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

CPT Code: 90965 Tracking Number: K15 Specialty Society Recommended RVU: 8.25
RUC Recommended RVU: 8.69

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-year-old anuric girl with IgA nephropathy and failed renal transplant, does her own home continuous cycling peritoneal dialysis (CCPD) treatments with back-up supervision from her parents. Her disease burden includes dialysis access problems, hypertension, fluid overload, renal osteodystrophy, anemia, acidosis, anorexia and malnutrition, growth failure, adolescent non-adherent behavior, school problems and polypharmacy (>7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage her condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in her general condition; evaluation of the integrity and functionality of her dialysis access; episodic changes in his dialysis prescription for growth, weight gain or loss and fluid overload; scheduled review of routinely collected laboratory data; episodic adjustment of home medications including oral antihypertensives, iron supplements, vitamin D metabolites or surrogates, phosphate binders, potassium exchange resins, anti-constipation drugs, and ESA and growth hormone injections; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, school personnel, transplantation centers, and other medical specialists; and overall care coordination. Growth and nutritional monitoring and intervention plus the monitoring of pubertal development and school progress will be accomplished along with counseling of the parents/caregivers for malnutrition, need for special renal dietary supplements, delayed puberty and growth failure, behavioral problems related to dietary and fluid restriction, medication non-adherence and coping with an technologically dependent adolescent with chronic kidney disease. Planning for future transition to adult care will be initiated, and progress periodically addressed. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient/ parents/caregivers, and may see the patient one or more times during the month in order to accomplish her care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J Hamburger, M.D., F.A.C P., F.A.S N ; Robert J. Kossmann, M.D.					
Specialty(s):	American Soceity of Pediatric Nephrology (ASPN)					
CPT Code:	90965					
Sample Size:	30	Resp N:	7	Response: 23.3 %		
Sample Type:	Convenience					
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate		12.00	18.00	52.00	161.00	231.00

Number of Visits	1	1	1	1	2
Number of Days of Dialysis	30	30	30	30	30
Physician Work	4.35	6.03	7.17	7.73	8.27
Physician Time	120	143	180	188	195
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR SERVICES OF PHYSICIANS (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/code	Total Est Time	Total E: Time divid by #surve
99215	6	2.00	12.00	1.71	40	240	34
99442	8	0.50	4.00	0.57	15	120	17
99339	5	1.25	6.25	0.89	25	125	18
99441	6	0.25	10.00	1.43	10	60	9
99214	1	1.42	1.42	1.42	25	25	4
99443	6	0.75	4.50	0.64	30	180	26
99367	10	1.10	11.00	1.57	30	300	43
SUM	42	7.27	49.17	8.23	175	1050	151

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	2
Number of Days of Dialysis	30
Physician Work	8.69
Physician Time	218
Extender Work	0
Extender Time	0

BREAK-OUT OF SPECIALTY SOCIETY RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
1-99215	2.00	35			
2-99354	3.54	120			
1-G0182	1.73	38			
1-99214	1.42	25			
Sum	8.69	218			

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

<u>CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90920	XXX	7.26	RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

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

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.*

Almost all of the 7 respondents were uncertain about work description codes and thought they were restricted in picking from the office E&M 99211-99215 categories for patient visits to the dialysis clinic, which did not accurately reflect the work effort, specialized pediatric nephrology expertise and the usual 45-60 min face-to-face visit with adolescents 12-19 years old and their parent caregivers at peritoneal dialysis clinic visits. In addition, adolescent non-adherent and defiant behavior against their technologically dependent chronic renal disease is perceived to require more effort from the physician to intervene with the adolescent patient individually to try to improve outcomes. Two respondents were particularly low in their assessment of work effort at 4.35 and 5.2, which significantly affected the total estimate of work associated with these services. For this reason, the survey median artificially undervalued the work effort. The 75th percentile was chosen as more reflective of the amount of effort to care for these adolescents.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0322, End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

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 ped nephrology

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? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 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?
 2,017 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. 2005 Medicare utilization for code G0322

Specialty ped nephrology	Frequency 2017	Percentage 100.00 %
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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? 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. G0322 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90966 Tracking Number: K16 Specialty Society Recommended RVU: 4.32
RUC Recommended RVU: 4.26

Global Period: XXX

CPT Descriptor: End stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year-old chronic peritoneal dialysis patient dialyzes at home. His disease burden includes Type II diabetes mellitus, vascular disease, hypertension, secondary hyperparathyroidism, anemia, and polypharmacy (> 7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Description of Services Provided by Physician: His nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition including post hospitalization; evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription; scheduled review of routinely collected laboratory data; episodic administration of IV iron or other medications in the dialysis center; episodic adjustments of home medications including antihypertensives and phosphate binders; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, transplantation centers, and other medical specialists; and overall care coordination. The nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient or his caregiver.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008			
Presenter(s):	Robert J. Kossmann, M.D., F.A.C.P., F.A.S.N.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.;				
Specialty(s):	Renal Physicians Association (RPA)				
CPT Code:	90966				
Sample Size:	145	Resp N:	20	Response: 13.7 %	
Sample Type:	Convenience				
	<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate	1.00	29.50	94.50	191.75	240.00
Number of Visits	1	1	1	2	9
Number of Days of Dialysis	N/A	N/A	N/A	N/A	N/A
Physician Work	2.30	2.92	3.53	4.23	4.55
Physician Time	40	55.25	76	90	135
Extender Work *	0.00	0.00	0.00	0.00	1.99
Extender Time	0.00	0.00	0.00	0.00	35.00

BREAK-OUT OF SURVEY DATA

Services of Physician	Services of Extender
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Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU *	Estimated Time
99215	2.00	40.00	99213	0.92	15
99367	1.10	30.00			
99441	0.25	10.00			
99442	0.50	20.00			
Sum	3.85	100.00		0.92	15

*** The resulting work RVUs for the physician extender have been multiplied by 0.85 to reflect the Medicare payment policy of these professionals.**

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	3
Number of Days of Dialysis	30
Work	4.26
Time	75

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
3-99214	4.26	75			
Sum	4.26	75			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

<u>CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90921	XXX	4.46	RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services per full month; for patients twenty years of age and older

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor

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.*

2008 RVW value for G0323 (current code for service): 4.24

RPA Recommendation for 9096X6: 4.33

The American Renal Physicians Association surveyed:

- 9096X6, End stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over

Code 9096X6 represents a bundle of medical management services provided to an adult ESRD patient receiving home dialysis.

BACKGROUND

The society was requested to survey this service by the Centers for Medicare and Medicaid Services (CMS).

UNIQUE SURVEY INSTRUMENT

These services are provided by a physician in conjunction with a physician extender. The survey instrument allowed survey respondents to record what services were typically provided to a patient over a month period. The respondent was requested to estimate both physician and extender work and time.

RPA ANALYSIS

A panel of RPA physicians reviewed the survey data.

Days of Dialysis

None of the survey respondents reported on the number of days of dialysis (column 2). The panel attributed this to lack of familiarity with the survey instrument. The medical standard which is consistent with the panel's professional experience is 30 days per month. The panel unanimously agreed to recommend 30 days of dialysis per month.

Physician Extender

The striking characteristic of the data was that only 15% of the respondents reported extender services in addition to physician services. The panel of physicians concluded that this reflected the varying practice patterns across the US.

Because of the low number of responses with physician extender data the work RVU and time data for physician extenders was 0.00 up to and including the 75th percentile value. When the responses that included physician extender data were extracted and reviewed separately, it was found that the median RVU for a physician extender was 0.85 (RVU discounted by 15%) and the median time was 20 minutes. These respondents also tended to have lower physician time and RVU. This indicated to the panel that for the practices that used extenders these professionals were an important component of providing the service.

Blended Data

The panel concluded that the most accurate method to capture the work and the time of both the physician and extender that reflects all types of practices providing these services is to recommend a weighted analysis that blended (85%/15%) physician and extender RVU and time data. In this instance, partially due to the lower number of responses, the panel agreed that the 75th percentile of the blended data was a more appropriate recommendation. This resulted in RVU of 4.33 and a time of 91.25 minutes. The panel concluded that these values were consistent with the CPT codes or "surrogate services" reported by survey respondents.

The 2008 work RVU for code G0323 which is currently being reported to provide this service is 4.24. The panel concluded that this increase of 0.09 RVUs was appropriate.

In view of the above, RPA recommends 4.33 RVU for code 9096X6 and a time of 91.25 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0323, End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twenty years of age and older

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 Nephrology 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? 174535

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for code G0323 (174,535) reflects the national utilization for this service.

Specialty Nephrology	Frequency 174535	Percentage 100.00 %
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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? 174,535 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for code G0323

Specialty Nephrology	Frequency 174535	Percentage 100.00 %
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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

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. G0323 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90951 Tracking Number: K1 Specialty Society Recommended RVU: 18.46
RUC Recommended RVU: 18.46

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 7-month-old boy with renal dysplasia, ESRD from birth and failed peritoneal dialysis undergoes chronic hemodialysis at a pediatric facility. His disease burden includes catheter access problems, renal osteodystrophy, anemia, acidosis, growth failure, developmental delay, anorexia and feeding problems, family dysfunction related to a technologically dependent infant, modified childhood immunizations, and polypharmacy (>7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition; evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription; frequent adjustment of target weight for growth and fluid intake; scheduled review of routinely collected laboratory data, including frequent hemoglobin assessment for blood loss in the dialyzer; episodic adjustment of intravenous ESAs, iron and vitamin D metabolites given during the dialysis treatment, and of home medications including oral iron supplements, vitamin D metabolites or surrogates, potassium supplements or exchange resins, calcium supplements, phosphate supplements or binders and growth hormone injections; growth and nutritional monitoring with frequent adjustments of gastrostomy or nasogastric tube feedings of a special infant formula with added protein, carbohydrate and/or oil for adequate caloric intake for growth; monitoring of developmental progress and initiation and coordination of intervention for delayed milestones; coordination and appropriate dosing of childhood immunizations; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, transplantation centers, and other medical specialists; and overall care coordination with regular counseling and support of the parents/caregivers and siblings for the care of a technologically dependent infant with chronic kidney disease. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers, and will see the patient during dialysis sessions four or more times during the month in order to accomplish his care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.					
Specialty(s):	American Soceity of Pediatric Nephrology (ASPN)					
CPT Code:	90951					
Sample Size:	30	Resp N:	3	Response: 10.0 %		
Sample Type:	Convenience					
		Low	25th pctl	Median*	75th pctl	High

Service Performance Rate	1.00	1.00	2.00	3.00	4.00
Number of Visits	5	9	13	14	15
Number of Days of Dialysis	13	13	13	15	17
Physician Work	13.86	15.37	16.87	17.93	18.98
Physician Time	290	305	320	340	360
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR PHYSICIAN SERVICES (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/code	Total Est Time	Total Est Time divided by #survey
99215	3	2.00	6	2.00	40	120	40
99214	9	1.42	12.78	4.26	25	225	75
99213	18	0.92	16.56	5.52	15	270	90
99339	3	1.25	3.75	1.25	15	45	15
99367	2	1.10	2.2	0.73	30	60	20
99443	2	0.75	1.5	0.50	15	30	10
SUM	37	7.44	42.79	14.26	140	750	250

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	5	
Number of Days of Dialysis	13	
Physician Work	18.46	
Physician Time	274	
Extender Work	0	
Extender Time	0	

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
1-99295	18.46	274			
Sum	18.46	274			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

<u>CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90918	XXX	11.16	RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent</u> <u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u> <u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor**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.*

Chronic hemodialysis treatments of an infant/toddler less than 2 years old are difficult to perform, at the limits of specialized pediatric/newborn equipment and only done at specialized pediatric centers, usually those that are hospital-based. These infants need frequent adjustments during treatments and are usually seen at each dialysis treatment during the month by the pediatric nephrologist. In many centers the pediatric nephrologist remains on-site during the entire time of the treatment for patient safety. Infants with no urine output often need 4 treatments weekly or 17 treatments/30 days to allow sufficient fluid intake for rapid growth at this age. The facility supplies one-to-one nursing to perform hemodialysis on these infants for safety and due to the degree of difficulty of the procedure. The physician work is extensive and intensive and reflected by the break-out survey for the physician work RVU. These codes are billed rarely, because there are rarely more than 10-15 infants in the USA requiring this service. The 3 responders to this survey all expressed high work value for this code. We recommend the low value as consistent with the current G-code 308 (12.74) for this new CPT code and still reflective of current practice.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0308, End stage renal disease (ESRD) related services during the course of treatment, for patients less than two years of age; with 4 or more face-to-face physician visits per month.

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 ped nephrology

How often? Rarely

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty ped nephrology	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? 40
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization for code G0308

Specialty ped nephrology	Frequency 40	Percentage 100.00 %
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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? 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. 99295 which is the service that has been directly crosswalked to establish a value and time for this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90952 Tracking Number: K2 Specialty Society Recommended RVU: Carrier Priced
RUC Recommended RVU: Carrier Priced

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 7-month-old boy with renal dysplasia, ESRD from birth and failed peritoneal dialysis undergoes chronic hemodialysis at a pediatric facility. His disease burden includes catheter access problems, renal osteodystrophy, anemia, acidosis, growth failure, developmental delay, anorexia and feeding problems, family dysfunction related to a technologically dependent infant, modified childhood immunizations, and polypharmacy (>7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition; evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription; frequent adjustment of target weight for growth and fluid intake; scheduled review of routinely collected laboratory data, including frequent hemoglobin assessment for blood loss in the dialyzer; episodic adjustment of intravenous ESAs, iron and vitamin D metabolites given during the dialysis treatment, and of home medications including oral iron supplements, vitamin D metabolites or surrogates, potassium supplements or exchange resins, calcium supplements, phosphate supplements or binders and growth hormone injections; growth and nutritional monitoring with frequent adjustments of gastrostomy or nasogastric tube feedings of a special infant formula with added protein, carbohydrate and/or oil for adequate caloric intake for growth; monitoring of developmental progress and initiation and coordination of intervention for delayed milestones; coordination and appropriate dosing of childhood immunizations; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, transplantation centers, and other medical specialists; and overall care coordination with regular counseling and support of the parents/caregivers and siblings for the care of a technologically dependent infant with chronic kidney disease. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers, and will see the patient during dialysis sessions two to three times during the month in order to accomplish his care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.					
Specialty(s):	American Soceity of Pediatric Nephrology (ASPN)					
CPT Code:	90952					
Sample Size:	30	Resp N:	0**	Response: 0.0 %		
Sample Type:	Convenience					
		Low	25th pctl	Median*	75th pctl	High

Service Performance Rate	0.00	0.00	0.00	0.00	0.00
Number of Visits	0	0	0	0	0
Number of Days of Dialysis	0	0	0	0	0
Physician Work	0	0	0	0	0
Physician Time	0	0	0	0	0
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

**** Response: 0.0%; no respondents personally reported this MCP in the past year.**

BREAK-OUT OF SURVEY DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU *	Estimated Time
Sum					

*** The resulting work RVUs for the physician extender have been multiplied by 0.85 to reflect the Medicare payment policy of these professionals.**

SUMMARY OF SPECIALTY SOCIETY RECOMMENDED DATA

Number of Visits		
Number of Days of Dialysis		
Physician Work		
Physician Time		
Extender Work		
Extender Time		

BREAK-OUT OF SPECIALTY SOCIETY RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
Sum					

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

CPT Code Global Work RVU Time Source
 90918 XXX 11.16 RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 1

MPC CPT Code 2 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 2

Other Reference CPT Code Global Work RVU Time Source

CPT Descriptor

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.*

None of the pediatric survey respondents were able to fill out the survey for 9095X2, because none had personally reported this MCP in the last year. A less than 2-year-old receiving in-center hemodialysis would usually be seen at every treatment, because of the degree of difficulty in performing hemodialysis in small children (usually less than 20 lbs). It is rare that patients with this chronic illness at this age would be seen 2-3 times per month and would likely only occur when the infant was hospitalized for part of the month. We recommend that the physician work RVU for this code be crosswalked from the current value of 10.61.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0309, End stage renal disease (ESRD) related services during the course of treatment, for patients less than two years of age; with 2-3 face-to-face physician visits per month.

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 ped nephrology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty ped nephrology Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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? 19
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization for code G0309

Specialty ped nephrology	Frequency 19	Percentage 100.00 %
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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? 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. G0309 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90953 Tracking Number: K3 Specialty Society Recommended RVU: Carrier Priced
RUC Recommended RVU: Carrier Priced

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 7-month-old boy with renal dysplasia, ESRD from birth and failed peritoneal dialysis undergoes chronic hemodialysis at a pediatric facility. His disease burden includes catheter access problems, renal osteodystrophy, anemia, acidosis, growth failure, developmental delay, anorexia and feeding problems, family dysfunction related to a technologically dependent infant, modified childhood immunizations, and polypharmacy (>7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition; evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription; frequent adjustment of target weight for growth and fluid intake; scheduled review of routinely collected laboratory data, including frequent hemoglobin assessment for blood loss in the dialyzer; episodic adjustment of intravenous ESAs, iron and vitamin D metabolites given during the dialysis treatment, and of home medications including oral iron supplements, vitamin D metabolites or surrogates, potassium supplements or exchange resins, calcium supplements, phosphate supplements or binders and growth hormone injections; growth and nutritional monitoring with frequent adjustments of gastrostomy or nasogastric tube feedings of a special infant formula with added protein, carbohydrate and/or oil for adequate caloric intake for growth; monitoring of developmental progress and initiation and coordination of intervention for delayed milestones; coordination and appropriate dosing of childhood immunizations; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, transplantation centers, and other medical specialists; and overall care coordination with regular counseling and support of the parents/caregivers and siblings for the care of a technologically dependent infant with chronic kidney disease. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers, and will see the patient during dialysis sessions once during the month in order to accomplish his care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008			
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.				
Specialty(s):	American Soceity of Pediatric Nephrology (ASPN)				
CPT Code:	90953				
Sample Size:	30	Resp N:	0**	Response: 0.0 %	
Sample Type:	Convenience				
	<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate	0.00	0.00	0.00	0.00	0.00

Number of Visits	0	0	0	0	0
Number of Days of Dialysis	0	0	0	0	0
Physician Work	0	0	0	0	0
Physician Time	0	0	0	0	0
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

****Response: 0.0%; no respondents personally reported this MCP in the past year.**

BREAK-OUT OF SURVEY DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU *	Estimated Time
Sum					

*** The resulting work RVUs for the physician extender have been multiplied by 0.85 to reflect the Medicare payment policy of these professionals.**

SUMMARY OF SPECIALTY SOCIETY RECOMMENDED DATA

Number of Visits		
Number of Days of Dialysis		
Physician Work		
Physician Time		
Extender Work		
Extender Time		

BREAK-OUT OF SPECIALTY SOCIETY RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
Sum					

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

CPT Code Global Work RVU Time Source
 90918 XXX 11.16 RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 1

MPC CPT Code 2 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 2

Other Reference CPT Code Global Work RVU Time Source

CPT Descriptor

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.*

None of the pediatric survey respondents were able to fill out the survey for 9095X3, because none had personally reported this MCP in the last year. A less than 2-year-old receiving in-center hemodialysis would usually be seen at every treatment, because of the degree of difficulty in performing hemodialysis in small children (usually less than 20 lbs). It is rare that patients with this chronic illness at this age would be seen at only 1 face-to-face visit per month and would likely only occur when the infant was hospitalized for almost all of the month. We recommend that the physician work RVU for this code be crosswalked from the current value of 8.49.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0310, End stage renal disease (ESRD) related services during the course of treatment, for patients less than two years of age; with 1 face-to-face physician visits per month.

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 ped nephrology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty ped nephrology Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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? 18
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization for code G0310

Specialty ped nephrology	Frequency 18	Percentage 100.00 %
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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? 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. G0310 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90954

Tracking Number: K4

Specialty Society Recommended RVU: 15.98

RUC Recommended RVU: 15.98

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 9-year-old girl with ESRD from congenital renal anomalies and failed renal transplant, who is now anephric, undergoes chronic hemodialysis at a pediatric facility. Her disease burden includes catheter access problems, hypertension, fluid overload, intermittent hyperkalemia, renal osteodystrophy, anemia, acidosis, growth failure, behavior problems, family dysfunction related to a technologically dependent child and polypharmacy (>7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage her condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in her general condition; evaluation of the integrity and functionality of her dialysis access; episodic changes in her dialysis prescription for growth, weight gain or loss and fluid overload; scheduled review of routinely collected laboratory data; episodic adjustment of intravenous ESAs, iron and vitamin D metabolites given during the dialysis treatment and of home medications including oral antihypertensives, iron supplements, vitamin D metabolites or surrogates, phosphate binders, potassium exchange resins, anti-constipation drugs and growth hormone injections; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, school personnel, transplantation centers, and other medical specialists; and overall care coordination. Growth and nutritional monitoring and intervention plus monitoring of developmental and school progress and intervention will be accomplished along with counseling of the parents/caregivers for patient's behavior problems related to dietary and fluid restriction, medication non-adherence and coping with a technologically dependent child with chronic kidney disease. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers, and may see the patient during dialysis sessions four or more times during the month in order to accomplish her care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.					
Specialty(s):	American Sociey of Pediatric Nephrology (ASPN)					
CPT Code:		90954				
Sample Size:	30	Resp N:	7	Response: 23.3 %		
Sample Type:		Convenience				
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate		1.00	6.00	15.00	44.00	64.00
Number of Visits		4	4	6	13	13

Number of Days of Dialysis	13	13	13	14	17
Physician Work	9.38	9.51	11.17	14.24	17.14
Physician Time	175	213	255	270	330
Extender Work	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR SERVICES OF PHYSICIANS (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/cod e	Total Est Time	Total Est Time divided by #surveys
99215	6	2.00	12.00	1.71	40	240	34
99442	12	0.50	6.00	0.86	15	180	26
99367	7	1.10	7.70	1.10	30	210	30
99213	22	0.92	20.24	2.89	15	330	47
99214	17	1.42	24.14	3.45	25	425	61
99212	9	0.45	4.05	0.58	10	90	13
SUM	73	6.39	74.13	10.59	135	1475	211

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	13
Number of Days of Dialysis	13
Physician Work	15.98
Physician Time	240
Extender Work	0
Extender Time	0

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
1-99293	15.98	240			
Sum	15.98	240			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

CPT Code Global Work RVU Time Source
 90919 XXX 8.53 RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services per full month; for patients two to eleven years of age.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 1

MPC CPT Code 2 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 2

Other Reference CPT Code Global Work RVU Time Source

CPT Descriptor

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 median value was best supported by the break-out survey data. The pediatric nephrologist work effort to perform in-center hemodialysis for children 2-11 years old is intensive and extensive as reflected by all the respondents. In some referral pediatric dialysis centers, the pediatric nephrologist sees the patient for evaluation at every treatment during the month due to the instability of many of the patients. This work effort is reflected in the high value. The median value best reflects the spectrum of practice at all pediatric centers for this age group as detailed in the break-out survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0311, End stage renal disease (ESRD) related services during the course of treatment, for patients 2-11 yrs of age; with 4 or more face-to-face physician visits per month.

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 ped nephrology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 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? 507
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization for code G0311

Specialty ped nephrology	Frequency 507	Percentage 100.00 %
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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? 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. 99293 which is the service that has been directly crosswalked to establish a value and time for this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90955

Tracking Number: K5

Specialty Society Recommended RVU: 11.25

RUC Recommended RVU: 8.79

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 9-year-old girl with ESRD from congenital renal anomalies and failed renal transplant, who is now anephric, undergoes chronic hemodialysis at a pediatric facility. Her disease burden includes catheter access problems, hypertension, fluid overload, intermittent hyperkalemia, renal osteodystrophy, anemia, acidosis, growth failure, behavior problems, family dysfunction related to a technologically dependent child and polypharmacy (>7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage her condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in her general condition; evaluation of the integrity and functionality of her dialysis access; episodic changes in her dialysis prescription for growth, weight gain or loss and fluid overload; scheduled review of routinely collected laboratory data; episodic adjustment of intravenous ESAs, iron and vitamin D metabolites given during the dialysis treatment and of home medications including oral antihypertensives, iron supplements, vitamin D metabolites or surrogates, phosphate binders, potassium exchange resins, anti-constipation drugs and growth hormone injections; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, school personnel, transplantation centers, and other medical specialists; and overall care coordination. Growth and nutritional monitoring and intervention plus monitoring of developmental and school progress and intervention will be accomplished along with counseling of the parents/caregivers for patient's behavior problems related to dietary and fluid restriction, medication non-adherence and coping with a technologically dependent child with chronic kidney disease. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers, and may see the patient during dialysis sessions two to three times during the month in order to accomplish her care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.					
Specialty(s):	American Society of Pediatric Nephrology (ASPN)					
CPT Code:		90955				
Sample Size:	30	Resp N:	2	Response: 6.6 %		
Sample Type:		Convenience				
		Low	25 th pctl	Median*	75 th pctl	High
Service Performance Rate		3.00	5.00	7.00	8.00	10.00
Number of Visits		3	3	3	3	3

Number of Days of Dialysis	13	13	13	13	13
Physician Work	8.19	8.83	9.47	10.10	10.74
Physician Time	195	210	225	240	255
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR PHYSICIAN SERVICES (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/code	Total Est Time	Total Est Time divided by #survey
99442	12	0.50	6.00	3.00	15	180	90
99367	2	1.10	2.20	1.10	30	60	30
99283	2	1.34	2.68	1.34	30	60	30
99215	1	2.00	2.00	1.00	40	40	20
99214	1	1.42	1.42	0.71	25	25	13
99284	1	2.56	2.56	1.28	15	50	25
SUM	19	8.92	16.86	8.43	155	415	208

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	3
Number of Days of Dialysis	13
Physician Work	8.79
Physician Time	198
Extender Work	0
Extender Time	0

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
1-99215	2.00	35			
2-99214	2.84	50			
1-99354	1.77	60			
1-G0182	1.73	38			
1-97802	0.45	15			
Sum	8.79	198			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

<u>CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90919	XXX	8.53	RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services per full month; for patients two to eleven years of age.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent</u> <u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u> <u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor

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.*

Only 2 respondents were able to fill out this survey, because these codes are billed rarely and the other pediatric survey respondents had not personally reported this MCP in the last year. The pediatric nephrologist work effort to perform in-center hemodialysis for children 2-11 years old is intensive and extensive as reflected by both respondents. Only rarely would a patient 2-11 years be seen only 2-3 times a month, likely during a month the patient was hospitalized. The median of the 2 surveys seems to best reflect the spectrum of work required for this code and is consistent with the current G-code 312, which is 8.11.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0312, End stage renal disease (ESRD) related services during the course of treatment, for patients 2-11 yrs of age; with 2-3 face-to-face physician visits per month.

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 ped nephrology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

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 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 137
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization for code G0312

Specialty ped nephrology Frequency 137 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. G0312 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90956

Tracking Number: K6

Specialty Society Recommended RVU: 6.75

RUC Recommended RVU: 5.95

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 9-year-old girl with ESRD from congenital renal anomalies and failed renal transplant, who is now anephric, undergoes chronic hemodialysis at a pediatric facility. Her disease burden includes catheter access problems, hypertension, fluid overload, intermittent hyperkalemia, renal osteodystrophy, anemia, acidosis, growth failure, behavior problems, family dysfunction related to a technologically dependent child and polypharmacy (>7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage her condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in her general condition; evaluation of the integrity and functionality of her dialysis access; episodic changes in her dialysis prescription for growth, weight gain or loss and fluid overload; scheduled review of routinely collected laboratory data; episodic adjustment of intravenous ESAs, iron and vitamin D metabolites given during the dialysis treatment and of home medications including oral antihypertensives, iron supplements, vitamin D metabolites or surrogates, phosphate binders, potassium exchange resins, anti-constipation drugs and growth hormone injections; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, school personnel, transplantation centers, and other medical specialists; and overall care coordination. Growth and nutritional monitoring and intervention plus monitoring of developmental and school progress and intervention will be accomplished along with counseling of the parents/caregivers for patient's behavior problems related to dietary and fluid restriction, medication non-adherence and coping with a technologically dependent child with chronic kidney disease. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers, and may see the patient during dialysis sessions once during the month in order to accomplish her care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.					
Specialty(s):	American Soceity of Pediatric Nephrology (ASPN)					
CPT Code:		90956				
Sample Size:	30	Resp N:	2	Response: 6.6 %		
Sample Type:		Convenience				
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate		1.00	1.00	2.00	2.00	2.00
Number of Visits		1	1	1	1	1

Number of Days of Dialysis	13	13	13	13	13
Physician Work	6.91	6.93	6.96	6.95	7.00
Physician Time	175	179	183	186	190
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR SERVICES OF PHYSICIAN (EXTENDERS N/A)

Break-out of survey data

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/code	Total Est Time	Total Time divided by #surveys
99215	2	2.00	4.00	2.00	40	80	4
99360 (stand by no face 2 face)	1	1.25	1.25	0.63	25	25	1
99367	1	1.10	1.10	0.55	30	30	1
99442	10	0.50	5.00	2.50	15	150	7
SUM	14	4.85	11.35	5.68	110	285	14

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	1
Number of Days of Dialysis	13
Physician Work	5.95
Physician Time	148
Extender Work	0
Extender Time	0

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
1-99215	2.00	35			
1-99354	1.77	60			
1-G0182	1.73	38			
1-97802	0.45	15			
Sum	5.95	148			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

<u>CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90919	XXX	8.53	RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services per full month; for patients two to eleven years of age.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor

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.*

Only 2 respondents were able to fill out this survey, because these codes are billed rarely and the other pediatric survey respondents had not personally reported this MCP in the last year. The pediatric nephrologist work effort to perform in-center hemodialysis for children 2-11 years old is intensive and extensive as reflected by both respondents. Only rarely would a patient 2-11 years be seen once a month, likely during a month the patient was hospitalized for most of the month. The median of the 2 surveys seems to best reflect the spectrum of work required for this code and is consistent with the current G-code 313, which is 6.49.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0313, End stage renal disease (ESRD) related services during the course of treatment, for patients 2-11 yrs of age; with one face-to-face physician visits per month.

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 ped nephrology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty	Frequency 0	Percentage 0.00 %
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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? 190
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization for code G0313

Specialty ped nephrology	Frequency 190	Percentage 100.00 %
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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? 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. G0313 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90957

Tracking Number: K7

Specialty Society Recommended RVU: 13.50

RUC Recommended RVU: 12.52

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-year-old boy with ESRD from focal segmental glomerulosclerosis undergoes chronic hemodialysis at a dialysis facility. His disease burden includes dialysis access problems, hypertension, fluid overload, hyperkalemia, renal osteodystrophy, anemia, acidosis, anorexia and malnutrition, growth failure, adolescent non-adherent behavior, school problems, family stress and polypharmacy (> 7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition; evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription for growth, weight gain or loss and fluid overload; scheduled review of routinely collected laboratory data; episodic adjustment of intravenous ESAs, iron and vitamin D metabolites given during the dialysis treatment and of home medications including oral antihypertensives, iron supplements, vitamin D metabolites or surrogates, phosphate binders, potassium exchange resins, anti-constipation drugs and growth hormone injections; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, school personnel, transplantation centers, and other medical specialists; and overall care coordination. Growth and nutritional monitoring and intervention plus the monitoring of pubertal development and school progress will be accomplished along with counseling of the parents/caregivers for malnutrition, need for special renal dietary supplements, delayed puberty and growth failure, behavioral problems related to dietary and fluid restriction, medication non-adherence and coping with an technologically dependent adolescent with chronic kidney disease. Planning for future transition to adult care will be initiated, and progress periodically addressed. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers, and will see the patient during dialysis sessions four or more times during the month in order to accomplish her care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.					
Specialty(s):	American Soceity of Pediatric Nephrology (ASPN)					
CPT Code:	90957					
Sample Size:	30	Resp N:	7	Response: 23.3 %		
Sample Type:	Convenience					
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate		10.00	16.00	21.00	172.00	244.00
Number of Visits		4	4.5	5	13	13

Number of Days of Dialysis	13	13	13	14	14
Physician Work	8.13	8.57	9.28	10.69	11.85
Physician Time	165	180	185	228	250
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR SERVICES OF PHYSICIAN (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/cod e	Total Est Time	Total Time divided by #surveys
99211	8	0.17	1.36	0.19	5	40	5
99212	16	0.45	7.20	1.03	10	160	10
99213	13	0.92	11.96	1.71	15	195	15
99215	3	2.00	6.00	0.86	40	120	40
99367	6	1.10	6.60	0.94	30	180	30
99283	2	1.34	2.68	0.38	15	30	15
99339	1	1.25	1.25	0.18	25	25	25
99284	1	2.56	2.56	0.37	20	20	20
99442	9	0.50	4.50	0.64	15	135	15
99214	6	1.42	8.52	1.22	25	150	25
SUM	65	11.71	52.63	7.52	200	1055	16.23

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	7
Number of Days of Dialysis	13
Physician Work	12.52
Physician Time	253
Extender Work	0
Extender Time	0

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
1-99215	2.00	35			
1-99354	1.77	60			
1-G0182	1.73	38			
3-99213	2.76	45			
3-99214	4.26	75			
Sum	12.52	253			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

CPT Code Global Work RVU Time Source
 90920 XXX 7.26 RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services per full month; for patients twelve through nineteen years of age.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 1

MPC CPT Code 2 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 2

Other Reference CPT Code Global Work RVU Time Source

CPT Descriptor

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 pediatric nephrologist work effort to perform in-center hemodialysis for children 12-19 years old is extensive as reflected by all the respondents, especially due to adolescent non-adherent and defiant behavior against their technologically dependent chronic renal disease. About half the respondents divided their work load in small increments over 13 visits (each treatment for the month), while the rest did their work in blocks during 4-5 visits for the month. For this reason, the total RVUs in the break-out survey data was not the best picture of the physician work. The median value of the surveys best reflects the spectrum of work effort by the physicians managing adolescents on chronic hemodialysis.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0314, End stage renal disease (ESRD) related services during the course of treatment, for patients 12-19 yrs of age; with 4 or more face-to-face physician visits per month.

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 ped nephrology 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? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty	Frequency	Percentage
	0	0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
3,205 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. 2005 Medicare utilization for code G0314

Specialty ped nephrology	Frequency 3205	Percentage 100.00 %
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Specialty	Frequency	Percentage
	0	0.00 %

Specialty	Frequency 0	Percentage 0.00 %
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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. G0314 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90958 Tracking Number: K8 Specialty Society Recommended RVU: 9.00
RUC Recommended RVU: 8.34

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-year-old boy with ESRD from focal segmental glomerulosclerosis undergoes chronic hemodialysis at a dialysis facility. His disease burden includes dialysis access problems, hypertension, fluid overload, hyperkalemia, renal osteodystrophy, anemia, acidosis, anorexia and malnutrition, growth failure, adolescent non-adherent behavior, school problems, family dysfunction and polypharmacy (> 7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition; evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription for growth, weight gain or loss and fluid overload; scheduled review of routinely collected laboratory data; episodic adjustment of intravenous ESAs, iron and vitamin D metabolites given during the dialysis treatment and of home medications including oral antihypertensives, iron supplements, vitamin D metabolites or surrogates, phosphate binders, potassium exchange resins, anti-constipation drugs and growth hormone injections; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, school personnel, transplantation centers, and other medical specialists; and overall care coordination. Growth and nutritional monitoring and intervention plus the monitoring of pubertal development and school progress will be accomplished along with counseling of the parents/caregivers for malnutrition, need for special renal dietary supplements, delayed puberty and growth failure, behavioral problems related to dietary and fluid restriction, medication non-adherence and coping with an technologically dependent adolescent with chronic kidney disease. Planning for future transition to adult care will be initiated, and progress periodically addressed. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers, and will see the patient during dialysis sessions two to three times during the month in order to accomplish her care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.					
Specialty(s):	American Socety of Pediatric Nephrology (ASPN)					
CPT Code:	90958					
Sample Size:	30	Resp N:	2	Response: 6.6 %		
Sample Type:	Convenience					
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate		2.00	5.00	8.00	10.00	13.00
Number of Visits		3	3	3	3	3

Number of Days of Dialysis	13	13	13	13	13
Physician Work	5.44	5.88	6.32	6.75	7.19
Physician Time	125	138	150	163	175
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR SERVICES OF PHYSICIAN (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/cod e	Total Est Time	Tot T div #su
99442	3	0.50	1.50	0.75	15	45	:
99441	3	0.25	0.75	0.38	10	30	.
99367	2	1.10	2.20	1.10	30	60	.
99215	2	2.00	4.00	2.00	40	80	.
99214	1	1.42	1.42	0.71	25	25	.
99213	3	0.92	2.76	1.38	15	45	:
SUM	14	6.19	12.63	6.32	135	285	1

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	3
Number of Days of Dialysis	13
Physician Work	8.34
Physician Time	183
Extender Work	0
Extender Time	0

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
1-99215	2.00	35			
2-99214	2.84	50			
1-99354	1.77	60			
1-G0182	1.73	38			
Sum	8.34	183			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

<u>CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90920	XXX	7.26	RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services per full month; for patients twelve through nineteen years of age.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent</u> <u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u> <u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor

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.*

Only 2 respondents were able to fill out this survey, because these codes are billed rarely and the other pediatric survey respondents had not personally reported this MCP in the last year. The pediatric nephrologist work effort to perform in-center hemodialysis for children 12-19 years old is extensive as reflected by both respondents, especially due to adolescent non-adherent and defiant behavior against their technologically dependent chronic renal disease. Only rarely would a patient 12-19 years be seen only 2-3 times a month, likely during a month the patient was hospitalized. One respondent, who only billed this MCP twice last year, seems to have undervalued the work RVU. The other respondent's assessment of the work RVU is similar to the current G-code 315 for this age group, which is 6.90. For this reason, we recommend the high value of 7.19 for code 9095x8.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0315, End stage renal disease (ESRD) related services during the course of treatment, for patients 12-19 yrs of age; with 2 to 3 face-to-face physician visits per month.

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 ped nephrology 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? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty ped nephrology Frequency 0 Percentage 0.00 %

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?
1,145 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. 2005 Medicare utilization for code G0315

Specialty ped nephrology	Frequency 1145	Percentage 100.00 %
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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? 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. G0315 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90959

Tracking Number: K9

Specialty Society Recommended RVU: 4.50

RUC Recommended RVU: 5.50

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visits per month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-year-old boy with ESRD from focal segmental glomerulosclerosis undergoes chronic hemodialysis at a dialysis facility. His disease burden includes dialysis access problems, hypertension, fluid overload, hyperkalemia, renal osteodystrophy, anemia, acidosis, anorexia and malnutrition, growth failure, adolescent non-adherent behavior, school problems, family stress and polypharmacy (> 7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition; evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription for growth, weight gain or loss and fluid overload; scheduled review of routinely collected laboratory data; episodic adjustment of intravenous ESAs, iron and vitamin D metabolites given during the dialysis treatment and of home medications including oral antihypertensives, iron supplements, vitamin D metabolites or surrogates, phosphate binders, potassium exchange resins, anti-constipation drugs and growth hormone injections; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, school personnel, transplantation centers, and other medical specialists; and overall care coordination. Growth and nutritional monitoring and intervention plus the monitoring of pubertal development and school progress will be accomplished along with counseling of the parents/caregivers for malnutrition, need for special renal dietary supplements, delayed puberty and growth failure, behavioral problems related to dietary and fluid restriction, medication non-adherence and coping with an technologically dependent adolescent with chronic kidney disease. Planning for future transition to adult care will be initiated, and progress periodically addressed. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers, and will see the patient during dialysis sessions once during the month in order to accomplish her care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.					
Specialty(s):	American Soceity of Pediatric Nephrology (ASPN)					
CPT Code:	90959					
Sample Size:	30	Resp N:	2	Response: 6.6 %		
Sample Type:	Convenience					
		Low	25 th pctl	Median*	75 th pctl	High
Service Performance Rate		7.00	18.00	29.00	18.00	50.00
Number of Visits		1	1	1	1	1

Number of Days of Dialysis	13	13	13	13	13
Physician Work	5.85	6.14	6.43	6.71	7.00
Physician Time	185	186	188	189	190
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR PHYSICIANS SERVICES (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/code	Total Est Time	Total T di
99215	2	2	4.00	2.00	40	80	
99442	14	0.5	7.00	3.50	15	210	
99441	3	0.25	0.75	0.38	10	30	
99367	1	1.1	1.10	0.55	30	30	
SUM	20	3.85	12.85	6.43	95	350	

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	1
Number of Days of Dialysis	13
Physician Work	5.50
Physician Time	133
Extender Work	0
Extender Time	0

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
1-99215	2.00	35			
1-99354	1.77	60			
1-G0182	1.73	38			
Sum	5.50	133			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

<u>CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90920	XXX	7.26	RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services per full month; for patients twelve through nineteen years of age.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor

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.*

Only 2 respondents were able to fill out this survey, because these codes are billed rarely and the other pediatric survey respondents had not personally reported this MCP in the last year. The pediatric nephrologist work effort to perform in-center hemodialysis for children 12-19 years old is extensive as reflected by both respondents, especially due to adolescent non-adherent and defiant behavior against their technologically dependent chronic renal disease. Only rarely would a patient 12-19 years be seen once a month, likely during a month the patient was hospitalized for most of the month. The median of the 2 surveys seems to best reflect the spectrum of work required for this code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
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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) G0316, End stage renal disease (ESRD) related services during the course of treatment, for patients 12-19 yrs of age; with 1 face-to-face physician visits per month.

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 ped nephrology 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? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty	Frequency 0	Percentage 0.00 %
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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? 802
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization for code G0316

Specialty ped nephrology	Frequency 802	Percentage 100.00 %
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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? 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. G0316 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90963 Tracking Number: K13 Specialty Society Recommended RVU: 11.00
RUC Recommended RVU: 10.56

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services for home dialysis per full month, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10-month-old boy with ESRD from prune belly syndrome with renal dysplasia receives nightly home continuous cycling peritoneal dialysis (CCPD) by parent caregivers. His disease burden includes catheter access problems, renal osteodystrophy, anemia, acidosis, growth failure, developmental delay, anorexia and feeding problems, family dysfunction related to a technologically dependent infant, modified childhood immunizations and polypharmacy (> 7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition; evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription; frequent adjustment of target weight for growth and fluid intake; scheduled review of routinely collected laboratory data; episodic adjustment of home medications including oral iron supplements, vitamin D metabolites or surrogates, potassium supplements or exchange resins, calcium supplements, phosphate supplements or binders, and ESA and growth hormone injections; growth and nutritional monitoring with frequent adjustments of gastrostomy or nasogastric tube feedings of a special infant formula with added protein, carbohydrate and/or oil for adequate caloric intake for growth; monitoring of developmental progress and initiation and coordination of intervention for delayed milestones; coordination and appropriate dosing of childhood immunizations; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, transplantation centers, and other medical specialists; and overall care coordination with regular counseling and support of the parents/caregivers and siblings for the care of a technologically dependent infant with chronic kidney disease using high-tech home therapy. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers. He/she will see the patient one or more times during the month in order to accomplish his care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.					
Specialty(s):	American Soceity of Pediatric Nephrology (ASPN)					
CPT Code:	90963					
Sample Size:	30	Resp N:	5	Response: 16.6 %		
Sample Type:	Convenience					
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate		1.00	4.00	7.00	10.00	12.00
Number of Visits		1	2	2	2	4

Number of Days of Dialysis	30	30	30	30	30
Physician Work	7.30	8.02	8.21	10.11	10.44
Physician Time	195	200	210	255	255
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR PHYSICIAN SERVICES (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/code	Total Est Time	Total Est Time divided by #surveys
99215	6	2.00	12.00	2.40	40	240	48
99339	2	1.25	2.50	0.50	20	40	8
99441	6	0.25	1.50	0.30	10	60	12
99367	9	1.10	9.90	1.98	30	270	54
99442	12	0.50	6.00	1.20	15	180	36
99443	2	0.75	1.50	0.30	25	50	10
99214	5	1.42	7.10	1.42	25	125	25
99283	1	1.34	1.34	0.27	60	60	12
SUM	43	8.61	41.84	8.37	225	1025	205

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	3
Number of Days of Dialysis	30
Physician Work	10.56
Physician Time	258
Extender Work	0
Extender Time	0

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU*	Estimated Time
1-99215	2.00	35			
2-99354	3.54	120			
1-G0182	1.73	38			
1-97802	0.45	15			
2-99214	2.84	50			
Sum	10.56	258			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

<u>CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90918	XXX	11.16	RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services for home dialysis per full month, for patients less than two years of age.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent</u> <u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u> <u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor

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 had only 5 survey respondents for this rarely billed code, because 2 other pediatric survey respondents had not personally reported this MCP in the last year. Almost all of the 5 respondents thought they were restricted in picking from the office E&M 99211-99215 categories for patient visits to the dialysis clinic, which did not accurately reflect the work effort, specialized pediatric nephrology expertise and the usual 60 min face-to-face visit with these infants and their home caregiver parents at peritoneal dialysis clinic visits. For this reason, the survey median artificially undervalued the work effort. Almost all the respondents reported the infants needed to be seen at least twice monthly, if not weekly at face-to-face visits. The less than 2 year old, who is rapidly growing and developing, requires frequent formula changes and laboratory assessment, and has frequent intercurrent illnesses, is the most difficult home dialysis patient for the pediatric nephrologist to manage. The 75th percentile was chosen as more reflective of the amount of effort to care for these infants and more consistent with the current G-code 320, which is 10.61.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0320, End-stage renal disease (ESRD) related services for home dialysis per full month, for patients less than two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

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 ped nephrology

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty	Frequency 0	Percentage 0.00 %
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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? 203

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization for code G0320

Specialty ped nephrology	Frequency 203	Percentage 100.00 %
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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? 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. G0320 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90964 Tracking Number: K14 Specialty Society Recommended RVU: 9.63
RUC Recommended RVU: 9.14

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 6-year-old boy with posterior urethral valves and obstructive uropathy receives home continuous cycling peritoneal dialysis (CCPD) by parent caregivers. His disease burden includes catheter access problems, renal osteodystrophy, anemia, acidosis, growth failure, behavior problems, family stress related to a technologically dependent child and polypharmacy (> 7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage his condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in his general condition; evaluation of the integrity and functionality of his dialysis access; episodic changes in his dialysis prescription; frequent adjustment of target weight for growth and fluid intake; scheduled review of routinely collected laboratory data; episodic adjustment of home medications including oral iron supplements, vitamin D metabolites or surrogates, potassium supplements or exchange resins, calcium supplements, phosphate supplements or binders, and ESA and growth hormone injections; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, transplantation centers, and other medical specialists; and overall care coordination. Growth and nutritional monitoring and intervention with special renal supplemental formula plus monitoring of developmental, behavioral and school problems and initiation of intervention will be accomplished along with counseling of the parents or caregivers for coping with a technologically dependent child with chronic kidney disease receiving high-tech home therapy. The pediatric nephrologist will also likely have multiple unscheduled telephone interventions generated by the dialysis center, an emergency room, another physician, or by the patient's parents/caregivers, and may see the patient one or more times during the month in order to accomplish his care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.					
Specialty(s):	American Soceity of Pediatric Nephrology (ASPN)					
CPT Code:		90964				
Sample Size:	30	Resp N:	7	Response: 23.3 %		
Sample Type:		Convenience				
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		2.00	6.50	20.00	73.00	79.00
Number of Visits		1	1	1	1	2
Number of Days of Dialysis		30	30	30	30	30
Physician Work		4.35	6.66	7.85	8.21	10.34

Physician Time	195	200	210	210	255
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR PHYSICIAN SERVICES (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/code	Total Est Time
99215	6	2.00	12.00	1.71	40	240
99442	17	0.50	8.50	1.27	15	255
99339	7	1.25	8.75	1.25	25	175
99441	5	0.25	1.25	0.18	10	50
99443	4	0.75	3.00	0.43	25	100
99214	2	1.42	2.84	0.18	25	175
99367	12	1.10	13.20	1.90	30	360
SUM	53	7.27	49.54	6.92	170	1355

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	2
Number of Days of Dialysis	30
Physician Work	9.14
Physician Time	233
Extender Work	0
Extender Time	0

BREAK-OUT OF RUC RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU*	Estimated Time
1-99215	2.00	35			
1-99214	1.42	25			
2-99354	3.54	120			
1-G0182	1.73	38			
1-97802	0.45	15			
Sum	9.14	233			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

CPT Code Global Work RVU Time Source
 90919 XXX 8.53 RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 1

MPC CPT Code 2 Global Most Recent Medicare Utilization Work RVU Time Source

CPT Descriptor 2

Other Reference CPT Code Global Work RVU Time Source

CPT Descriptor

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.*

Almost all of the 7 respondents were uncertain about work description codes and thought they were restricted in picking from the office E&M 99211-99215 categories for patient visits to the dialysis clinic, which did not accurately reflect the work effort, specialized pediatric nephrology expertise and the usual 60 min face-to-face visit with young children 2-11 years old and their parent caregivers at peritoneal dialysis clinic visits. Two respondents were particularly low in their assessment of work effort at 4.35 and 5.95, which significantly affected the total estimate of work associated with these services. For this reason, the survey median artificially undervalued the work effort. The 75th percentile was chosen as more reflective of the amount of effort to care for these young children and more consistent with the current G-code 321, which is 8.11.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0321, End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

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 ped nephrology

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? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty

Frequency 0

Percentage 0.00 %

Specialty	Frequency 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?
1,105 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. 2005 Medicare utilization for code G0321

Specialty ped nephrology	Frequency 1105	Percentage 100.00 %
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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? 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. G0321 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90965 Tracking Number: K15 Specialty Society Recommended RVU: 8.25
RUC Recommended RVU: 8.69

Global Period: XXX

CPT Descriptor: End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-year-old anuric girl with IgA nephropathy and failed renal transplant, does her own home continuous cycling peritoneal dialysis (CCPD) treatments with back-up supervision from her parents. Her disease burden includes dialysis access problems, hypertension, fluid overload, renal osteodystrophy, anemia, acidosis, anorexia and malnutrition, growth failure, adolescent non-adherent behavior, school problems and polypharmacy (>7 medications).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Services Provided by Physician: The patient's pediatric nephrologist will manage her condition over the entire month by providing the following services: scheduled examinations for management of known and anticipated problems; episodic examinations for intercurrent changes in her general condition; evaluation of the integrity and functionality of her dialysis access; episodic changes in his dialysis prescription for growth, weight gain or loss and fluid overload; scheduled review of routinely collected laboratory data; episodic adjustment of home medications including oral antihypertensives, iron supplements, vitamin D metabolites or surrogates, phosphate binders, potassium exchange resins, anti-constipation drugs, and ESA and growth hormone injections; establishing and modifying short and long term care plans in cooperation with social services, nutritional support services, Child Life specialists, school personnel, transplantation centers, and other medical specialists; and overall care coordination. Growth and nutritional monitoring and intervention plus the monitoring of pubertal development and school progress will be accomplished along with counseling of the parents/caregivers for malnutrition, need for special renal dietary supplements, delayed puberty and growth failure, behavioral problems related to dietary and fluid restriction, medication non-adherence and coping with an technologically dependent adolescent with chronic kidney disease. Planning for future transition to adult care will be initiated, and progress periodically addressed. The pediatric nephrologist will also likely have multiple unscheduled telephone and electronic interventions generated by the dialysis center, an emergency room, another physician, or by the patient/ parents/caregivers, and may see the patient one or more times during the month in order to accomplish her care and to comply with facility specific quality requirements.

Description of Services Provided by Extender: N/A

SUMMARY OF SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008				
Presenter(s):	Eileen Brewer, M.D., F.A.A.P.; Richard J. Hamburger, M.D., F.A.C.P., F.A.S.N.; Robert J. Kossmann, M.D.					
Specialty(s):	American Soceity of Pediatric Nephrology (ASPN)					
CPT Code:		90965				
Sample Size:	30	Resp N:	7	Response: 23.3 %		
Sample Type:		Convenience				
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate		12.00	18.00	52.00	161.00	231.00
Number of Visits		1	1	1	1	2

Number of Days of Dialysis	30	30	30	30	30
Physician Work	4.35	6.03	7.17	7.73	8.27
Physician Time	120	143	180	188	195
Extender Work *	0	0	0	0	0
Extender Time	0	0	0	0	0

BREAK-OUT OF SURVEY DATA FOR SERVICES OF PHYSICIANS (EXTENDERS N/A)

Service Described by CPT Code	# of times listed	Estimated Work RVU/code	Total Est Work RVUs	Total Est Work RVU divided by #surveys	Estimated Time/code	Total Est Time	Total E: Time divid by #surve
99215	6	2.00	12.00	1.71	40	240	34
99442	8	0.50	4.00	0.57	15	120	17
99339	5	1.25	6.25	0.89	25	125	18
99441	6	0.25	10.00	1.43	10	60	9
99214	1	1.42	1.42	1.42	25	25	4
99443	6	0.75	4.50	0.64	30	180	26
99367	10	1.10	11.00	1.57	30	300	43
SUM	42	7.27	49.17	8.23	175	1050	151

SUMMARY OF RUC RECOMMENDED DATA

Number of Visits	2
Number of Days of Dialysis	30
Physician Work	8.69
Physician Time	218
Extender Work	0
Extender Time	0

BREAK-OUT OF SPECIALTY SOCIETY RECOMMENDED DATA

Services of Physician			Services of Extender		
Service Described by CPT Code	Estimated Work RVU	Estimated Time	Service Described by CPT Code	Estimated Work RVU	Estimated Time
1-99215	2.00	35			
2-99354	3.54	120			
1-G0182	1.73	38			
1-99214	1.42	25			
Sum	8.69	218			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

REFERENCE SERVICE:

<u>CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90920	XXX	7.26	RUC Time

CPT Descriptor End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent</u> <u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u> <u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor

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.*

Almost all of the 7 respondents were uncertain about work description codes and thought they were restricted in picking from the office E&M 99211-99215 categories for patient visits to the dialysis clinic, which did not accurately reflect the work effort, specialized pediatric nephrology expertise and the usual 45-60 min face-to-face visit with adolescents 12-19 years old and their parent caregivers at peritoneal dialysis clinic visits. In addition, adolescent non-adherent and defiant behavior against their technologically dependent chronic renal disease is perceived to require more effort from the physician to intervene with the adolescent patient individually to try to improve outcomes. Two respondents were particularly low in their assessment of work effort at 4.35 and 5.2, which significantly affected the total estimate of work associated with these services. For this reason, the survey median artificially undervalued the work effort. The 75th percentile was chosen as more reflective of the amount of effort to care for these adolescents.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
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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) G0322, End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

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 ped nephrology 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? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty	Frequency	Percentage
	0	0.00 %

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?
2,017 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. 2005 Medicare utilization for code G0322

Specialty ped nephrology	Frequency 2017	Percentage 100.00 %
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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? 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. G0322 which is the G-code that is being replaced with this new CPT code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1																	
2																	
3	ESRD Services			90960		90961		90962		90966		90951		90952		90953	
				End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month		End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 2-3 face-to-face physician visits per month		End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 1 face-to-face physician visit per month		End stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over		End stage renal disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents, with 4 or more face-to-face physician visits per month		End stage renal disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month		End stage renal disease (ESRD) related services during the course of treatment, for patients under 2 years of age, to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD																
6	TOTAL CLINICAL LABOR TIME			42.0	42.0	42.0	42.0	42.0	42.0	42.0	42.0	36.0	36.0	36.0	36.0	36.0	36.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			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
9	TOTAL POST-SERV CLINICAL LABOR TIME			6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE																
11	Start: Following visit when decision for surgery or procedure made																
12	Coordination of care (crosswalked from 99375)	L037D	RN/LPN /MTA	36	36	36	36	36	36	36	36	36	36	36	36	36	36
13	End: When patient enters office/facility for surgery/procedure																
14	SERVICE PERIOD																
15	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure																
16	Intra-service																
17																	
18	Post-Service																
19	End: Patient leaves office																
20	POST-SERVICE Period																
21	Start: Patient leaves office/facility																
30	Phone calls	L037D	RN/LPN /MTA	6	6	6	6	6	6	6	6						
33	End: with last office visit before end of global period																
34	MEDICAL SUPPLIES	CMS Code	Unit														
35																	
36	Equipment	CMS Code															

	A	B	C	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
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AMA/Specialty Society RVS Update RUC
Summary of Recommendations

April 2008

Cardiac Device Monitoring

The CPT Editorial Panel created 23 new codes to distinguish the work of a programming evaluation from an interrogation evaluation, in person or remotely, performed with different modern devices such as pacemakers and implantable cardioverter defibrillators. Since the first pacemaker implantation in 1958, tremendous advances have occurred in pacemaker and monitoring technology. Similarly, since the first human implant of an implantable cardioverter defibrillator (ICD) in 1980 at the Johns Hopkins Hospital, the indications for ICD therapy have broadened from secondary to primary prevention. Recently, implantable cardiovascular monitor (ICM) technology, incorporated into ICDs, measure and record physiologic cardiovascular data such as intracardiac pressure and thoracic impedance allowing response to hemodynamic changes prior to symptom onset. In addition, long distance telemetry and remote interrogation network systems have become integral to current practice. This technology merges outpatient monitoring, device and arrhythmia detection, wireless communications, and the internet to allow device and cardiac rhythm related problems to be quickly identified, analyzed and communicated to the prescribing physician. When a device event or arrhythmia is detected, it is transmitted via wireless technology and over the Internet to a monitoring station where it is received and reviewed by a monitoring specialist who according to physician prescription notifies the treating physician. This new technology and patient care paradigm was not correctly described by the current AMA CPT code selections. Correctly describing and valuing the work provided by the physician including complex data collection and the collective efforts of the physician, independent testing facilities (IDTF) and office personnel requires a new strategic approach to coding.

The current coding convention does not recognize the value of the information obtained and presented for physician review independent of whether it is derived directly from the implanted device or from remote sensors in contact with the device and its telemetry system. Physiologic monitoring reflecting evidence of volume overload through measurements of intrathoracic impedance, left atrial pressure, weight, and or blood pressure from sensors provide data separate from heart rhythm data. This required codes that clearly distinguish the unique services performed by electrophysiologists from heart failure and other physicians. Codes are required to describe the work done in reference to the implantable cardiovascular monitors and to distinguish the work done in regard to the heart rhythm by the electrophysiologist to the physiologic data usually interpreted and reported by the heart failure or general cardiologist.

Coding options were not available that account for the work performed when preparing an ICD or pacemaker patient for a procedure or surgery. This periprocedural device assessment and programming is a common and necessary service for ICD patients to turn the devices off and back on again to avoid unexpected ICD shocks and to prevent undesirable inhibition or tachycardia in pacemaker patients during delicate operations. This entails identifying the precise device manufacturer and model, retrieving and reviewing the historical records and collecting the appropriate equipment.

The current CPT terminology also did not appropriately distinguish the work of a programming evaluation from an interrogation evaluation performed in modern devices and in practice. These devices are both more complex. It is appropriate to do a substantial evaluation of both pacemakers and ICDs with a full interrogation of the programmed and measured data from the device. The data collected is no different for these evaluations than when the interrogation is done remotely or in person. However, a much more complex and customized programming evaluation is required periodically to prescribe the appropriate behavior of the device for the patient and to evaluate both the patient's condition and the device's function. This iterative temporary and sometimes permanent adjustment of the device's function is increasingly important and intensive paralleling the complexity of both the patients and the devices.

Twenty new implantable device codes and 3 new wearable device codes were developed to: 1) Establish consistency in code descriptions; 2) Simplify code language; 3) Establish uniform frequency standards and eliminated the potential for inappropriate billing; 4) Update codes to reflect remote monitoring service components; 5) Maintain budget neutrality; and 6) Update codes to reflect current technology. For the implantable device and wearable defibrillator codes, the major changes from current to proposed codes provide for work currently not represented in current CPT codes, including complete device analysis without parameter change, remote or in-person interrogation follow-up, biventricular device analysis differentiated, perioperative limited programming, limitations on frequency of follow-up interrogations to include transtelephonic pacemaker monitoring (90 days), parallel codes for wearable defibrillator and implantable pacemaker/ICD, provides physician and service center components and incorporates codes for implantable cardiovascular monitor technology.

Physician work for the interrogation device codes (remote) was predicated on the preparation of the report covering the specified time period, no matter how many transmissions are received. If during the specified interrogation period a programming evaluation is needed, the codes can be billed concurrently. Definitions for the new codes are provided in the introductory language to avoid ambiguity. For example, the number of leads will be based on the number of active leads and the number of chambers paced. Single is defined as a pacemaker or ICD with pacing and sensing function in only one chamber of the heart (e.g., an atrial pacemaker only, a ventricular pacemaker only). Dual is defined as a pacemaker or ICD with pacing and sensing function in only two chambers of the heart (e.g., leads in the atrium and ventricle, leads in both atria, leads in both ventricles). Multiple leads are defined as pacemaker or ICD with pacing and sensing function in three or more chambers of the heart as would be seen in a biventricular device with a lead in the atria. Separate codes were established between implantable and wearable defibrillators to capture the difference in work for evaluation and frequency distinguished by the device technology.

The RUC deliberated over the values for these cardiac device monitoring services for three days throughout the duration of the April 2008 RUC meeting.

Pacemaker Services

93288 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead pacemaker system

The RUC first reviewed specialty society survey data for pacemaker codes 93288, 93279, 93280 and 93281. In order to develop a work RVU for 93288 the RUC reviewed the two codes in which this code is currently being reported. The specialty society is estimating that 40% of code 93734 *Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and*

device response); without reprogramming (work RVU = 0.38, 2006 frequency = 95,862) and 40% of code 93731 Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming (work RVU=0.45, 2006 frequency = 329,529) will be coded under 93288 once this code is developed. By calculating for work neutrality the RUC developed a work RVU of 0.43 for code 93288.

The RUC reviewed the physician time required to perform this procedure and determined that the survey physician time was appropriate. The RUC recommends 5 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time.

Additionally, the RUC compared code 93288 to the following codes which involve similar levels of physician work, time and intensity:
99212 *Office or other outpatient visit for the evaluation and management of an established patient (work RVU=0.45, 2 minutes pre-service, 10 minutes intra-service and 4 minutes immediate post-service time)*
75902 *Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation (work RVU=0.39, 5 minutes pre-service, 10 minutes intra-service and 5 minutes immediate post-service time)*

The RUC recommends a work RVU of 0.43 for 93288.

93279 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; single lead pacemaker system (Do not report 93279 in conjunction with 93286 or 93288)

The RUC examined the increment between the base code 93288 (recommended RVU=0.43) and code 93279 (recommended RVU=0.65) and determined the intensity increment was appropriate. The RUC reviewed the specialty society survey data for code 93279 and compared it to a similar service, code 95937 *Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method (work RVU=0.65, 5 minutes pre-service, 12 minutes intra-service and 5 minutes immediate post-service time)*. The RUC determined that 0.65 work RVUs for 93279 and the survey physician times of 5 minutes pre-, 10 minutes intra- and 5 minutes immediate post-service time are appropriate. **The RUC recommends a work RVU of 0.65 for 93279.**

93280 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead pacemaker system

The RUC examined the increment between the code 93279 (recommended RVU=0.65) and code 93280 (recommended RVU=0.77) and determined the intensity increment was appropriate. The RUC reviewed the specialty society survey data for code 93280 and compared it to similar services, codes 95971 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming (work RVU=0.77, 3 minutes pre-service, 20 minutes intra-service and 3 minutes immediate post-service time)* and 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 (work RVU=0.75, 2 minutes pre-service,*

15 minutes intra-service and 4 minutes immediate post-service time). The RUC determined that 0.77 work RVUs for 93280 and the physician time components of 5 minutes pre-, 17 minutes intra- and 5 minutes immediate post-service time are appropriate. The RUC removed 2 minutes of immediate post-service time and added it to the intra-service time as the RUC determined that the survey respondents incorrectly placed some interpretation and report time for this XXX global code in the immediate post-service time. **The RUC recommends a work RVU of 0.77 for 93280.**

93281 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; multiple lead pacemaker system

The RUC determined that the intensity for 93279, 93280 and 93281 have progressively higher intensity across these services. The RUC reviewed the specialty society survey results for code 93281 and compared it to similar services, codes 92002 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient* (work RVU = 0.88, 5 minutes pre-, 15 minutes intra- and 5 minutes post-service time) and 95921 *Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including two or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio* (work RVU = 0.90, 10 minutes pre-, 15 minutes intra- and 10 minutes post-service time). The RUC determined that 0.90 work RVUs for 93281 and the physician times of 5 minutes pre-, 20 minutes intra- and 5 minutes post-service time are appropriate. **The RUC recommends a work RVU of 0.90 for 93281.**

Implantable Cardioverter Defibrillator (ICD)

93289 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead implantable cardioverter defibrillator system, including analysis of heart rhythm derived data elements

The RUC reviewed the specialty society survey results for code 93289 and determined that the survey 25th percentile work RVU of 1.00 was slightly high for this service. The RUC crosswalked 93289 to a 99213 office visit (work RVU=0.92, 3 minutes pre-, 15 minutes intra- and 5 minutes post-service time) and determined the physician work is comparable, both with 15 minutes of intra-service time. The RUC determined that the surveyed physician time was appropriate with 5 minutes pre-, 15 minutes intra- and 5 minutes post-service time). **The RUC recommends a work RVU of 0.92 for code 93289.**

93282 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; single lead implantable cardioverter defibrillator system

The RUC reviewed the specialty society survey results for code 93282 and determined that the survey 25th percentile work RVU of 0.85 and survey physician time of 8 minutes pre-, 15 minutes intra- and 5 minutes post-service time appropriate represent the physician work, time and intensity required to perform this procedure. Additionally, recommending the survey 25th percentile work RVU for 93282 appropriately places this service in the proper rank order for this family of services. The RUC also compared code 93282 to a 99213 office visit (work RVU=0.92, 3

minutes pre-, 15 minutes intra- and 5 minutes post-service time) and determined the physician work was comparable. **The RUC recommends the survey 25th percentile work RVU of 0.85 for code 93282.**

93283 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead implantable cardioverter defibrillator system

The RUC reviewed the specialty society survey results for code 93283 and determined that the survey 25th percentile work RVU of 1.18 and survey physician times of 8 minutes pre-, 15 minutes intra- and 10 minutes post-service time appropriately represents the physician work, time and intensity required to perform this procedure. The RUC also compared code 93283 to code 70544 *Magnetic resonance angiography, head; without contrast material(s)* (work RVU= 1.20, 5 minutes pre-, 10 minutes intra- and 10 minutes post-service time) and determined the physician work was comparable. The RUC identified that the work RVU increment between 93289 and 93283 was 0.26 and determined that this increment is appropriate to account for the physician work required for reprogramming and the dual lead. **The RUC recommends the survey 25th percentile work RVU of 1.18 for code 93283.**

93284 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; multiple lead implantable cardioverter defibrillator system

The RUC reviewed the specialty society survey results for code 93284 and determined that the survey 25th percentile work RVU of 1.25 and survey physician times of 8.5 minutes pre-, 15 minutes intra- and 10 minutes post-service time appropriately represents the physician work, time and intensity required to perform this procedure. The RUC also compared code 93284 to a 99214 office visit (work RVU = 1.42, 5 minutes pre-, 25 minutes intra- and 10 minutes post-service time). The RUC determined that 93284 would be appropriately valued at 1.25 work RVUs relative to 99214 as 99214 requires 10 minutes more intra-service time. **The RUC recommends the survey 25th percentile work RVU of 1.25 for code 93284.**

Implantable Loop Recorder

93291 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm data derived analysis

The RUC reviewed the specialty society survey results for code 93291 and determined that this service is parallel to the pacemaker interrogation device evaluation, code 93288. Therefore the RUC recommends to crosswalk the work RVU of 93288 (recommended work RVU=0.43) to 93291. However, the RUC recommends the survey physician times of 5 minutes pre-, 12 minutes intra- and 5 minutes for 93291 as these patients are more complicated than the typical patient for 93288, having syncope episodes and many arrhythmia episodes. The RUC also determined that 93291 would be appropriately valued at 0.43 relative to a 99212 office visit (work RVU=0.45). **The RUC recommends a work RVU of 0.43 for 93291.**

93285 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; implantable loop recorder system

The RUC reviewed the specialty society survey results for code 93285 and determined that the survey 25th percentile work RVU of 0.52 and survey physician times of 5 minutes pre-, 12 minutes intra- and 5 minutes post-service time appropriately represent the physician work, time and intensity required to perform this procedure. The RUC determined that although the recommended physician times for 93291 and 93285 are identical, the work for 93285 is slightly higher because this service detects different rhythm disturbances and includes interrogation and programming. Since 93285 is not a therapeutic device the RUC determined that the increment should be smaller and the intensity slightly higher to account for the softer programming required which detects different rhythm disturbances. The RUC also referenced 93285 to code 76820 *Doppler velocimetry, fetal; umbilical artery* (work RVU = 0.50, 5 minutes pre-, 10 minutes intra- and 5 minutes post-service time) to support a value of 0.52. **The RUC recommends the survey 25th percentile work RVU of 0.52 for code 93285.**

Implantable Cardiovascular Monitor

93290 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors

The RUC reviewed the specialty society survey results for code 93290 and determined that this service is parallel to the other interrogation codes 93288 and 93291 (recommended work RVU = 0.43). The RUC recommends the survey physician times of 5 minutes pre, 12 minutes intra- and 8 minutes post-service time. The RUC also determined that 93291 would be appropriately valued at 0.43 relative to a 99212 office visit (work RVU = 0.45). **The RUC recommends a work RVU of 0.43 for 93290.**

Wearable Defibrillator

93292 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system

The RUC reviewed the specialty society survey results for code 93292 and determined that this service is parallel to the other interrogation codes in this family, 93288 (recommended work RVU = 0.43). The RUC recommends the survey physician times of 5 minutes pre-, 10 minutes intra- and 5 minutes post-service time. The RUC also determined that 93292 would be appropriately valued at 0.43 relative to a 99212 office visit (work RVU = 0.45). **The RUC recommends a work RVU of 0.43 for 93292.**

93286 Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead pacemaker system

The RUC reviewed the specialty society survey results for code 93286 and determined that this service is similar to 93279 (recommended work RVU = 0.65) but should be valued at approximately half the work RVU of 93279 because 93286 will be reported peri-procedurally, once before the procedure and once after the procedure. Additionally, code 93286 and 93279 are comparable because both involve interrogation and programming of a pacemaker device. The RUC determined a lesser relative value for 93286 is appropriate because this service involves only interrogating certain parameters and programming certain parameters. Therefore, the RUC recommends a work RVU of 0.30 for code 93286. The RUC reviewed the physician time required to perform this service and determined that the survey times of 5 minutes pre-, 12 minutes intra-, and 5 minutes post-service time are appropriate. **The RUC recommends a work RVU of 0.30 for code 93286.**

93287 Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead implantable cardioverter defibrillator system

The RUC reviewed the specialty society survey results for code 93287 and determined that this service is similar to 93282 (recommended work RVU = 0.85) but should be valued at approximately half the work RVU of 93282 because 93287 will be reported peri-procedurally, once before the procedure and once after the procedure. Additionally, code 93287 and 93282 are comparable because both involve interrogation and programming of a defibrillator device. The RUC determined a lesser relative value for 93287 is appropriate because this service involves only interrogating certain parameters and programming certain parameters. Therefore, the RUC recommends a work RVU of 0.45 for code 93287. The RUC reviewed the physician time required to perform this service and determined that the survey times of 7.5 minutes pre-, 13.5 minutes intra-, and 5 minutes post-service time are appropriate. **The RUC recommends a work RVU of 0.45 for code 93287.**

Trans Telephonic Monitoring

93293 Transtelephonic rhythm strip pacemaker evaluation(s) single, dual or multiple lead pacemaker system, includes recording with and without magnet application with report(s) up to 90 days

The RUC reviewed the specialty society survey results for code 93293 and determined that the average number of transmissions per patient per 90 days is 1.9. The RUC determined that other than the physician work associated with the transmissions, the physician work for 93293 is similar to 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17, 4 minutes intra- and 1 minute post-service time). The RUC derived at an appropriate work RVU by taking the frequency of reporting this service multiplied by the work RVU for 93010 ($1.9 \times 0.17 = 0.32$ work RVUs). The RUC determined that the physician time required to perform this service is the survey physician time multiplied by the frequency of reporting this service ($5/10/5 \times 1.9 = 9.5$ minutes pre-, 19 minutes intra-, and 7.5 minutes post-service time). **The RUC recommends a work RVU of 0.32 for 93293.**

Wearable Mobile Cardiovascular Telemetry

93228 Mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report

The RUC reviewed specialty society survey data for code 93228 and determined that the physician work required to perform this service is comparable to 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 and 10 minutes pre-, 20 minutes intra- and 12 minutes post-service time). The RUC recommends the survey physician time of 5 minutes pre- 12 minutes intra- and 8 minutes post-service time. The RUC also referenced code 99212 office visit (work RVU=0.45) to further support the recommended physician work and time. **The RUC recommends a work RVU of 0.52 for code 93228.**

Remote Interrogation

93294 Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead pacemaker system with interim physician analysis and physician review and report(s)

The RUC reviewed code 93294 and determined that the average number of transmissions per patient per 90 days is 1.5. The RUC determined that other than the physician work associated with transmissions, the physician work for 93294 is parallel to 93288 (recommended work RVU = 0.43). The RUC derived an appropriate work RVU by taking the frequency of reporting this service multiplied by the work RVU for 93288 (1.5×0.43 RVU = 0.65 work RVUs). The RUC determined that the physician time required to perform this service was also 1.5 multiplied by the service times for 93288 ($1.5 \times 5/10/5 = 7.5$ minutes pre-, 15 minutes intra-, and 7.5 minutes post-service time). **The RUC recommends a work RVU of 0.65 for 93294.**

93295 Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead implantable cardioverter defibrillator system with interim physician analysis and physician review and report(s)

The RUC reviewed code 93295 and determined that the average number of transmissions per patient per 90 days is 1.5. The RUC determined that other than the physician work associated with transmissions, the physician work for 93295 is parallel to 93289 (recommended work RVU = 0.92). The RUC derived at an appropriate work RVU by taking the frequency of reporting this service multiplied by the work RVU for 93289 (1.5×0.92 RVU = 1.38 work RVUs). The RUC noted that the physician work and time for 93295 is also similar to a 99214 visit (work RVU = 1.42). The RUC determined that the physician time required to perform this service was also 1.5 multiplied by the service times for 93289, $1.5 \times 5/15/5 = 7.5$ minutes pre-, 22.5 minutes intra-, and 7.5 minutes post-service time. **The RUC recommends a work RVU of 1.38 for 93295.**

93297 Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s)

The RUC reviewed code 93297 and determined that the average number of transmissions per patient per 30 days is 2. The RUC determined that other than the physician work associated with transmissions, the physician work for 93297 is parallel to 93290 (recommended work RVU = 0.43). The RUC discussed taking the frequency of reporting this service and multiplying it by the work RVU for 93290 (2×0.43 RVU = 0.86 work RVUs) to develop a work RVU for 93297. However, recognizing that the value for 93228, which requires similar physician work and time, is 0.52 RVUs, the RUC determined to alleviate any rank order anomaly and recommended a work RVU of 0.52 for code 93297. The RUC determined that the physician time required to perform this service was the service times for 93290 multiplied by 2 ($2 \times 5/12/8 = 10$ minutes pre-, 24 minutes intra-, and 16 minutes post-service time). **The RUC recommends a work RVU of 0.52 for 93297.**

93298 Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s)

The RUC reviewed code 93298 and determined that the average number of transmissions per patient per 30 days is 2. The RUC determined that other than the physician work associated with transmissions, the physician work for 93298 is parallel to 93291 (recommended work RVU = 0.43). The RUC discussed taking the frequency of reporting this service and multiplying it by the work RVU for 93290 (2×0.43 RVU = 0.86 work RVUs) to develop a work RVU for 93298. However, recognizing that the value for 93228, which requires similar physician work and time, is 0.52 RVUs, the RUC determined to alleviate any rank order anomaly and recommended a work RVU of 0.52 for 93298. The RUC determined that the physician time required to perform this service was the service times for 93290 multiplied by 2 ($2 \times 5/12/5 = 10$ minutes pre-, 24 minutes intra-, and 10 minutes post-service time). **The RUC recommends a work RVU of 0.52 for 93298.**

93296, 93299 and 93229 (All PE Only)

The RUC recommends the revised direct practice expense inputs for the practice expense only codes 93296, 93299 and 93229.

Practice Expense:

The RUC reviewed the direct practice expense inputs and determined that for 93294, 93295, 93297, 93298 and 93228 there should be zero clinical labor time. The RUC determined any information collected for physician review is performed by administrative staff and not an RN/LPN/MTA. All other practice expense inputs as revised by the Practice Expense Subcommittee were appropriate.

New Technology

The RUC requests that this family of codes 93279 – 93229 be placed on the new technology list. The RUC determined this family will need to be revisited, especially the volume data for codes that may be reported every 90 or 30 days in which RVUs were calculated by the frequency in which the service is performed. The RUC specifically requests that codes 93299 and 93229 be brought back from review in 2 years. Data will need to be collected from the vendors/manufactures because the frequency of the reports will not be apparent in the Medicare frequency data as they may only be reported once every 30 or 90 days. However, the specialty society indicated that each physician practice will have this data available.

Database Notation

The RUC recommends that the RUC database note that physician times for codes 93286, 93287, 93293, 93294, 93295, 93297 and 93298 should not be used for comparison as these times were calculated from crosswalks and are not specialty society survey data.

Work Neutrality

The RUC noted that with the Medicare frequency data available the family of codes appears to be work neutral. The work RVUs for most of these codes which have been previously reported with a current code have decreased. Additionally, now that the remote codes may only be reported once every 30 or 90 days, the frequency is expected to decrease.

Cardiac Device Monitoring RUC Recommendations:

Code	RVU	Pre	Intra	Post	Reference	Ref RVU	Ref Pre	Ref Intra	Ref Post
93288	0.43	5	10	5	99212 75902	0.45 0.39	2 5	10 10	4 5
93279	0.65	5	10	5	95937	0.65	5	12	5
93280	0.77	5	17	5	95971 93015	0.77 0.75	3 2	20 15	3 4
93281	0.90	5	20	5	92521 92002	0.90 0.88	10 5	15 15	10 5
93289	0.92	5	15	5	99213	0.92	3	15	5
93282	0.85	8	15	5	99213	0.92	3	15	5
93283	1.18	8	15	10	70544	1.20	5	10	10
93284	1.25	8.5	15	10	99214	1.42	5	25	10
93291	0.43	5	12	5	93288 99212	0.43 0.45	5 2	10 10	5 4
93285	0.52	5	12	5	76820	0.50	5	10	5
93290	0.43	5	12	8	93288 93291 99212	0.43 0.43 0.45	5 5 2	10 10 10	5 5 4
93292	0.43	5	10	5	99212	0.45	2	10	4
93286	0.30	5	12	5	93279 / 2	0.65	5	12	5
93287	0.45	7.5	13.5	5	93282 / 2	0.85	8	15	5
93293	0.32	9.5	19	9.5	93010 x 1.9	0.17	0	4	1
93294	0.65	7.5	15	7.5	93288 x 1.5	0.43	5	10	5
93295	1.38	7.5	22.5	7.5	93289 x 1.5 99214	0.92 1.42	5 5	15 25	5 10
93297	0.52	10	24	16	93290	0.43	5	12	8
93298	0.52	10	24	10	93291	0.43	5	12	5
93228	0.52	5	12	8	93014 99212	0.52 0.45	10 2	20 10	12 4

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
e 93224		Wearable E electrocardiographic <u>rhythm derived</u> monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation	XXX	0.52 (No Change)
e 93225		recording (includes connection hook-up , recording, and disconnection)	XXX	0.00 (PE Inputs Only)
e 93226		scanning analysis with report	XXX	0.00 (PE Inputs Only)
e 93227		physician review and interpretation	XXX	0.52 (No Change)
e 93230		Wearable E electrocardiographic rhythm derived monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation	XXX	0.52 (No Change)
e 93231		recording (includes connection hook-up , recording, and disconnection)	XXX	0.00 (PE Inputs Only)
e 93232		microprocessor-based analysis with report	XXX	0.00 (PE Inputs Only)
e 93233		physician review and interpretation	XXX	0.52 (No Change)

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
e 93235		Wearable E-electrocardiographic rhythm derived monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient activated; includes monitoring and real-time data analysis with report, physician review and interpretation	XXX	Carrier Priced (No Change)
e 93236		monitoring and real-time data analysis with report	XXX	Carrier Priced (No Change)
e 93237		physician review and interpretation	XXX	0.45 (No Change)
e 93268		Wearable pPatient activated demand single or multiple electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission, physician review and interpretation	XXX	0.52 (No Change)
e 93270		recording (includes hook-up connection, recording, and disconnection)	XXX	0.00 (PE Inputs Only)
e 93271		monitoring, receipt of transmissions, and analysis	XXX	0.00 (PE Inputs Only)
e 93272		physician review and interpretation only (For postsymptom recording, see 93012, 93014) (For implanted patient activated cardiac event recording, see 33282, 93285, 932793, 932800 93727)	XXX	0.52 (No Change)

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●93279	L1	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system (Do not report 93279 in conjunction with 93286 or 93288)	XXX	0.65
●93280	L2	dual lead pacemaker system (Do not report 93280 in conjunction with 93286, 93288)	XXX	0.77
●93281	L3	multiple lead pacemaker system (Do not report 93281 in conjunction with 93286, 93288)	XXX	0.90
●93282	L4	single lead implantable or wearable cardioverter defibrillator system (Do not report 93282 in conjunction with 93287, 93289, 93745)	XXX	0.85
●93283	L5	dual lead implantable cardioverter defibrillator system (Do not report 93283 in conjunction with 93287 or 93289)	XXX	1.18
●93284	L6	multiple lead implantable cardioverter defibrillator system (Do not report 93284 in conjunction with 93287 or 93289)	XXX	1.25
●93285	L7	implantable loop recorder system (Do not report 93285 in conjunction with 33282, 93279-93284, 93291)	XXX	0.52

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●93286	L8	<p>Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with physician analysis, review and report; single, dual or multiple lead pacemaker system</p> <p>(Report 93286 once before and once after surgery, procedure, or test, when device evaluation and programming is performed before and after surgery, procedure or test)</p> <p>(Do not report 93286 in conjunction with, 93279-93281 or 93288)</p>	XXX	0.30
●93287	L9	<p>single, dual or multiple lead implantable cardioverter defibrillator system</p> <p>(Report 93287 once before and once after surgery, procedure, or test, when device evaluation and programming performed before and after surgery, procedure or test)</p> <p>(Do not report 93287 in conjunction with 93282-93284, 93289)</p>	XXX	0.45
●93288	L10	<p>Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead pacemaker system</p> <p>(Do not report 93288 in conjunction with 93279-93281, 93294, 93296)</p>	XXX	0.43
●93289	L11	<p>single, dual or multiple lead implantable cardioverter defibrillator system, including analysis of heart rhythm derived data elements</p> <p>(For monitoring physiologic cardiovascular data elements derived from an ICD, use 93290)</p> <p>(Do not report 93289 in conjunction with 93282-93284, 93295, 93296)</p>	XXX	0.92

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●93290	L12	implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors (For heart rhythm derived data elements, use 93289) (Do not report 93290 in conjunction with 93297, 93299)	XXX	0.43
●93291	L13	implantable loop recorder system, including heart rhythm data derived analysis (Do not report 93291 in conjunction with 33282, 93288, 93289, 93290, 93298, 93299)	XXX	0.43
●93292	L14	wearable defibrillator system (Do not report 93292 in conjunction with 93745)	XXX	0.43
●93293	L15	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and report(s) up to 90 days (Report 93293 only once per 90 days) (Do not report 93293 in conjunction with 93294) (For in person evaluation, see 93040, 93041, 93042)	XXX	0.32
●93294	L16	Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead pacemaker system with interim physician analysis and	XXX	0.65

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>physician review and report(s)</p> <p>(Do not report 93294 in conjunction with 93288, 93293)</p> <p>(Report 93294 only once per 90 days)</p>		
●93295	L17	<p>single, dual or multiple lead implantable cardioverter defibrillator system with interim physician analysis and physician review and report(s)</p> <p>(For remote monitoring of physiologic cardiovascular data elements derived from an ICD, use 93297)</p> <p>(Do not report 93295 in conjunction with 93289)</p> <p>(93295 should be reported only once per 90 days)</p>	XXX	1.38
●93296	L18	<p>single, dual, or multiple lead pacemaker system or implantable cardioverter defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results</p> <p>(Do not report 93296 in conjunction with 93288, 93289, 93299)</p> <p>(Report 93296 only once per 90 days)</p>	XXX	0.00 (PE Inputs Only)
●93297	L19	<p>Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s)</p> <p>(For heart rhythm derived data elements, use 93295)</p> <p>(Do not report 93297 in conjunction with 93290, 93298)</p>	XXX	0.52

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Report 93297 only once per 30 days)		
●93298	L20	implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s) (Do not report 93298 in conjunction with 93291) (Report 93298 only once per 30 days)	XXX	0.52
●93299	L21	implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results (Do not report 93299 in conjunction with 93290, 93291, 93296) (Report 93299 only once per 30 days)	XXX	0.00 (PE Inputs Only)
●93228	L22	Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report (Report 93228 only once per 30 days) (Do not report 93014 in conjunction with 93228)	XXX	0.52
●93229	L23	technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed	XXX	0.00

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>transmission of daily and emergent data reports</p> <p>(Report 93229 only once per 30 days)</p> <p>(Do not report 93012 with 93229)</p> <p>(For wearable cardiovascular monitors that do not perform automatic ECG triggered transmissions to an attended surveillance center, see 93224-93272)</p>		(PE Inputs Only)
D 93727		<p>Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)</p> <p>(93727 has been deleted. For programming of implantable loop recorder, use 93285. For interrogation of implantable loop recorder, see 93291, 93298)</p>	XXX	N/A
D 93731		<p>Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable; using electrocardiographic recording and interpretation of recordings at rest and during exercise; analysis of event markers and device response); without reprogramming</p>	XXX	N/A
D 93732		<p>with reprogramming</p> <p>(93731 and 93732 have been deleted. For interrogation of dual lead pacemaker, see 93288, 93294. For programming of dual chamber pacemaker, use 93280)</p>	XXX	N/A
D 93733		<p>Electronic analysis of dual-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); telephonic analysis</p>	XXX	N/A

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(93733 has been deleted. For transtelephonic rhythm strip pacemaker, single and dual, or multiple lead pacemaker evaluation, use 93293)		
D 93734		Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming	XXX	N/A
D 93735		with reprogramming (93734 and 93735 have been deleted. For interrogation of single lead pacemaker, see 93288, 93294. For programming of single lead pacemaker, use 93279)	XXX	N/A
D 93736		Electronic analysis of single chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis (93736 has been deleted. For transtelephonic rhythm strip pacemaker, single and dual, or multiple lead pacemaker evaluation, use 93293)	XXX	N/A
93740		<i>Temperature gradient studies</i>	XXX	0.16 (No Change)
D 93741		Electronic analysis of pacing cardioverter defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable,	XXX	N/A

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
		using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber or wearable cardioverter defibrillator system, without reprogramming (Do not report 93742 in conjunction with 93745)		
D 93742		single chamber or wearable cardioverter defibrillator system, with reprogramming (Do not report 93742 in conjunction with 93745) (93741, 93742 have been deleted. For interrogation of single chamber implantable cardioverter-defibrillator (ICD), see 93289, 93295. For programming of single ICD, use 93282. For interrogation of wearable cardioverter-defibrillator, use 93292)	XXX	N/A
D 93743		dual chamber, without reprogramming	XXX	N/A
D 93744		dual chamber, with reprogramming (93743, 93744 have been deleted. For interrogation of dual chamber implantable cardioverter-defibrillator (ICD), see 93289, 93295. For programming of dual ICD, use 93283)	XXX	N/A
93745		Initial set-up and programming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events (Do not report 93745 in conjunction with 93741, 93742) (Do not report 93745 in conjunction with 93292)	XXX	N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93228 Tracking Number L22

Specialty Society Recommended RVU: **1.20**

Global Period: XXX

RUC Recommended RVU: **0.52**

CPT Descriptor: Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report

(Use 93X22 only once per 30 days)

(Do not report 93014 in conjunction with 93X22)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52 year old patient receives a mobile cardiovascular telemetry monitor to investigate severe near syncopal episodes that occur once or twice a month. Electrocardiographic rhythm strips are transmitted to the physician for review demonstrating atrial fibrillation with a rapid ventricular heart rate and with a four second pause correlating with a near syncopal symptom.

This is for all evaluations received for up to a 30 day period.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient records are reviewed to identify the indication for wearable MCT monitoring and therapy, as appropriate.

Description of Intra-Service Work: The information is interrogated from the MCT by telemetric communication and either printed for review or reviewed on the programmer or computer monitor. Critical review of the interrogated data with the assessment of the appropriateness of the function of the wearable device and appropriateness of the current programmed parameters is performed.

Data reviewed may include, but are not limited to:

1. Presenting electrograms.
2. Stored episodes of data.
3. Alerts generated from the device.
4. Battery voltage and impedance, pacing and shocking lead impedance and sensed electrogram voltage amplitude.
5. Histogram and/or counters of paced and sensed events from each chamber.

Additionally, stored episodes of data are reviewed to assess the history and trends identified by any of the collected data.

Description of Post-Service Work: Modifications to the patient's medical regimen are made as appropriate. The patient is informed of the test result. A final report is prepared, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93228				
Sample Size:	83	Resp N:	27	Response: 32.5 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	50.00	111.00	500.00
Survey RVW:	0.20	0.59	0.80	1.39	8.00
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	9.00	12.00	15.00	20.00
Immediate Post Service-Time:	8.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.0	99291x	99292x		
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x	
Discharge Day Mgmt:	0.0	99238x	99239x		
Office time/visit(s):	0.0	99211x	12x	13x	14x 15x
Prolonged Services:	0.0	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	93228	Recommended Physician Work RVU: 1.20			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		5.00	7.0	-2.0	
Pre-Service Positioning Time:		0.00	0.0	0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0	
Intra-Service Time:		12.00			
Immediate Post Service-Time:	8.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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 0.0	99239x 0.0		
Office time/visit(s):	0.0	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93014	XXX	0.52	RUC Time

CPT Descriptor 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

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00	RUC Time	0

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 19 % of respondents: 70.3 %

TIME ESTIMATES (Median)

	CPT Code: 93228	Key Reference CPT Code: 93014	Source of Time RUC Time
Median Pre-Service Time	5.00	10.00	
Median Intra-Service Time	12.00	20.00	
Median Immediate Post-service Time	8.00	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	
Prolonged Services Time	0.0	0.00	
Median Total Time	25.00	42.00	
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	3.65	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	3.35
Urgency of medical decision making	3.65	3.18

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.82
Physical effort required	1.82	1.71
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	3.29	3.06
Outcome depends on the skill and judgment of physician	3.71	3.41
Estimated risk of malpractice suit with poor outcome	3.60	3.51

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	0.00	0.00
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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 93279 Tracking Number L1

Specialty Society Recommended RVU: **0.74**

Global Period: XXX

RUC Recommended RVU: **0.65**

CPT Descriptor: Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; single lead pacemaker system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman with chronic atrial fibrillation and complete heart block had a single chamber, rate adaptive, ventricular pacemaker (VVIR) implanted two years ago. The patient contacted her internist because she had "passed out." The physician has the patient come in for a symptom assessment and a programming device evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: History is assessed for pacing indications and for changes in, or development of new, symptoms. Prior records of the implanted pacemaker and lead hardware and programmed parameters are reviewed. Prior assessments of capture thresholds, sensing thresholds and pacemaker dependency are reviewed.

Description of Intra-Service Work: Verbal consent from patient to proceed. The patient is connected to a single or multi-lead free running ECG monitor. A communication link is obtained between the pacemaker and the programmer. The current rhythm is assessed and recorded, magnet mode response is assessed and recorded and an attempt to obtain and record the patient's underlying rhythm is performed with appropriate safety given to patients who are pacemaker dependent.

Detailed physician analysis is made of the following:

1. A full interrogation of the stored pacemaker data is obtained and reviewed for alert conditions.
2. The current interrogated measurements are compared to the extensive stored and trended data and is reviewed for device alerts in regard to battery and lead function including voltage, impedance and current. Additional measurements are made when necessary to assess the status of the insulation and conductors of the leads. The appropriate lead polarity for sensing and capture parameters are identified.
3. Stored summary and recorded rhythm information is reviewed for evidence of atrial fibrillation, PVCs and non sustained and sustained ventricular tachycardia. The appropriate rhythm alerts and recording parameters are identified.
4. Pacing capture threshold is measured in a single chamber by varying the voltage output and pulse width in a step-wise fashion to determine the appropriate safety margin for final device parameters and to optimize pacemaker device longevity. The appropriate voltage and pulse width parameters are identified.

5. Sensing threshold is measured by recording the signal from a single lead and chamber and by iterative (step-wise) adjustment of pacemaker sensing value to determine the appropriate sensing safety margin. The appropriate mode and threshold for sensing is identified
6. Heart rate adaptation to exercise or physiologic stress data is reviewed and adjusted in an iterative (step-wise) technique. Data considered to select the appropriate final programmed values include multiple heart rate histograms and trended activity levels, and when necessary in-office assessment through patient exercise activity to establish adequate heart rate response to exercise. The appropriate rate response parameters are identified.

After the detailed analysis of each of the above parameters, a decision is made about the adequacy of the initial programmed pacemaker parameters and any identified changes which need to be made to optimize the device performance relative to the patient's clinical condition. These device programming changes are made and any additional recommendations for further cardiac evaluation or treatment are given.

Description of Post-Service Work: Stability of the patient is assessed post device evaluation. The results of the device interrogation are discussed with the patient and programming changes to the device, if any, are explained in detail. Timing of the next device interrogation appointment is explained. A final report is prepared, reviewed by the attending physician, added as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Bruce Wilkoff, MD; Rich Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93279				
Sample Size:	273	Resp N:	42	Response: 15.3 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	22.50	100.00	175.00	1500.00
Survey RVW:	0.38	0.74	0.74	0.91	2.70
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	1.00	9.50	15.00	15.00	20.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.0	99291x	99292x		
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x	
Discharge Day Mgmt:	0.0	99238x	99239x		
Office time/visit(s):	0.0	99211x	12x	13x	14x 15x
Prolonged Services:	0.0	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	93279	Recommended Physician Work RVU: 0.74				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:		5.00	7.0	-2.0		
Pre-Service Positioning Time:		0.00	0.0	0.0		
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0		
Intra-Service Time:		10.00				
Immediate Post Service-Time:	5.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	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 0.0	99239x 0.0			
Office time/visit(s):	0.0	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93735	XXX	0.74	RUC Time

CPT Descriptor Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); with reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99202	XXX	0.88	RUC Time	2,552,204

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
76700	XXX	0.81	RUC Time	1,056,943

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; complete

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 33 % of respondents: 78.5 %

TIME ESTIMATES (Median)

	CPT Code: 93279	Key Reference CPT Code: 93735	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	25.00	
Median Immediate Post-service Time	5.00	8.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	20.00	38.00
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	3.26	3.21
--------------------------------------------------------------------------------------------------	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.37	3.37
--------------------------------------------------------------------------------------------------------------------------------	------	------

Urgency of medical decision making	3.32	3.26
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.21	3.26
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Physical effort required	2.05	2.11
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.27	3.26
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	3.63	3.58
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Estimated risk of malpractice suit with poor outcome	3.21	3.16
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INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.84	2.89
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Intra-Service intensity/complexity	3.32	3.37
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Post-Service intensity/complexity	2.89	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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93735

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 500000
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
 Please explain the rationale for this estimate.

Specialty Cardiology Frequency 450000 Percentage 90.00 %

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? 445,000
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Cardiology Frequency 400000 Percentage 89.88 %

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

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: 93280 Tracking Number L2

Specialty Society Recommended RVU: **0.92**

Global Period: XXX

RUC Recommended RVU: **0.77**

CPT Descriptor: Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead pacemaker system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70 year old male with acquired complete heart block had a dual chamber pacemaker (DDD) implanted five years ago. The patient calls his general cardiologist concerned about increasing "shortness of breath" and some "palpitations." The cardiologist orders a programming device evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: History is assessed for pacing indications and for changes in, or development of new, symptoms. Prior records of the implanted pacemaker and lead hardware and programmed parameters are reviewed. Prior assessments of capture thresholds, sensing thresholds and pacemaker dependency are reviewed.

Description of Intra-Service Work: Verbal consent from patient to proceed. The patient is connected to a single or multi-lead free running ECG monitor. A communication link is obtained between the pacemaker and the programmer. The current rhythm is assessed and recorded, magnet mode response is assessed and recorded and an attempt to obtain and record the patient's underlying rhythm is performed with appropriate safety given to patients who are pacemaker dependent.

Detailed physician analysis is made of the following:

1. A full interrogation of the stored pacemaker data is obtained and reviewed for alert conditions.
2. The current interrogated measurements are compared to the extensive stored and trended data and is reviewed for device alerts in regard to battery and lead function including voltage, impedance and current. Additional measurements are made when necessary to assess the status of the insulation and conductors of the leads. The appropriate lead polarity for sensing and capture parameters are identified.
3. Stored summary and recorded rhythm information is reviewed for evidence of atrial fibrillation, PVCs and non sustained and sustained ventricular tachycardia. The appropriate rhythm alerts and recording parameters are identified.
4. Pacing capture threshold is measured in a single chamber by varying the voltage output and pulse width in a step-wise fashion to determine the appropriate safety margin for final device parameters and to optimize pacemaker device longevity. The appropriate voltage and pulse width parameters are identified.
5. Sensing threshold is measured by recording the signal from a single lead and chamber and by iterative (step-wise) adjustment of pacemaker sensing value to determine the appropriate sensing safety margin. The appropriate mode and threshold for sensing is identified

6. Heart rate adaptation to exercise or physiologic stress data is reviewed and adjusted in an iterative (step-wise) technique. Data considered to select the appropriate final programmed values include multiple heart rate histograms and trended activity levels, and when necessary in-office assessment through patient exercise activity to establish adequate heart rate response to exercise. The appropriate rate response parameters are identified.

After the detailed analysis of each of the above parameters, a decision is made about the adequacy of the initial programmed pacemaker parameters and any identified changes which need to be made to optimize the device performance relative to the patient's clinical condition. These device programming changes are made and any additional recommendations for further cardiac evaluation or treatment are given.

Description of Post-Service Work: Stability of the patient is assessed post device evaluation. The results of the device interrogation are discussed with the patient and programming changes to the device, if any, are explained in detail. Timing of the next device interrogation appointment is explained. A final report is prepared, reviewed by the attending physician, addended as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93280				
Sample Size:	273	Resp N:	35	Response: 12.8 %	
Sample Type: Convenience					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	40.00	100.00	250.00	1500.00
Survey RVW:	0.45	0.92	0.92	1.05	4.00
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	1.00	9.50	15.00	15.00	20.00
Immediate Post Service-Time:	<u>7.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93280	Recommended Physician Work RVU: 0.92			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		5.00	7.0	-2.0	
Pre-Service Positioning Time:		0.00	0.0	0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0	
Intra-Service Time:		17.00			
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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 0.0	99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93732	XXX	0.92	RUC Time

CPT Descriptor Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); with reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99213	XXX	0.92	RUC Time	107,236,268

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 23 % of respondents: 65.7 %

TIME ESTIMATES (Median)

	CPT Code: 93280	Key Reference CPT Code: 93732	Source of Time RUC Time
Median Pre-Service Time	5.00	10.00	
Median Intra-Service Time	17.00	40.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	27.00	55.00
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	3.50	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.50
Urgency of medical decision making	3.05	3.05

Technical Skill/Physical Effort (Mean)

Technical skill required	3.40	3.40
Physical effort required	2.15	2.15

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.35	3.30
Outcome depends on the skill and judgment of physician	3.65	3.65
Estimated risk of malpractice suit with poor outcome	3.10	3.10

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	2.95
Intra-Service intensity/complexity	3.40	3.40
Post-Service intensity/complexity	2.90	2.90

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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93732

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 500000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology Frequency 450000 Percentage 90.00 %

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? 445,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Cardiology Frequency 400000 Percentage 89.88 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93281 Tracking Number L3

Specialty Society Recommended RVU: **1.09**

Global Period: XXX

RUC Recommended RVU: **0.90**

CPT Descriptor: Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; multiple lead pacemaker system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75 year old male with a nonischemic cardiomyopathy, LVEF of 35%, sinus rhythm and QRS duration of 160 ms had a biventricular pacemaker implanted for treatment of moderately severe heart failure symptoms. The patient returns for a programming device evaluation of his pacemaker and lead function one year since his last programming device evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? Yes Percent of survey respondents who stated it is typical in the office setting? 1%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: History is assessed for pacing indications and for changes in, or development of new, symptoms. Prior records of the implanted pacemaker and lead hardware and programmed parameters are reviewed. Prior assessments of capture thresholds, sensing thresholds and pacemaker dependency are reviewed.

Description of Intra-Service Work: Verbal consent from patient to proceed. The patient is connected to a single or multi-lead free running ECG monitor. A communication link is obtained between the pacemaker and the programmer. The current rhythm is assessed and recorded, magnet mode response is assessed and recorded and an attempt to obtain and record the patient's underlying rhythm is performed with appropriate safety given to patients who are pacemaker dependent.

Detailed physician analysis is made of the following:

1. A full interrogation of the stored pacemaker data is obtained and reviewed for alert conditions.
2. The current interrogated measurements are compared to the extensive stored and trended data and is reviewed for device alerts in regard to battery and lead function including voltage, impedance and current. Additional measurements are made when necessary to assess the status of the insulation and conductors of the leads. The appropriate lead polarity for sensing and capture parameters are identified. Appropriate sensing of chamber specific electrical activity and adjustment of pacemaker device parameters to accommodate for interim changes in patient's status.
3. Stored summary and recorded rhythm information is reviewed for evidence of atrial fibrillation, PVCs and non sustained and sustained ventricular tachycardia. The appropriate rhythm alerts and recording parameters are identified.
4. Pacing capture threshold is measured separately in three or more chambers (usually right atrium, right ventricle and left ventricle) by varying the voltage output and pulse width in a step-wise fashion to determine the appropriate safety margin for final device parameters and to optimize pacemaker device longevity. Care is taken to appropriately

identify the capture of the ventricular chamber of interest (right, left or both) to avoid incorrect conclusions about capture safety margins. The appropriate voltage and pulse width parameters are identified.

5. Sensing threshold is measured separately in both chambers (usually right atrium and right ventricle) by recording the signal from each lead and chamber and by iterative (step-wise) adjustment of pacemaker sensing value to determine the appropriate sensing safety margin. The appropriate mode and threshold for sensing is identified.

6. Influence of the stimulation of one chamber on the sensing and activation of the other chamber is evaluated for atrial to right and left ventricular, ventricular to atrial, right ventricle to left ventricle and left ventricle to right ventricle conduction, crosstalk sensing between the chambers and far field electrogram detection. The potential influence of these issues for permanent programming is identified.

7. An assessment of anodal right ventricular stimulation during left ventricular pacing and the presence or absence of phrenic nerve (diaphragmatic) stimulation in regard to pacing output and pacing polarity configuration. The potential influence of these issues for permanent programming is identified.

8. Iterative (step-wise) programming of AV interval timing, whether fixed or dynamic, and its influence on the percentage of ventricular pacing and hemodynamics or limitation of heart rate response is completed. The potential influence of these issues for permanent programming is identified.

9. Heart rate adaptation to exercise or physiologic stress data is reviewed and adjusted in an iterative (step-wise) technique. Data considered to select the appropriate final programmed values include multiple heart rate histograms and trended activity levels, and when necessary in-office assessment through patient exercise activity to establish adequate heart rate response to exercise. The appropriate rate response parameters are identified.

After the detailed analysis of each of the above parameters, a decision is made about the adequacy of the initial programmed pacemaker parameters and any identified changes which need to be made to optimize the device performance relative to the patient's clinical condition. These device programming changes are made and any additional recommendations for further cardiac evaluation or treatment are given.

Description of Post-Service Work: Stability of the patient is assessed post device evaluation. The results of the device interrogation are discussed with the patient and programming changes to the device, if any, are explained in detail. Timing of the next device interrogation appointment is explained. A final report is prepared, reviewed by the attending physician, added as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93281				
Sample Size:	273	Resp N:	38	Response: 13.9 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	16.25	45.00	78.75	1500.00
Survey RVW:	0.51	1.10	1.20	1.30	5.00
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	14.25	15.00	20.00	60.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.0	99291x	99292x		
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x	
Discharge Day Mgmt:	0.0	99238x	99239x		
Office time/visit(s):	0.0	99211x	12x	13x	14x 15x
Prolonged Services:	0.0	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93281	Recommended Physician Work RVU: 1.09			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		5.00	7.0	-2.0	
Pre-Service Positioning Time:		0.00	0.0	0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0	
Intra-Service Time:		20.00			
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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 0.0	99239x 0.0		
Office time/visit(s):	0.0°	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93732	XXX	0.92	RUC Time

CPT Descriptor Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); with reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99213	XXX	0.92	RUC Time	107,236,268

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 23 % of respondents: 65.7 %

TIME ESTIMATES (Median)

	CPT Code: 93281	Key Reference CPT Code: 93732	Source of Time RUC Time
Median Pre-Service Time	5.00	10.00	
Median Intra-Service Time	20.00	40.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	30.00	55.00
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	4.00	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.06	3.44
Urgency of medical decision making	3.31	3.06

Technical Skill/Physical Effort (Mean)

Technical skill required	3.43	3.38
Physical effort required	2.10	2.05

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.90	3.81
Outcome depends on the skill and judgment of physician	3.95	3.86
Estimated risk of malpractice suit with poor outcome	3.67	3.67

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.24	3.14
Intra-Service intensity/complexity	3.76	3.71
Post-Service intensity/complexity	3.43	3.33

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93732

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 60000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty Cardiology Frequency 57000 Percentage 95.00 %

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?

65,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Cardiology Frequency 63000 Percentage 96.92 %

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

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: 93282 Tracking Number L4

Specialty Society Recommended RVU: **0.91**

Global Period: XXX

RUC Recommended RVU: **0.85**

CPT Descriptor: Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; single lead implantable cardioverter defibrillator system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman with sinus rhythm and an ischemic cardiomyopathy with an LVEF of 30% had a single chamber implantable cardioverter defibrillator (VVI ICD) implanted. The patient tells her cardiologist that she “fainted” without palpitations, warning or feeling a shock. The cardiologist requests a programming device evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 72%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient history is assessed for ICD indications and for changes in, or development of, interval symptoms or clinical episodes of ventricular tachyarrhythmia. Prior arrhythmia history and previous programmed settings of the device are reviewed as well as interim remote assessments if available. Changes in antiarrhythmic medications since the last device evaluation are queried.

Description of Intra-Service Work: Verbal consent from the patient to proceed is obtained. The patient is connected to a single or multi-lead ECG recording system. A communication link is established between the device and the programmer.

Detailed physician analysis is made of the following:

1. A full interrogation of the stored device parameters is obtained.
2. The current rhythm is assessed and recorded.
3. Stored pacing and tachyarrhythmia episode data are retrieved and detailed physician analysis of these data is performed.
4. Stored summary and recorded rhythm data are reviewed.
5. Pacing capture threshold data and lead impedance are measured within the ventricular chamber.
6. Based on this information, the physician identifies any pacing or integrity issues with the existing lead and determines the appropriate pacing output settings.
7. Sensing threshold data are obtained by recording the signal from the ventricular chamber and utilizing iterative (stepwise) adjustment of ICD sensing level.
8. Based on this information, the physician identifies the appropriate ICD sensing settings.

9. An assessment of ventricular stimulation and the presence or absence of phrenic nerve (diaphragmatic) stimulation in regard to pacing output and pacing polarity configuration is made.

After the detailed analysis of the data a decision is made regarding the appropriateness of the initial programmed pacing and anti-tachycardia parameters and therapies relative to the patient's clinical status and, if indicated, alteration in the device's programming is performed at this time.

Description of Post-Service Work: Stability of the patient is assessed post device evaluation. The results of the device interrogation are discussed with the patient and programming changes to the device, if any, are explained in detail. Timing of the next device interrogation appointment is explained. A final report is prepared, reviewed by the attending physician, addended as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD					
Specialty(s):	Cardiology					
CPT Code:	93282					
Sample Size:	273	Resp N:	37	Response: 13.5 %		
Sample Type: Random						
	Low	25th pctl	Median*	75th pctl	High	
Service Performance Rate	0.00	27.50	100.00	275.00	1000.00	
Survey RVW:	0.55	0.85	0.91	1.06	3.00	
Pre-Service Evaluation Time:			8.0			
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:	2.00	10.00	15.00	20.00	30.00	
Immediate Post Service-Time:	<u>5.00</u>					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x			
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x		
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x			
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x	15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93282	Recommended Physician Work RVU: 0.91									
		Specialty Recommended Pre-Service Time		Specialty Recommended Pre Time Package		Adjustments to Pre-Service Time					
Pre-Service Evaluation Time:		8.00		7.0		1.0					
Pre-Service Positioning Time:		0.00		0.0		0.0					
Pre-Service Scrub, Dress, Wait Time:		0.00		0.0		0.0					
Intra-Service Time:		15.00									
Immediate Post Service-Time:	<u>5.00</u>										
Post Operative Visits	Total Min**	CPT Code and Number of Visits									
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	0.0	99239x	0.0						
Office time/visit(s):	<u>0.0</u>	99211x	0.0	12x	0.0	13x	0.0	14x	0.0	15x	0.0
Prolonged Services:	<u>0.0</u>	99354x	0.0	55x	0.0	56x	0.0	57x	0.0		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93742	XXX	0.91	RUC Time

CPT Descriptor Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber or wearable cardioverter-defibrillator system, with reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99213	XXX	0.92	RUC Time	107,236,268

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
	XXX	0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 28 % of respondents: 75.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 93282	<u>Key Reference CPT Code:</u> 93742	<u>Source of Time</u> RUC Time
Median Pre-Service Time	8.00	5.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	5.00	3.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	28.00	38.00
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	3.68	3.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.89	3.68
Urgency of medical decision making	3.63	3.47

Technical Skill/Physical Effort (Mean)

Technical skill required	3.25	3.13
Physical effort required	2.00	2.13

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.63	3.19
Outcome depends on the skill and judgment of physician	2.88	3.44
Estimated risk of malpractice suit with poor outcome	3.00	2.88

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.06	2.94
Intra-Service intensity/complexity	4.06	3.31
Post-Service intensity/complexity	3.00	2.81

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel was convened. After thorough review of the work survey results, the panel agreed to recommend the survey median of 0.91.

The panel took these steps in reaching their conclusion:

- 1) Reviewed the results of the survey
- 2) Compared the recommended RVW and total time to the reference service code 93742
- 3) Magnitude Estimation and Rank Order

Review of Survey Results

The panel felt the survey respondents underestimated the intra-service time at 15 minutes. It was discussed that a programming service for ICD would require at a minimum 30 minutes; 15 minutes more than the interrogation 93X11. The panel also felt that due to the number of codes requested for review, there was confusion among survey participants and request that an additional 15 minutes be added to the intra-service period.

Comparison of Recommended RVW

This new code 93XX4 - Programming device evaluation, single lead implantable cardioverter defibrillator system is a direct crosswalk to the existing CPT code 93742 - electronic analysis single chamber ICD or wearable defibrillator, with reprogramming. We recommend Median survey RVW was 0.91, which represents no change from current value. The devices are substantially more complex, systems are more intricate and more data is retrieved for review and comment from the newer generation devices.

Magnitude Estimation and Rank Order:

The specialty society agreed that median survey value places this code in correct rank order relative to the other 20 cardiac event monitoring codes; 93XX4 is the first programming code for the implantable cardioverter defibrillator system series. The expert panel reviewed the survey data and agreed that the survey median RVU for this code seems appropriate.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93742

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 75000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology Frequency 70000 Percentage 93.33 %

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? 52,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Cardiology Frequency 48000 Percentage 92.30 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93283 Tracking Number L5

Specialty Society Recommended RVU: **1.20**

Global Period: XXX

RUC Recommended RVU: **1.18**

CPT Descriptor: PProgramming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead implantable cardioverter defibrillator system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70 year old male with intermittent complete heart block had an implantable defibrillator with dual chamber pacemaker capacity (DDD ICD) implanted. The patient had an interrogation device evaluation (remote) that noted a marked elevation of shocking impedance. The ICD clinic contacted the patient to assess his current symptoms and to urge him to come to the ICD clinic for a programming device evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 70%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient history is assessed for ICD indications and for changes in, or development of, interval symptoms or clinical episodes of ventricular tachyarrhythmia. Prior arrhythmia history and previous programmed settings of the device are reviewed as well as interim remote assessments if available. Changes in antiarrhythmic medications since the last device evaluation are queried.

Description of Intra-Service Work: Verbal consent from the patient to proceed is obtained. The patient is connected to a single or multi-lead ECG recording system. A communication link is established between the device and the programmer.

Detailed physician analysis is made of the following:

1. A full interrogation of the stored device parameters is obtained.
2. The current rhythm is assessed and recorded to include the differentiation between the presence of an underlying native rhythm (if present).
3. Stored pacing and tachyarrhythmia episode data are retrieved and detailed physician analysis of these data is performed.
4. Stored summary and recorded rhythm data are reviewed for evidence of interval arrhythmias.
5. Pacing capture threshold data and lead impedance are measured separately in both chambers (usually the right atrium and ventricle).
6. Based on this information, the physician identifies any pacing or integrity issues within the existing leads and determines the appropriate pacing output settings (voltage, pulse width duration) individually for each chamber.
7. Sensing threshold data are obtained in each chamber by recording the signal from the atrial and the ventricular chambers individually.

8. Influence of the stimulation of one chamber on the sensing and activation of the other chambers (crosstalk) is evaluated.
9. An assessment of atrial and ventricular stimulation individually in each chamber to confirm the presence or absence of phrenic nerve (diaphragmatic) stimulation is made.
10. Iterative programming of the AV interval timing, whether fixed or dynamic, is completed.
11. Heart rate adaptation to exercise or physiologic stress data is reviewed and adjusted in an iterative fashion.
12. Based on this information, the physician identifies the appropriate ICD sensing settings to allow for appropriate sensing safety margins.

After the detailed analysis of the data a decision is made regarding the appropriateness of the initial programmed pacing and anti-tachycardia parameters and therapies relative to the patient's clinical status and, if indicated, alteration in the device's programming is performed at this time.

Description of Post-Service Work: Stability of the patient is assessed post device evaluation. The results of the device interrogation are discussed with the patient and programming changes to the device, if any, are explained in detail. Timing of the next device interrogation appointment is explained. A final report is prepared, reviewed by the attending physician, added as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93283				
Sample Size:	273	Resp N:	35	Response: 12.8 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	22.50	50.00	150.00	1000.00
Survey RVW:	0.60	1.18	1.20	1.25	4.50
Pre-Service Evaluation Time:			8.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	12.00	15.00	20.00	40.00
Immediate Post Service-Time:	<u>10.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	93283	Recommended Physician Work RVU: 1.20				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:		8.00	7.0	1.0		
Pre-Service Positioning Time:		0.00	0.0	0.0		
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0		
Intra-Service Time:		15.00				
Immediate Post Service-Time:	<u>10.00</u>					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
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 0.0	99239x 0.0			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93744	XXX	1.18	RUC Time

CPT Descriptor Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, with reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99213	XXX	0.92	RUC Time	107,236,268

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78494	XXX	1.19	RUC Time	6,551

CPT Descriptor 2 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 26 % of respondents: 74.2 %

TIME ESTIMATES (Median)

	CPT Code: 93283	Key Reference CPT Code: 93744	Source of Time RUC Time
Median Pre-Service Time	8.00	5.00	
Median Intra-Service Time	15.00	33.00	
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
Prolonged Services Time	0.0	0.00
Median Total Time	33.00	43.00
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	3.76	3.62
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	3.67
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Urgency of medical decision making	3.71	3.57
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.58	3.53
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Physical effort required	2.42	2.26
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.74	3.42
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	4.00	3.74
--------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	3.74	3.42
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INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.16	3.05
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Intra-Service intensity/complexity	3.63	3.47
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Post-Service intensity/complexity	3.21	3.05
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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 code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93744

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 225000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
 Please explain the rationale for this estimate.

Specialty Cardiology Frequency 215000 Percentage 93.33 %

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? 210,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 205000	Percentage 92.30 %
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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

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: 93284 Tracking Number L6

Specialty Society Recommended RVU: **1.39**

Global Period: XXX

RUC Recommended RVU: **1.25**

CPT Descriptor: Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; multiple lead implantable cardioverter defibrillator system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68 year old male with an ischemic cardiomyopathy, LVEF of 35%, NYHA FC III heart failure symptoms and a complete left bundle branch block had an ICD with biventricular pacemaker stimulation implanted. The patient returns to the ICD clinic for a programming device evaluation six months later because although the patient initially improved he is now feeling more "short of breath."

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient history is assessed for ICD indications and for changes in, or development of, interval symptoms or clinical episodes of ventricular tachyarrhythmia. Prior arrhythmia history and previous programmed settings of the device are reviewed as well as interim remote assessments if available. Changes in antiarrhythmic medications since the last device evaluation are queried.

Description of Intra-Service Work: Verbal consent from the patient to proceed is obtained. The patient is connected to a single or multi-lead ECG recording system. A communication link is established between the device and the programmer.

Detailed physician analysis is made of the following:

1. A full interrogation of the stored device parameters is obtained and reviewed.
2. The current rhythm is assessed and recorded to include the differentiation between the presence of an underlying native rhythm (if present) in each chamber.
3. Stored pacing and tachyarrhythmia episode data are retrieved and detailed physician analysis of these data is performed.
4. Stored summary and recorded rhythm data are reviewed for evidence of interval arrhythmias.
5. Pacing capture threshold data and lead impedance are measured separately in all chambers (usually the right atrium and ventricle and the left ventricle).
6. Based on this information, the physician identifies any pacing or integrity issues within the existing leads and determines the appropriate pacing output settings (voltage, pulse width duration) individually for each chamber.
7. Sensing threshold data are obtained in each chamber by recording the signal from atrial (sensed P waves) and ventricular (sensed R waves) activity, if present.

8. Influence of the stimulation of one chamber on the sensing and activation of the other chambers (crosstalk) is evaluated.
9. An assessment of atrial and ventricular stimulation individually in each chamber to confirm the presence or absence of phrenic nerve (diaphragmatic) stimulation in regard to pacing output and pacing polarity configuration is performed.
10. Iterative programming of the AV interval timing, whether fixed or dynamic, and its influence on the percentage of ventricular pacing and hemodynamics or limitation of heart rate response is completed.
11. Heart rate adaptation to exercise or physiologic stress data is reviewed and adjusted in an iterative fashion.

After the detailed analysis of the data a decision is made regarding the appropriateness of the initial programmed pacing and anti-tachycardia parameters and therapies relative to the patient's clinical status and, if indicated, alteration in the device's programming is performed at this time.

Description of Post-Service Work: Stability of the patient is assessed post device evaluation. The results of the device interrogation are discussed with the patient and programming changes to the device, if any, are explained in detail. Timing of the next device interrogation appointment is explained. A final report is prepared, reviewed by the attending physician, added as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93284				
Sample Size:	273	Resp N:	33	Response: 12.0 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	27.50	50.00	125.00	1000.00
Survey RVW:	0.70	1.25	1.35	1.50	3.00
Pre-Service Evaluation Time:			8.5		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	4.00	14.75	15.00	25.00	50.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.0	99291x	99292x		
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x	
Discharge Day Mgmt:	0.0	99238x	99239x		
Office time/visit(s):	0.0	99211x	12x	13x	14x 15x
Prolonged Services:	0.0	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	93284	Recommended Physician Work RVU: 1.39			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		8.50	7.0	1.5	
Pre-Service Positioning Time:		0.00	0.0	0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0	
Intra-Service Time:		15.00			
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.0	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 0.0	99239x 0.0		
Office time/visit(s):	0.0	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93744	XXX	1.18	RUC Time

CPT Descriptor Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, with reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99214	XXX	1.42	RUC Time	62,901,327

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A 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>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78494	XXX	1.19	RUC Time	6,551

CPT Descriptor 2 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 21 % of respondents: 63.6 %

TIME ESTIMATES (Median)

	CPT Code: 93284	Key Reference CPT Code: 93744	Source of Time RUC Time
Median Pre-Service Time	8.50	5.00	
Median Intra-Service Time	15.00	33.00	
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
Prolonged Services Time	0.0	0.00
Median Total Time	33.50	43.00
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	4.30	3.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.35	3.70
Urgency of medical decision making	3.80	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.75	3.40
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Physical effort required	2.25	2.20
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.10	3.65
Outcome depends on the skill and judgment of physician	4.35	3.85
Estimated risk of malpractice suit with poor outcome	3.70	3.60

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.50	3.30
Intra-Service intensity/complexity	4.30	3.70
Post-Service intensity/complexity	3.65	3.25

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93744

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

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.
Please explain the rationale for this estimate.

Specialty Cardiology Frequency 18000 Percentage 90.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 25,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 23000	Percentage 92.00 %
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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

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: 93285 Tracking Number L7

Specialty Society Recommended RVU: **0.60**

Global Period: XXX

RUC Recommended RVU: **0.52**

CPT Descriptor: Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; implantable loop recorder system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52 year old male with coronary artery disease and diabetes who received an ILR implant two months ago presents for in-office device evaluation of near syncope and palpitations and adjustment of his rhythm detection parameters with a programming device evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The history is assessed for cardiac rhythm monitoring indications and for changes in, or the development of new symptoms. Prior records of the ILR, lead hardware, if present, and programmed parameters are reviewed. The results of prior ILR interrogations are reviewed.

Description of Intra-Service Work: Verbal consent from the patient to proceed is obtained A communication link is created between the ILR and the programmer. Programmed parameters are obtained. Stored ILR data is obtained and downloaded for physician review

Detailed physician analysis is made of the following:

1. A full interrogation of the stored ILR data is obtained and reviewed for alert conditions.
2. The current interrogated measurements are compared to the extensive stored and trended data and are reviewed for device alerts in regard to battery function, including voltage and impedance.
3. An assessment of the underlying signal strength is made. Sensing threshold is measured by recording the signal from the ILR and by iterative (step-wise) adjustment of the sensing value to determine the appropriate sensing safety margin. The appropriate threshold for sensing is identified. The sensing and gain parameters are programmed as appropriate to insure optimal device sensing.
4. Patient-activated recorded rhythm episodes are reviewed for evidence of tachycardia, bradycardia and cardiac rhythm pauses. Specific rhythm waveforms are downloaded and reviewed for atrial fibrillation, PACs, SVT, PVCs, non sustained ventricular tachycardia, sustained ventricular tachycardia, sinus pauses, evidence of cardiac AV block, and recording system artifact. The appropriate rhythm alerts and recording parameters are identified.
5. Automatically recorded rhythm episodes (based on previously programmed detection parameters) are reviewed for evidence of tachycardia, bradycardia and cardiac rhythm pauses. Specific rhythm waveforms are downloaded and reviewed for atrial fibrillation, PACs, SVT, PVCs, non sustained ventricular tachycardia, sustained ventricular

tachycardia, sinus pauses, evidence of cardiac AV block, and recording system artifact. The appropriate rhythm alerts and recording parameters are identified.

6. Parameters describing the criteria for automatic rhythm detection are reviewed for appropriateness and programmed for optimal rhythm detection.

7. Parameters describing the device memory capacity and the recording capacity of the number of patient-activated, and automatically detected episodes are reviewed. The amount of pre and post detection electrocardiographic recording time is assessed. Programmed changes to these values are made as appropriate to optimize ILR recording function.

After the detailed analysis of each of the above parameters, a decision is made about the adequacy of the initial programmed ILR parameters and any identified changes which need to be made to optimize the device performance relative to the patient's clinical condition. These device programming changes are made and any additional recommendations for further cardiac evaluation or treatment are given.

Description of Post-Service Work: The results of the device interrogation are discussed with the patient and programming changes to the device, if any, are explained in detail. Timing of the next device interrogation appointment is explained. A final report is prepared, reviewed by the attending physician, added as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93285				
Sample Size:	273	Resp N:	34	Response: 12.4 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	10.00	24.00	200.00
Survey RVW:	0.15	0.52	0.60	0.77	6.00
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	8.00	12.00	15.00	20.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	93285	Recommended Physician Work RVU: 0.60				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:		5.00	7.0	-2.0		
Pre-Service Positioning Time:		0.00	0.0	0.0		
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0		
Intra-Service Time:		12.00				
Immediate Post Service-Time:	<u>5.00</u>					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
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 0.0	99239x 0.0			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93727	XXX	0.52	RUC Time

CPT Descriptor Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78478	XXX	0.50	RUC Time	2,976,030

CPT Descriptor 1 Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
			RUC Time	

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 23 % of respondents: 67.6 %

TIME ESTIMATES (Median)

	CPT Code: 93285	Key Reference CPT Code: 93727	Source of Time RUC Time
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	12.00	20.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	22.00	20.00	
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	3.00	2.95
--------------------------------------------------------------------------------------------------	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.00
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Urgency of medical decision making	2.70	2.70
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.00	2.85
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Physical effort required	1.80	1.80
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.85	2.85
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	3.25	3.15
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Estimated risk of malpractice suit with poor outcome	2.65	2.65
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INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.65	2.55
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Intra-Service intensity/complexity	3.10	2.80
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Post-Service intensity/complexity	2.70	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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93727

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 12000	Percentage 80.00 %
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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? 12,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 11000	Percentage 91.66 %
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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

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: 93286 Tracking Number L8

Specialty Society Recommended RVU: **0.60**

Global Period: XXX

RUC Recommended RVU: **0.30**

CPT Descriptor: Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead pacemaker system.

(Use once before and once after surgery, procedure, or test, when device evaluation and programming performed before and after surgery, procedure or test)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman with chronic atrial fibrillation and complete heart block had a single chamber, rate adaptive, ventricular pacemaker (VVIR) implanted. The patient requires a contralateral breast mastectomy, with electrosurgical cautery. To avoid pacemaker induced heart rate increases or inhibition during the surgery, the surgeon requests evaluation and programming of the pacemaker sensor and settings to prepare the patient for the surgery. After the surgery the surgeon requests a reevaluation of the pacemaker system with appropriate adjustment of the device to permit full activity of the patient.

Percentage of Survey Respondents who found Vignette to be Typical: 65%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: History is reviewed to confirm patient's planned procedure, tests or surgery. Records are reviewed to identify the manufacturer and model of the pacemaker and lead or leads. Prior records of the implanted pacemaker and lead hardware and programmed parameters are reviewed. Prior assessments of capture thresholds, sensing thresholds and pacemaker dependency are reviewed. A determination is made if the device had been recently assessed with a programming evaluation adequate to provide confidence that the pacemaker system is functioning adequately or if a programming evaluation is require

Description of Intra-Service Work: part I - Prior to intervention (test, surgery): Verbal consent from patient to proceed.

A communication link is obtained between the pacemaker and the programmer. The doctor specified parameter(s) is changed and device reinterrogation completed to confirm programming. The stability of the patient is assessed after the pre-procedural (test, surgery) programming. The patient is informed about temporary changes which have been made and the expected timing of post procedure (test, surgery) restoration to baseline settings. An initial note is placed in the patient's chart documenting the temporary changes.

Intra-procedure, part II - After intervention (test, surgery): Interim history is obtained and the appropriateness of returning the pacemaker to the original programmed settings is determined. Verbal consent form the patient to proceed.

A communication link is obtained between the pacemaker and the programmer. The doctor specified parameter(s) is changed and device reinterrogation completed to confirm programming. The stability of the patient is assessed after the post-procedural (test, surgery) programming. The patient is informed about the permanent changes (restoration of

programming) which have been made and the expected timing of their next pacemaker evaluation. A second note is placed in the patient's chart documenting the changes.

Description of Post-Service Work: A final report, summarizing the findings and changes is created. Physician approval and sign-off is completed. The final summary report is placed in the patient's chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93286				
Sample Size:	273	Resp N:	36	Response: 13.1 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	25.00	62.50	300.00
Survey RVW:	0.17	0.65	0.80	1.14	3.50
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	8.75	12.00	15.00	30.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.0	99291x	99292x		
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x	
Discharge Day Mgmt:	0.0	99238x	99239x		
Office time/visit(s):	0.0	99211x	12x	13x	14x 15x
Prolonged Services:	0.0	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93286	Recommended Physician Work RVU: 0.60				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:		5.00	7.0	-2.0		
Pre-Service Positioning Time:		0.00	0.0	0.0		
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0		
Intra-Service Time:		12.00				
Immediate Post Service-Time:	5.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
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 0.0	99239x 0.0			
Office time/visit(s):	0.0	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93735	XXX	0.74	RUC Time

CPT Descriptor Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); with reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		0

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 23 % of respondents: 63.8 %

TIME ESTIMATES (Median)

	CPT Code: 93286	Key Reference CPT Code: 93735	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	12.00	25.00	
Median Immediate Post-service Time	5.00	8.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	22.00	38.00	
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	3.20	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.30	3.10
Urgency of medical decision making	3.30	3.10

Technical Skill/Physical Effort (Mean)

Technical skill required	3.40	3.30
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Physical effort required	2.60	2.30
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.90
Outcome depends on the skill and judgment of physician	3.30	3.30
Estimated risk of malpractice suit with poor outcome	3.20	3.10

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.20	2.90
Intra-Service intensity/complexity	3.40	3.20
Post-Service intensity/complexity	2.90	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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) n/a

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Consensus Panel

Specialty Cardiology Frequency 9000 Percentage 80.00 %

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?
8,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Consensus Panel

Specialty Cardiology Frequency 9000 Percentage 91.66 %

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. 33508

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: 93287 Tracking Number L9

Specialty Society Recommended RVU: **0.90**

Global Period: XXX

RUC Recommended RVU: **0.45**

CPT Descriptor: Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead implantable cardioverter defibrillator system.

(Use once before and once after surgery, procedure, or test, when device evaluation and programming performed before and after surgery, procedure or test)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year old woman with chronic atrial fibrillation and complete heart block had a single chamber ICD with rate adaptive ventricular pacemaker function (VVIR ICD) implanted. The patient requires an abdominal aortic aneurysm surgery. To avoid ICD shocks during the surgery related to electrosurgical cautery and manipulation, the surgeon requests evaluation and programming of the ICD to prepare the patient for the surgery. After the surgery the surgeon requests a reevaluation of the ICD system in the intensive care unit with appropriate adjustment of the device to permit full protection of the patient from bradycardia and tachycardia events.

The reevaluation is reported separately from the initial evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 60%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: History is reviewed to confirm the patient's planned procedure, test or surgery. Records are reviewed to identify the manufacturer and model of the ICD generator and lead(s). Prior records of the implanted ICD generator and lead hardware and the programmed parameters as well as the presence or absence of pacemaker dependence are reviewed. Prior assessments of capture thresholds, sensing thresholds, and arrhythmia therapies (if any) are reviewed. A determination is made if the device has been evaluated recently such that adequate confidence as to the function of the device can be determined. The patient's arrhythmia history including any recent clinical events is reviewed. The planned procedure is discussed with the operating physician to review any concerns regarding the patient's arrhythmia status and to determine the exact nature of the procedure including the use of electrocautery.

Description of Intra-Service Work: part I - Prior to intervention (test, surgery): Verbal consent from the patient to proceed is obtained. A communication link is established between the device and the programmer. Doctor specified changes in the device's programmed pacing and anti-tachycardia parameters based upon the pre-procedural evaluation are performed and the device reinterrogated to confirm programming changes. The changes made to the device including expected timing of post-procedure restoration or reprogramming of settings are explained to the patient. An initial report is placed in the patient's chart documenting the device issues and the changes made prior to the procedure.

Intra-procedure, part II - After intervention (test, surgery): Stability of the patient is assessed. Interim history is obtained and the appropriateness of returning the device to its original settings is determined. Verbal consent is obtained from the patient to proceed. A communication link is established between the ICD and the programmer. Physician specified changes in the device programming are made and the device interrogated to confirm programming. Stability of the patient is assessed. The patient is informed of any changes or restoration of the original programmed settings. A second report is placed in the patient's chart.

Description of Post-Service Work: A final report is prepared, reviewed by the attending physician, addended as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician. The final report is considered to encompass all of the evaluation described above and is submitted as a single physician entry (charge).

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD					
Specialty(s):	Cardiology					
CPT Code:	93287					
Sample Size:	273	Resp N:	32	Response: 11.7 %		
Sample Type: Random						
	Low	25th pctl	Median*	75th pctl	High	
Service Performance Rate	0.00	10.00	25.00	100.00	1000.00	
Survey RVW:	0.52	0.88	1.13	1.21	2.70	
Pre-Service Evaluation Time:			7.5			
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:	3.00	10.00	13.50	16.25	30.00	
Immediate Post Service-Time:	5.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x	99292x			
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x		
Discharge Day Mgmt:	0.0	99238x	99239x			
Office time/visit(s):	0.0	99211x	12x	13x	14x	15x
Prolonged Services:	0.0	99354x	55x	56x	57x	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93287	Recommended Physician Work RVU: 0.90				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:		7.50	7.0	0.5		
Pre-Service Positioning Time:		0.00	0.0	0.0		
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0		
Intra-Service Time:		13.50				
Immediate Post Service-Time:	5.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
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 0.0	99239x 0.0			
Office time/visit(s):	0.0	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93744	XXX	1.18	RUC Time

CPT Descriptor Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, with reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99213	XXX	0.92	RUC Time	107,236,268

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 56.2 %

TIME ESTIMATES (Median)

	CPT Code: 93287	Key Reference CPT Code: 93744	Source of Time RUC Time
Median Pre-Service Time	7.50	5.00	
Median Intra-Service Time	13.50	33.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	26.00	43.00
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	3.64	3.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.91
Urgency of medical decision making	3.36	3.73

Technical Skill/Physical Effort (Mean)

Technical skill required	3.64	3.64
Physical effort required	2.73	2.36
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.18	3.91
Outcome depends on the skill and judgment of physician	4.00	4.09
Estimated risk of malpractice suit with poor outcome	4.09	3.55

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.64	3.45
Intra-Service intensity/complexity	3.73	3.82
Post-Service intensity/complexity	3.27	3.27

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) n/a

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 14000 Percentage 93.33 %

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? 12,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology	Frequency 11000	Percentage 91.66 %
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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

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. 93731

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: 93288 Tracking Number L10

Specialty Society Recommended RVU: **0.65**

Global Period: XXX

RUC Recommended RVU: **0.43**

CPT Descriptor: Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead pacemaker system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74 year old patient with a pacemaker for sick sinus syndrome and CHF is followed with interrogation device evaluations (in person) for lightheadedness and dyspnea.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient records are reviewed to identify the indication for pacemaker therapy, manufacturer and model of the implanted pacemaker and leads, history of pacemaker dependency, atrial and ventricular arrhythmias. Prior records of pacing parameters are reviewed and compared to prior remote and in person interrogations.

Description of Intra-Service Work: The information is interrogated from the pacemaker by telemetric communication and either printed for review or reviewed on the programmer or computer monitor. Critical review of the interrogated data with assessment of the appropriateness of the function of pacemaker, safety of the current programmed parameters and to assess if the device function is normal. Data reviewed includes:

1. Presenting EGM for appropriateness or presence of arrhythmia and appropriate sensing and capture.
2. Stored episodes of data are reviewed for appropriate sensing, capture, appropriate magnet reversion and noise reversions.
3. Alerts generated from the pacemaker device.
4. Battery voltage and impedance, pacing lead impedance and sensed electrogram voltage amplitude for each lead.
5. Counters of paced and sensed events from each chamber for which there are leads located.
6. Stored episodes of sensed events including arrhythmias, ectopic beats, nonsustained and sustained atrial and ventricular arrhythmias and when appropriate, mode switch episodes. The frequency, rate and duration are noted.
7. Heart rate response during activities, rate histograms and indicators of patient activity level.

Description of Post-Service Work: A final report is prepared, reviewed by the attending physician, addended as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93288				
Sample Size:	273	Resp N:	37	Response: 13.5 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	25.00	62.50	300.00
Survey RVW:	0.40	0.50	0.75	0.95	2.00
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	8.75	10.00	15.00	30.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93288	Recommended Physician Work RVU: 0.65			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		5.00	7.0	-2.0	
Pre-Service Positioning Time:		0.00	0.0	0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0	
Intra-Service Time:		10.00			
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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 0.0	99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93731	XXX	0.45	RUC Time

CPT Descriptor Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.45	RUC Time	23,277,464

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 21 % of respondents: 56.7 %

TIME ESTIMATES (Median)

	CPT Code: 93288	Key Reference CPT Code: 93731	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	20.00	25.00
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	2.03	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.21	3.00
Urgency of medical decision making	2.57	2.36

Technical Skill/Physical Effort (Mean)

Technical skill required	3.14	2.93
Physical effort required	1.71	1.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.57	2.36
Outcome depends on the skill and judgment of physician	3.29	3.14
Estimated risk of malpractice suit with poor outcome	2.93	2.71

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.57	2.43
Intra-Service intensity/complexity	2.86	2.64
Post-Service intensity/complexity	2.57	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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93731

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 900000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 850000 Percentage 94.44 %

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? 830,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology	Frequency 800000	Percentage 96.38 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes



Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93289 Tracking Number L11

Specialty Society Recommended RVU: **1.03**

Global Period: XXX

RUC Recommended RVU: **0.92**

CPT Descriptor: Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead pacemaker system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74 year old patient with a pacemaker for sick sinus syndrome and CHF is followed with interrogation device evaluations (in person) for lightheadedness and dyspnea.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient records are reviewed to identify the indication for pacemaker therapy, manufacturer and model of the implanted pacemaker and leads, history of pacemaker dependency, atrial and ventricular arrhythmias. Prior records of pacing parameters are reviewed and compared to prior remote and in person interrogations.

Description of Intra-Service Work: The information is interrogated from the pacemaker by telemetric communication and either printed for review or reviewed on the programmer or computer monitor. Critical review of the interrogated data with assessment of the appropriateness of the function of pacemaker, safety of the current programmed parameters and to assess if the device function is normal. Data reviewed includes:

1. Presenting EGM for appropriateness or presence of arrhythmia and appropriate sensing and capture.
2. Stored episodes of data are reviewed for appropriate sensing, capture, appropriate magnet reversion and noise reversions.
3. Alerts generated from the pacemaker device.
4. Battery voltage and impedance, pacing lead impedance and sensed electrogram voltage amplitude for each lead.
5. Counters of paced and sensed events from each chamber for which there are leads located.
6. Stored episodes of sensed events including arrhythmias, ectopic beats, nonsustained and sustained atrial and ventricular arrhythmias and when appropriate, mode switch episodes. The frequency, rate and duration are noted.
7. Heart rate response during activities, rate histograms and indicators of patient activity level.

Description of Post-Service Work: A final report is prepared, reviewed by the attending physician, addended as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD					
Specialty(s):	Cardiology					
CPT Code:	93289					
Sample Size:	273	Resp N:	37	Response: 13.5 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		50.00	250.00	300.00	500.00	2000.00
Survey RVW:		0.70	1.03	1.20	1.45	3.25
Pre-Service Evaluation Time:				5.0		
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:		2.00	10.00	15.00	25.00	30.00
Immediate Post Service-Time:	5.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x	99292x			
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x		
Discharge Day Mgmt:	0.0	99238x	99239x			
Office time/visit(s):	0.0	99211x	12x	13x	14x	15x
Prolonged Services:	0.0	99354x	55x	56x	57x	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	93289	Recommended Physician Work RVU: 1.03				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package		Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		5.00	7.0		-2.0	
Pre-Service Positioning Time:		0.00	0.0		0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0		0.0	
Intra-Service Time:		15.00				
Immediate Post Service-Time:	5.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	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 0.0 99239x 0.0				
Office time/visit(s):	0.0	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0	
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93744	XXX	1.18	RUC Time

CPT Descriptor Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, with reprogrammingg

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.45	RUC Time	23,277,464

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 21 % of respondents: 56.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 93289	<u>Key Reference CPT Code:</u> 93744	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	15.00	33.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	25.00	43.00
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	4.65	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.67	4.44
Urgency of medical decision making	4.22	4.20

Technical Skill/Physical Effort (Mean)

Technical skill required	3.67	3.56
Physical effort required	2.78	2.67
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.33	4.22
Outcome depends on the skill and judgment of physician	4.56	4.44
Estimated risk of malpractice suit with poor outcome	4.11	4.11

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.78	3.78
Intra-Service intensity/complexity	4.33	4.11
Post-Service intensity/complexity	4.00	3.89

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 code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93743

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 700000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 640000 Percentage 91.42 %

Specialty Internal Medicine Frequency 20000 Percentage 2.85 %

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? 600,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology	Frequency 550000	Percentage 91.66 %
Specialty Internal Medicine	Frequency 30000	Percentage 5.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93290 Tracking Number L12

Specialty Society Recommended RVU: **0.65**

Global Period: XXX

RUC Recommended RVU: **0.43**

CPT Descriptor: Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58 year old patient with prior MI, VT and CHF had an implantable cardioverter defibrillator system that monitors physiologic cardiovascular data in addition to the heart rhythm implanted. The patient has ongoing dyspnea, orthopnea and peripheral edema and is evaluated in the heart failure clinic with interrogation device evaluations (in person).

Percentage of Survey Respondents who found Vignette to be Typical: 77%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient records are reviewed to identify the indication for ICM monitoring and therapy, manufacturer and model of the ICM, leads and sensors (both internal and external) as appropriate. Prior records of ICM parameters are reviewed and compared to prior remote and in person interrogations.

Description of Intra-Service Work: The information is interrogated from the ICM by telemetric communication and either printed for review or reviewed on the programmer or computer monitor. Critical review of the interrogated data with the assessment of the appropriateness of the function of the ICM and appropriateness of the current programmed parameters is performed.

Data reviewed may include, but are not limited to, (1) weight, (2) systemic blood pressure, (3) right atrial, right ventricular, left atrial, left ventricular, pulmonary arterial pressures, (4) intra-thoracic impedance measurements (5) other measures of physiologic parameters.

Additionally, stored episodes of data are reviewed to assess the history and trends identified by any of the collected data. Further, alerts generated from the ICM are reviewed along with battery voltage and sensor information to validate the integrity of the ICM system

Description of Post-Service Work: After physician review of above data a decision is made as to the adequacy of the programmed parameters including the appropriate data collection setup and the interval for the next scheduled interrogation evaluation. Modifications to the patient's medical regimen are made as appropriate. The patient is informed of the test result. A final report is prepared, reviewed by the attending physician, addended as necessary,

approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93290				
Sample Size:	273	Resp N:	31	Response: 11.3 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	18.75	50.00	120.00	250.00
Survey RVW:	0.40	0.65	1.25	1.50	4.50
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	10.00	12.00	20.00	40.00
Immediate Post Service-Time:	<u>8.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93290	Recommended Physician Work RVU: 0.65		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	7.0	-2.0
Pre-Service Positioning Time:		0.00	0.0	0.0
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0
Intra-Service Time:		12.00		
Immediate Post Service-Time:	<u>8.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
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 0.0	99239x 0.0	
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0 57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93727	XXX	0.52	RUC Time

CPT Descriptor Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00	RUC Time	0

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 15 % of respondents: 48.3 %

TIME ESTIMATES (Median)

	CPT Code: 93290	Key Reference CPT Code: 93727	Source of Time RUC Time
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	12.00	20.00	
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	
Prolonged Services Time	0.0	0.00	
Median Total Time	25.00	20.00	
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	3.33	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.33
Urgency of medical decision making	3.17	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.50	2.33
Physical effort required	1.83	1.83
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	3.00	2.83
Outcome depends on the skill and judgment of physician	3.50	3.33
Estimated risk of malpractice suit with poor outcome	3.00	2.83

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.83	2.67
Intra-Service intensity/complexity	3.17	3.17
Post-Service intensity/complexity	3.00	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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) n/a

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 13000 Percentage 86.66 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 9000 Percentage 90.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93291 Tracking Number L13

Specialty Society Recommended RVU: **0.52**

Global Period: XXX

RUC Recommended RVU: **0.43**

CPT Descriptor: Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm data derived analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 41 year old patient receives an implantable loop recorder (ILR) for recurrent syncopal spells. The patient has a syncopal episode resulting in a laceration to the head. The patient comes in for an interrogation device evaluation (in person).

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: History is assessed for cardiac rhythm monitoring indications and for changes in, or development of new symptoms. Prior records of the ILR, lead hardware, if present, and programmed parameters are reviewed. The results of prior ILR interrogations are reviewed.

Description of Intra-Service Work: Verbal consent from the patient to proceed is obtained A communication link is created between the ILR and the programmer. Programmed parameters are obtained. Stored ILR data is obtained and downloaded for physician review

Detailed physician analysis is made of the following:

- 1 A full interrogation of the stored ILR data is obtained and reviewed for alert conditions.
- 2 The current interrogated measurements are compared to the extensive stored and trended data and are reviewed for device alerts in regard to battery function, including voltage and impedance.
- 3 An assessment of the underlying signal strength is made. If sensing is inadequate, instructions are given to the patient for further follow-up and potential reprogramming
- 4 Patient-activated recorded rhythm episodes are reviewed for evidence of tachycardia, bradycardia and cardiac rhythm pauses. Specific rhythm waveforms are downloaded and reviewed for atrial fibrillation, PACs, SVT, PVCs, non sustained ventricular tachycardia, sustained ventricular tachycardia, sinus pauses, evidence of cardiac AV block, and recording system artifact. The appropriate rhythm alerts and recording parameters are identified.
- 5 Automatically recorded rhythm episodes (based on previously programmed detection parameters) are reviewed for evidence of tachycardia, bradycardia and cardiac rhythm pauses. Specific rhythm waveforms are downloaded and reviewed for atrial fibrillation, PACs, SVT, PVCs, non sustained ventricular tachycardia, sustained ventricular tachycardia, sinus pauses, evidence of cardiac AV block, and recording system artifact. The appropriate rhythm alerts and recording parameters are identified.

- 6 Parameters describing the criteria for automatic rhythm detect are reviewed for appropriateness.
- 7 Parameters describing the device memory capacity and the recording capacity of the number of patient-activated, and automatically detected episodes are reviewed. The amount of pre and post detection electrocardiographic recording time is assessed.

After the detailed analysis of each of the above parameters, recommendations for further cardiac evaluation or treatment are given.

Description of Post-Service Work: A final report is prepared, reviewed by the attending physician, addended as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93291				
Sample Size:	273	Resp N:	38	Response: 13.9 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	875.00	17.50	32.50	400.00
Survey RVW:	0.40	0.52	0.60	0.76	2.05
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	1.00	10.00	12.00	15.00	30.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	93291	Recommended Physician Work RVU: 0.52			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		5.00	7.0	-2.0	
Pre-Service Positioning Time:		0.00	0.0	0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0	
Intra-Service Time:		12.00			
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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 0.0	99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93727	XXX	0.52	RUC Time

CPT Descriptor Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00	RUC Time	0

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 15 % of respondents: 48.3 %

TIME ESTIMATES (Median)

	CPT Code: 93291	Key Reference CPT Code: 93727	Source of Time RUC Time
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	12.00	20.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	22.00	20.00	
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	3.14	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.18
Urgency of medical decision making	3.05	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.86	2.91
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Physical effort required	1.86	1.82
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.82	2.73
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Outcome depends on the skill and judgment of physician	3.41	3.36
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Estimated risk of malpractice suit with poor outcome	3.14	3.05
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INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.45	2.45
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	2.68	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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93727

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology	Frequency 12000	Percentage 80.00 %
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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? 10,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology	Frequency 8500	Percentage 85.00 %
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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

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: 93292 Tracking Number L14

Specialty Society Recommended RVU: **0.75**

Global Period: XXX

RUC Recommended RVU: **0.43**

CPT Descriptor: Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year old patient with history of sustained VT treated with an ICD required ICD and lead extraction and IV antibiotics for three months because of a bacterial infection with intracardiac vegetations before an ICD can be reimplanted. The patient returns one month later with her wearable cardioverter defibrillator (WCD) for interrogation device evaluation (in person).

Percentage of Survey Respondents who found Vignette to be Typical: 72 %

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0 %

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0 %

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient records are reviewed to identify the indication for waerable monitoring and therapy, manufacturer and model of the wearable. Prior records of wearable parameters are reviewed and compared to prior remote and in person interrogations.

Description of Intra-Service Work: The information is interrogated from the wearable device by telemetric communication and either printed for review or reviewed on the programmer or computer monitor. Critical review of the interrogated data with the assessment of the appropriateness of the function of the wearable device and appropriateness of the current programmed parameters is performed.

Data reviewed may include, but are not limited to:

1. Presenting electrograms.
2. Stored episodes of data.
3. Alerts generated from the device.
4. Battery voltage and impedance, pacing and shocking lead impedance and sensed electrogram voltage amplitude.
5. Histogram and/or counters of paced and sensed events from each chamber.
6. Stored episodes of sensed arrhythmia events including the type, frequency, rate and duration are noted.

Heart rate response during activities, rate histograms and indicators of patient activity level are evaluated. A rhythm strip is recorded for 30 seconds and evaluated for heart rate and capture and sensing of each of the leads and for atrial or ventricular arrhythmias. A second rhythm strip may be recorded with a magnet located over the device and evaluated for capture and sensing of each of the leads, for atrial or ventricular arrhythmias and for the magnet response including paced rate. Physician review of above data produces an assessment of the adequacy of each lead's sensing and capture and of battery function. Additionally, stored episodes of data are reviewed to assess the history and trends identified by any of the collected data.

Description of Post-Service Work: parameters including the appropriate data collection setup and the interval for the next scheduled interrogation evaluation. Modifications to the patient's medical regimen are made as appropriate. The patient is informed of the test result. A final report is prepared, reviewed by the attending physician, addended as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Kevin Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93292				
Sample Size:	273	Resp N:	32	Response: 11.7 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	1.00	7.50	50.00
Survey RVW:	0.36	0.75	0.80	1.05	7.00
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	10.00	10.00	16.50	35.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93292	Recommended Physician Work RVU: 0.75			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		5.00	7.0	-2.0	
Pre-Service Positioning Time:		0.00	0.0	0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0	
Intra-Service Time:		10.00			
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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 0.0	99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93741	XXX	0.80	RUC Time

CPT Descriptor Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber or wearable cardioverter-defibrillator system, without reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00	RUC Time	0

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 19 % of respondents: 59.3 %

TIME ESTIMATES (Median)

	CPT Code: 93292	Key Reference CPT Code: 93741	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	23.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	20.00	33.00	

Other time if appropriate		0.00
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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	3.21	3.21
--------------------------------------------------------------------------------------------------	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.14	3.29
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Urgency of medical decision making	2.93	2.86
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.64	2.64
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Physical effort required	1.64	1.71
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.93
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	3.21	3.14
--------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	3.14	3.14
------------------------------------------------------	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.86	2.86
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Intra-Service intensity/complexity	3.00	3.07
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Post-Service intensity/complexity	2.86	2.86
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Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an 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 code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93741

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 4000 Percentage 80.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
3,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 2500 Percentage 83.33 %

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. 93731

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: 93293 Tracking Number L15

Specialty Society Recommended RVU: **0.25**

Global Period: XXX

RUC Recommended RVU: **0.32**

CPT Descriptor: Transtelephonic rhythm strip pacemaker evaluation(s) single, dual or multiple lead pacemaker, includes recording with and without magnet application with report(s) up to 90 days

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 69 year old patient with complete heart block has a 6 year old dual chamber pacemaker which is being monitored for battery depletion with transtelephonic rhythm strip pacemaker evaluations.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient records are reviewed to identify the indication for pacemaker therapy, manufacturer and model of the implanted pacemaker and leads, history of pacemaker dependency, atrial and ventricular arrhythmias. Prior records of pacing parameters are reviewed and compared to prior remote and in person interrogations.

Description of Intra-Service Work: TA rhythm strip is recorded for 30 seconds and evaluated for heart rate and capture and sensing of each of the leads and for atrial or ventricular arrhythmias. A second rhythm strip is recorded with a magnet located over the pacemaker and evaluated for capture and sensing of each of the leads, for atrial or ventricular arrhythmias and for the magnet response including paced rate. Physician review of above data produces an assessment of the adequacy of each lead's sensing and capture and of battery function.

1. The Technician receives the rhythm strip data with and a second rhythm strip after the application of a magnet to the pacemaker.
2. The Technician reviews the rhythm strips for sensing, capture and intrinsic and paced heart rates.
3. The parameters are reviewed and analyzed by the Technician
4. If presented to Technician, document any patient symptoms that are patient reported during the interrogation.
5. Report to physician on any parameters that are designated by the physician.
6. The Technician enters findings into the monitoring center or local independent diagnostic testing facility's (IDTF's) database.
7. The Technician validates function by assessing if the lead data and arrhythmia events are normal or abnormal.
8. After the data is entered and evaluated, the Technician generates a comprehensive report of all evaluated parameters, which report is then delivered to the physician
9. The physician reviews the data and confirms the function of each of the leads, the battery, capture and sensing. An assessment is made of the adequacy of the function and the time interval to the next analysis and the type of device evaluation that should be done at that time.

Description of Post-Service Work: The patient is informed of the test result. A final report is prepared, reviewed by the attending physician, addended as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008				
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD					
Specialty(s):	Cardiology					
CPT Code:	93293					
Sample Size:	273	Resp N:	38	Response: 13.9 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	45.00	100.00	860.00	3000.00
Survey RVW:		0.00	0.17	0.20	0.45	1.30
Pre-Service Evaluation Time:				5.0		
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:		2.00	6.00	10.00	16.50	45.00
Immediate Post Service-Time:		5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x	99292x			
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x		
Discharge Day Mgmt:	0.0	99238x	99239x			
Office time/visit(s):	0.0	99211x	12x	13x	14x	15x
Prolonged Services:	0.0	99354x	55x	56x	57x	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93293	Recommended Physician Work RVU: 0.25					
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time			
Pre-Service Evaluation Time:		9.50	7.0	2.5			
Pre-Service Positioning Time:		0.00	0.0	0.0			
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0			
Intra-Service Time:		19.00					
Immediate Post Service-Time:	9.50						
Post Operative Visits	Total Min**	CPT Code and Number of Visits					
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 0.0	99239x 0.0				
Office time/visit(s):	0.0	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0	
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93733	XXX	0.17	RUC Time

CPT Descriptor Electronic analysis of dual chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00	RUC Time	0

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 19 % of respondents: 59.3 %

TIME ESTIMATES (Median)

	CPT Code: 93293	Key Reference CPT Code: 93733	Source of Time RUC Time
Median Pre-Service Time	9.50	5.00	
Median Intra-Service Time	19.00	10.00	
Median Immediate Post-service Time	9.50	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	38.00	20.00	
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	2.64	2.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.52	2.36
Urgency of medical decision making	2.52	2.40

Technical Skill/Physical Effort (Mean)

Technical skill required	2.76	2.64
Physical effort required	2.00	1.88
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	2.64	2.44
Outcome depends on the skill and judgment of physician	2.96	2.76
Estimated risk of malpractice suit with poor outcome	2.88	2.72

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	0.00	0.00
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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93733

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty IDTF How often? Sometimes

Specialty Internal Medicine How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1750000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 1500000 Percentage 85.71 %

Specialty IDTF Frequency 300000 Percentage 17.14 %

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?

1,682,327 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 1250000 Percentage 74.30 %

Specialty IDTF Frequency 300000 Percentage 17.83 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93294 Tracking Number L16

Specialty Society Recommended RVU: **0.80**

Global Period: XXX

RUC Recommended RVU: **0.65**

CPT Descriptor: Interrogation device evaluation(s) (remote), per 90 days; single, dual or multiple lead pacemaker system with interim physician analysis and physician review and report(s).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74 year old patient with a pacemaker for sick sinus syndrome and CHF is followed with interrogation device evaluations (remote) of the pacemaker from the patient's home. The patient has intermittent brief palpitations and lightheadedness.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient records are reviewed to identify the indication for pacemaker therapy, manufacturer and model of the implanted pacemaker and leads, history of pacemaker dependency, atrial and ventricular arrhythmias. Prior records of pacing parameters are reviewed and compared to prior remote and in person interrogations.

Description of Intra-Service Work: The information is interrogated from the pacemaker by telemetric communication and either printed for review or reviewed on the programmer or computer monitor. Critical review of the interrogated data with assessment of the appropriateness of the function of pacemaker, safety of the current programmed parameters and to assess if the device function is normal. Data reviewed includes:

1. Presenting EGM for appropriateness or presence of arrhythmia and appropriate sensing and capture.
2. Stored episodes of data are reviewed for appropriate sensing, capture, appropriate magnet reversion and noise reversions.
3. Alerts generated from the pacemaker device.
4. Battery voltage and impedance, pacing lead impedance and sensed electrogram voltage amplitude for each lead.
5. Counters of paced and sensed events from each chamber for which there are leads located.
6. Stored episodes of sensed events including arrhythmias, ectopic beats, nonsustained and sustained atrial and ventricular arrhythmias and when appropriate, mode switch episodes. The frequency, rate and duration are noted.
7. Heart rate response during activities, rate histograms and indicators of patient activity level.

Description of Post-Service Work: A final report is prepared, reviewed by the attending physician, addended as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93294				
Sample Size:	273	Resp N:	35	Response: 12.8 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	22.50	100.00	1000.00
Survey RVW:	0.17	0.44	0.64	1.03	1.80
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	7.50	15.00	16.50	35.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93294	Recommended Physician Work RVU: 0.80			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		7.50	7.0	0.5	
Pre-Service Positioning Time:		0.00	0.0	0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0	
Intra-Service Time:		15.00			
Immediate Post Service-Time:	<u>7.50</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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 0.0	99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93731	XXX	0.45	RUC Time

CPT Descriptor Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00	RUC Time	0

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 23 % of respondents: 65.7 %

TIME ESTIMATES (Median)

	CPT Code: 93294	Key Reference CPT Code: 93731	Source of Time RUC Time
Median Pre-Service Time	7.50	5.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	7.50	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	30.00	25.00	
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	3.25	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.25
Urgency of medical decision making	3.08	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.92	2.83
--------------------------	------	------

Physical effort required	1.83	1.83
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.33	3.25
Outcome depends on the skill and judgment of physician	3.33	3.33
Estimated risk of malpractice suit with poor outcome	3.25	3.25

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	0.00	0.00
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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93731

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 900000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 800000 Percentage 88.88 %

Specialty Internal Medicine Frequency 55000 Percentage 6.11 %

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? 823,823 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 700000 Percentage 84.96 %

Specialty Internal Medicine Frequency 50000 Percentage 6.06 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93295 Tracking Number X17

Specialty Society Recommended RVU: **1.28**

Global Period: XXX

RUC Recommended RVU: **1.38**

CPT Descriptor: Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead implantable cardioverter defibrillator system with interim physician analysis and physician review and report(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year old patient with history of sustained VT treated with an ICD is followed with interrogation device evaluations (remote) of the ICD from the patient's home. The patient has dyspnea on exertion and intermittent palpitations with lightheadedness.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: History is reviewed to identify the indication for ICD therapy. Records are reviewed to identify the manufacturer and model of the ICD generator and lead(s). Prior records of the implanted ICD generator and lead hardware and the programmed parameters as well as the presence or absence of pacemaker dependence are reviewed. Prior assessments of capture thresholds, sensing thresholds, and arrhythmia therapies (if any) are reviewed from prior remote and in person interrogations. The patient's arrhythmia history including any recent clinical events is reviewed. Changes in antiarrhythmic medications since the last device evaluation are queried.

Description of Intra-Service Work: The information is interrogated from the ICD by telemetric communication and either printed for review or reviewed on the programmer or computer monitor. Critical review of the interrogated data with assessment of the appropriateness of the function of ICD, safety of the current programmed pacing and anti-tachycardia parameters and assessment of device function is performed. Data reviewed include:

1. Presenting electrograms for appropriateness of pacing and sensing.
2. Stored episodes of data are reviewed.
3. Alerts generated from the device.
4. Battery voltage and impedance, pacing and shocking lead impedance and sensed electrogram voltage amplitude for each lead.
5. Histogram and/or counters of paced and sensed events from each chamber.
6. Stored episodes of sensed arrhythmia events including the type, frequency, rate and duration are noted.
7. Adequacy of heart rate response is evaluated.

Description of Post-Service Work: After physician review of above data a decision is made as to the adequacy of the programmed parameters including the appropriate data collection setup and the interval for the next scheduled programming or interrogation evaluation. The patient is informed of the test result. The final summary report is created of the interrogation evaluations performed every 90 days. A final report is prepared, reviewed by the attending

physician, addended as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93295				
Sample Size:	273	Resp N:	33	Response: 12.0 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	25.00	65.00	500.00	2000.00
Survey RVW:	0.28	0.78	1.10	1.60	3.50
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	7.50	15.00	16.50	35.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93295	Recommended Physician Work RVU: 1.28		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		7.50	7.0	0.5
Pre-Service Positioning Time:		0.00	0.0	0.0
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0
Intra-Service Time:		22.50		
Immediate Post Service-Time:	<u>7.50</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
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 0.0	99239x 0.0	
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0 57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93743	XXX	1.03	RUC Time

CPT Descriptor Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, without reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00	RUC Time	0

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 23 % of respondents: 65.7 %

TIME ESTIMATES (Median)

	CPT Code: 93295	Key Reference CPT Code: 93743	Source of Time RUC Time
Median Pre-Service Time	7.50	5.00	
Median Intra-Service Time	22.50	15.00	
Median Immediate Post-service Time	7.50	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	37.50	25.00	

Other time if appropriate		0.00
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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	3.56	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.56
Urgency of medical decision making	3.44	3.44

Technical Skill/Physical Effort (Mean)

Technical skill required	3.56	3.56
Physical effort required	2.11	2.11
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	3.56	3.56
Outcome depends on the skill and judgment of physician	3.56	3.56
Estimated risk of malpractice suit with poor outcome	3.44	3.44

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	0.00	0.00
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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93743

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 600000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 545000 Percentage 90.83 %

Specialty Internal Medicine Frequency 30000 Percentage 5.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

500,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 450000 Percentage 90.00 %

Specialty Internal Medicine Frequency 20000 Percentage 4.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93297 Tracking Number L19

Specialty Society Recommended RVU: **1.30**

Global Period: XXX

RUC Recommended RVU: **0.52**

CPT Descriptor: Interrogation device evaluation(s), (remote) per 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors, with physician analysis, review(s) and report(s).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58 year old patient with prior MI, VT and CHF has an implantable cardioverter defibrillator system that monitors physiologic cardiovascular data in addition to the heart rhythm. The patient is followed with interrogation device evaluations (remote). The patient has NYHA FC III heart failure symptoms and the physiologic cardiovascular data are transmitted from the patient's home to the remote surveillance database. This is for all evaluations received within a 30 day period.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient records are reviewed to identify the indication for ICM monitoring and therapy, manufacturer and model of the ICM, leads and sensors (both internal and external) as appropriate. Prior records of ICM parameters are reviewed and compared to prior remote and in person interrogations.

Description of Intra-Service Work: The information is interrogated from the ICM by telemetric communication and either printed for review or reviewed on the programmer or computer monitor. Critical review of the interrogated data with the assessment of the appropriateness of the function of the ICM and appropriateness of the current programmed parameters is performed.

Data reviewed may include, but are not limited to, (1) weight, (2) systemic blood pressure, (3) right atrial, right ventricular, left atrial, left ventricular, pulmonary arterial pressures, (4) intra-thoracic impedance measurements (5) other measures of physiologic parameters.

Additionally, stored episodes of data are reviewed to assess the history and trends identified by any of the collected data. Further, alerts generated from the ICM are reviewed along with battery voltage and sensor information to validate the integrity of the ICM system

Description of Post-Service Work: After physician review of above data a decision is made as to the adequacy of the programmed parameters including the appropriate data collection setup and the interval for the next scheduled interrogation evaluation. Modifications to the patient's medical regimen are made as appropriate. The patient is informed of the test result. A final report is prepared, reviewed by the attending physician, addended as necessary,

approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93297				
Sample Size:	83	Resp N:	32	Response: 38.5 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.25	25.00	62.50	500.00
Survey RVW:	0.29	0.79	1.03	1.40	3.20
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	7.50	12.00	15.00	25.00
Immediate Post Service-Time:	<u>8.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	93297	Recommended Physician Work RVU: 1.30			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		10.00	7.0	3.0	
Pre-Service Positioning Time:		0.00	0.0	0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0	
Intra-Service Time:		24.00			
Immediate Post Service-Time:	<u>16.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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 0.0	99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93743	XXX	1.03	RUC Time

CPT Descriptor Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, without reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00	RUC Time	0

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 23 % of respondents: 65.7 %

TIME ESTIMATES (Median)

	CPT Code: 93297	Key Reference CPT Code: 93743	Source of Time RUC Time
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	24.00	15.00	
Median Immediate Post-service Time	16.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	50.00	25.00	

Other time if appropriate		0.00
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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	3.71	2.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	3.71
Urgency of medical decision making	3.43	3.43

Technical Skill/Physical Effort (Mean)

Technical skill required	3.43	3.14
Physical effort required	2.29	2.43
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	3.29	3.29
Outcome depends on the skill and judgment of physician	3.86	3.71
Estimated risk of malpractice suit with poor outcome	3.59	3.43

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	0.00	0.00
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 IWPOT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

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. 93727

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: 93298

Tracking Number L20

Specialty Society Recommended RVU: **1.14**

Global Period: XXX

RUC Recommended RVU: **0.52**

CPT Descriptor: Interrogation device evaluation(s), (remote) per 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, with physician analysis review(s) and report(s).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 41 year old patient receives an implantable loop recorder for recurrent syncopal spells. The patient is followed with interrogation device evaluations (remote) for light-headed but non-syncopal episodes. This is for all evaluations received within a 30 day period.

Percentage of Survey Respondents who found Vignette to be Typical: 93 %

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0 %

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0 %

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The history is assessed for cardiac rhythm monitoring indications and for changes in, or the development of new symptoms. Prior records of the ILR, lead hardware, if present, and programmed parameters are reviewed. The results of prior ILR interrogations are reviewed

Description of Intra-Service Work: Verbal consent from the patient to proceed is obtained A communication link is created between the ILR and the programmer. Programmed parameters are obtained. Stored ILR data is obtained and downloaded for physician review

Detailed physician analysis is made of the following:

1. A full interrogation of the stored ILR data is obtained and reviewed for alert conditions.
2. The current interrogated measurements are compared to the extensive stored and trended data and are reviewed for device alerts in regard to battery function, including voltage and impedance.
3. An assessment of the underlying signal strength is made. Sensing threshold is measured by recording the signal from the ILR and by iterative (step-wise) adjustment of the sensing value to determine the appropriate sensing safety margin. The appropriate threshold for sensing is identified. The sensing and gain parameters are programmed as appropriate to insure optimal device sensing.
4. Patient-activated recorded rhythm episodes are reviewed for evidence of tachycardia, bradycardia and cardiac rhythm pauses. Specific rhythm waveforms are downloaded and reviewed for atrial fibrillation, PACs, SVT, PVCs, non sustained ventricular tachycardia, sustained ventricular tachycardia, sinus pauses, evidence of cardiac AV block, and recording system artifact. The appropriate rhythm alerts and recording parameters are identified.
5. Automatically recorded rhythm episodes (based on previously programmed detection parameters) are reviewed for evidence of tachycardia, bradycardia and cardiac rhythm pauses. Specific rhythm waveforms are downloaded and reviewed for atrial fibrillation, PACs, SVT, PVCs, non sustained ventricular tachycardia, sustained ventricular

tachycardia, sinus pauses, evidence of cardiac AV block, and recording system artifact. The appropriate rhythm alerts and recording parameters are identified.

6. Parameters describing the criteria for automatic rhythm detection are reviewed for appropriateness and programmed for optimal rhythm detection.

7. Parameters describing the device memory capacity and the recording capacity of the number of patient-activated, and automatically detected episodes are reviewed. The amount of pre and post detection electrocardiographic recording time is assessed. Programmed changes to these values are made as appropriate to optimize ILR recording function.

After the detailed analysis of each of the above parameters, a decision is made about the adequacy of the initial programmed ILR parameters and any identified changes which need to be made to optimize the device performance relative to the patient's clinical condition. These device programming changes are made and any additional recommendations for further cardiac evaluation or treatment are given.

Description of Post-Service Work: The results of the device interrogation are discussed with the patient and programming changes to the device, if any, are explained in detail. Timing of the next device interrogation appointment is explained. A final report is prepared, reviewed by the attending physician, added as necessary, approved, signed and distributed to the patient's record, the referring and primary physicians and the attending physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Bruce Wilkoff, MD; Richard Fogel, MD				
Specialty(s):	Cardiology				
CPT Code:	93298				
Sample Size:	273	Resp N:	35	Response: 12.8 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	1.00	12.00	100.00
Survey RVW:	0.52	0.55	0.80	1.20	2.50
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	2.00	7.00	10.00	20.00	45.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	93298	Recommended Physician Work RVU: 1.14				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:		10.00	7.0	3.0		
Pre-Service Positioning Time:		0.00	0.0	0.0		
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0		
Intra-Service Time:		24.00				
Immediate Post Service-Time:	<u>10.00</u>					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
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 0.0	99239x 0.0			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93727	XXX	0.52	RUC Time

CPT Descriptor Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00	RUC Time	0

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 56.2 %

TIME ESTIMATES (Median)

	CPT Code: 93298	Key Reference CPT Code: 93727	Source of Time RUC Time
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	24.00	20.00	
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	
Prolonged Services Time	0.0	0.00	
Median Total Time	44.00	25.00	
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	3.14	3.00
--------------------------------------------------------------------------------------------------	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.09	3.00
--------------------------------------------------------------------------------------------------------------------------------	------	------

Urgency of medical decision making	3.00	2.91
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	2.95	2.95
--------------------------	------	------

Physical effort required	2.14	2.09
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.18	3.09
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	3.41	3.27
--------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	3.27	3.18
------------------------------------------------------	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	0.00	0.00
------------------------------------	------	------

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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93727

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Rarely

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.

Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 17000 Percentage 85.00 %

Specialty Internal Medicine Frequency 1500 Percentage 7.50 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Panel Consensus

Specialty Cardiology Frequency 13500 Percentage 90.00 %

Specialty Internal Medicine Frequency 1000 Percentage 6.66 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

RUC Recommendations			93288		93279		93280		93281	
April 2008			Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead pacemaker system		Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report, single lead pacemaker system		Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead pacemaker system		Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; multiple lead pacemaker system	
LOCATION	CMS Code	Staff Type	Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility
GLOBAL PERIOD										
TOTAL CLINICAL LABOR TIME			30.0	N/A	33.0	N/A	37.0	N/A	43.0	N/A
TOTAL PRE-SERV CLINICAL LABOR TIME			2.0	N/A	2.0	N/A	2.0	N/A	2.0	N/A
TOTAL SERVICE PERIOD CL TIME			28.0	N/A	31.0	N/A	35.0	N/A	41.0	N/A
TOTAL POST-SERV CLINICAL LABOR TIME			0.0	N/A	0.0	N/A	0.0	N/A	0.0	N/A
PRE-SERVICE										
Start: Following visit when decision for surgery or procedure made										
Telephone triage with patient, complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	2		2		2		2	
Coordinate pre-surgery services										
Schedule space and equipment in facility	L026A	Tech								
Provide pre-service education/obtain consent										
Follow-up phone calls & prescriptions										
Other Clinical Activity (please specify)										
End/When patient enters office/facility for surgery/procedure										
SERVICE PERIOD										
Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure										
Review charts	L037D	RN/LPN/MTA	2		2		2		2	
Greet patient and provide gowning	L026A	Tech	3		3		3		3	
Obtain vital signs										
Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3		3		3		3	
Prepare room, equipment, supplies	L026A	Tech	2		2		2		2	
Setup scope (non facility setting only)										
Prepare and position patient/ monitor patient	L026A	Tech								
Sedate/apply anesthesia										
Intra-service										
Interrogating and obtaining information from device	L037D	RN/LPN/MTA	10		10		10		10	
Programming device	L037D	RN/LPN/MTA			3		7		13	
Post-Service										
Monitor pt following service/check tubes, monitors, drains										
Clean room/equipment by physician staff	L026A	Tech	3		3		3		3	
Clean Scope										
Clean Surgical Instrument Package										
Complete diagnostic forms, lab & X-ray requisitions										
Print PaceArt report & send	L037D	RN/LPN/MTA	3		3		3		3	
Scan & File	L026A	Tech	2		2		2		2	
Review/read X-ray, lab, and pathology reports										
Check dressings & wound/ home care instructions										
/coordinate office visits /prescriptions										
Other Clinical Activity (please specify)										
End Patient leaves office										
POST-SERVICE Period										
Start: Patient leaves office/facility										
Conduct phone calls/call in prescriptions										
Office visits										
List Number and Level of Office Visits										
99211 16 minutes		16								
99212 27 minutes		27								
99213 36 minutes		36								
99214 53 minutes		53								
99215 63 minutes		63								
Other										
Total Office Visit Time			0		0		0		0	
Other Activity (please specify)										
End: with last office visit before end of global period										
MEDICAL SUPPLIES										
Alcohol Pad	SJ053	1 pad	4		4		4		4	
Electrode	SJ019	1 pad	4		4		4		4	
Paper, laser printer	SK057	1 page	10		10		15		15	
pack, minimum multi-specialty visit	SA048	pack	1		1		1		1	
electrode adhesive disk	SJ019	item	4		4		4		4	
EQUIPMENT										
Equipment	EF011	1	10		13		17		23	
Cart	CMS									
Pacemaker Monitoring, System	EF023	1	15		18		23		28	
exam table	EF023	1	10		18		23		23	

AMA/Specialty Society RVS Update Committee Recommendation			93289		93282		93283		93284	
April 2008			Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead implantable cardioverter defibrillator system, including analysis of		Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report, single lead implantable cardioverter defibrillator system		Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead implantable cardioverter defibrillator system		Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report, multiple lead implantable cardioverter defibrillator system	
LOCATION	CMS Code	Staff Type	Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility
GLOBAL PERIOD										
TOTAL CLINICAL LABOR TIME			38.0	N/A	38.0	N/A	44.0	N/A	50.0	N/A
TOTAL PRE-SERV CLINICAL LABOR TIME			2.0	N/A	2.0	N/A	2.0	N/A	2.0	N/A
TOTAL SERVICE PERIOD CL TIME			36.0	N/A	36.0	N/A	42.0	N/A	48.0	N/A
TOTAL POST-SERV CLINICAL LABOR TIME			0.0	N/A	0.0	N/A	0.0	N/A	0.0	N/A
PRE-SERVICE										
Start: Following visit when decision for surgery or procedure made										
Telephone triage with patient, complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	2		2		2		2	
Coordinate pre-surgery services										
Schedule space and equipment in facility	L026A	Tech								
Provide pre-service education/obtain consent										
Follow-up phone calls & prescriptions										
Other Clinical Activity (please specify)										
End/When patient enters office/facility for surgery/procedure										
SERVICE PERIOD										
Start: When patient enters office/facility for surgery/procedure. Services Prior to Procedure										
Review charts	L037D	RN/LPN/MTA	2		2		2		2	
Greet patient and provide gowning	L026A	Tech	3		3		3		3	
Obtain vital signs										
Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3		3		3		3	
Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2		2	
Setup scope (non facility setting only)										
Prepare and position patient/ monitor patient	L026A	Tech								
Sedate/apply anesthesia										
Intra-service										
Interrogating and obtaining information from device	L037D	RN/LPN/MTA	18		16		18		18	
Programming device					2		6		12	
Post-Service										
Monitor pt following service/check tubes, monitors, drains										
Clean room/equipment by physician staff	L026A	Tech	3		3		3		3	
Clean Scope										
Clean Surgical Instrument Package										
Complete diagnostic forms, lab & X-ray requisitions										
Print PaceArt report & send	L037D	RN/LPN/MTA	3		3		3		3	
Scan & File	L026A	Tech	2		2		2		2	
Review/read X-ray, lab, and pathology reports										
End: Patient leaves office										
POST-SERVICE Period										
Start. Patient leaves office/facility										
Conduct phone calls/call in prescriptions										
Office visits NONE										
List Number and Level of Office Visits										
99211 16 minutes		16								
99212 27 minutes		27								
99213 36 minutes		36								
99214 53 minutes		53								
99215 63 minutes		63								
Total Office Visit Time			0		0		0		0	
Other Activity (please specify)										
End: with last office visit before end of global period										
MEDICAL SUPPLIES										
Alcohol Pad	SJ053	1 pad	4		4		4		4	
Electrode	SJ019	1 pad	4		4		4		4	
Paper, laser printer	SK057	1 page	15		15		20		20	
Pack, Minimum Multi-specialty visit	SA048	1	1		1		1		1	
electrode adhesive disk	SJ019	item	4		4		4		4	
Equipment										
Cart	EF011	1	18		18		24		30	
pacemaker monitoring, system	CMS Code	1	23		23		29		35	
exam table	EF023	1	18		18		24		30	

AMA/Specialty Society RVS Update Committee	Recommendation		93291		93285	
April 2008			Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; Implantable loop recorder system, including heart rhythm data derived analysis		Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; Implantable loop recorder system	
LOCATION	CMS Code	Staff Type	Non-Facility	Facility	Non-Facility	Facility
GLOBAL PERIOD						
TOTAL CLINICAL LABOR TIME			26.0	N/A	28.0	N/A
TOTAL PRE-SERV CLINICAL LABOR TIME			1.0	N/A	1.0	N/A
TOTAL SERVICE PERIOD CL TIME			25.0	N/A	27.0	N/A
TOTAL POST-SERV CLINICAL LABOR TIME			0.0	N/A	0.0	N/A
PRE-SERVICE						
Start: Following visit when decision for surgery or procedure made						
Telephone triage with patient, complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	1		1	
Coordinate pre-surgery services						
Schedule space and equipment in facility	L026A	Tech				
Provide pre-service education/obtain consent						
Follow-up phone calls & prescriptions						
Other Clinical Activity (please specify)						
End: When patient enters office/facility for surgery/procedure						
SERVICE PERIOD						
Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure						
Review charts	L037D	RN/LPN/MTA	2		2	
Greet patient and provide gowning	L026A	Tech	3		3	
Obtain vital signs						
Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	2		2	
Prepare room, equipment, supplies	L037D	RN/LPN/MTA	1		1	
Setup scope (non facility setting only)						
Prepare and position patient/ monitor patient	L026A	Tech				
Sedate/apply anesthesia						
Intra-service						
Interrogating and obtaining information from device	L037D	RN/LPN/MTA	11		13	
Post-Service						
Monitor pt following service/check tubes, monitors, drains						
Clean room/equipment by physician staff	L026A	Tech	3		3	
Clean Scope						
Clean Surgical Instrument Package						
Complete diagnostic forms, lab & X-ray requisitions						
Print PaceArt report & send	L037D	RN/LPN/MTA	2		2	
Scan & File	L026A	Tech	1		1	
Review/read X-ray, lab, and pathology reports						
End: Patient leaves office						
POST-SERVICE PERIOD						
Start: Patient leaves office/facility						
Conduct phone calls/call in prescriptions						
Office visits NONE						
List Number and Level of Office Visits						
99211 16 minutes		16				
99212 27 minutes		27				
99213 36 minutes		36				
99214 53 minutes		53				
99215 63 minutes		63				
Total Office Visit Time			0		0	
Other Activity (please specify)						
End: with last office visit before end of global period						
MEDICAL SUPPLIES						
	CMS Code	Unit				
Alcohol Pad	SJ053	1 pad	4		4	
Electrode	SJ019	1 pad	4		4	
Paper, laser printer	SK057	1 page	15		20	
Pack, Minimum Multi-specialty visit	SA048	1	1		1	
electrode adhesive disk	SJ019	item	4		4	
EQUIPMENT						
	CMS Code					
Cart	EF011	1	11		13	
pacemaker monitoring, system	CMS Code	1	14		16	
exam table	EF023	1	11		13	

AMA/Specialty Society RVS Update Committee Recommendation			93290		93292	
April 2008			Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors		Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	
LOCATION	CMS Code	Staff Type	Non-Facility	Facility	Non-Facility	Facility
GLOBAL PERIOD						
TOTAL CLINICAL LABOR TIME			17.0	N/A	20.0	N/A
TOTAL PRE-SERV CLINICAL LABOR TIME			1.0	N/A	1.0	N/A
TOTAL SERVICE PERIOD CL TIME			16.0	N/A	19.0	N/A
TOTAL POST-SERV CLINICAL LABOR TIME			0.0	N/A	0.0	N/A
PRE-SERVICE						
Start: Following visit when decision for surgery or procedure made						
Telephone tngage with patient, complete pre-service diagnostic & referral forms	L037D	RN/LPN/M TA	1		1	
Coordinate pre-surgery services						
Schedule space and equipment in facility	L026A	Tech				
Provide pre-service education/obtain consent						
Follow-up phone calls & prescriptions						
Other Clinical Activity (please specify)						
End:When patient enters office/facility for surgery/procedure						
SERVICE PERIOD						
Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure						
Review charts	L037D	RN/LPN/M TA	2		2	
Greet patient and provide gowning	L026A	Tech	3		3	
Obtain vital signs						
Provide pre-service education/obtain consent	L037D	RN/LPN/M TA	1		2	
Prepare room, equipment, supplies	L026A	Tech	1		1	
Setup scope (non facility setting only)						
Prepare and position patient/ monitor patient	L026A	Tech				
Sedate/apply anesthesia						
Intra-service						
Interrogating and obtaining information from device	L037D	RN/LPN/M TA	4		5	
Post-Service						
drains						
Clean room/equipment by physician staff	L026A	Tech	3		3	
Clean Scope						
Clean Surgical Instrument Package						
Complete diagnostic forms, lab & X-ray requisitions						
Print PaceArt report & send	L037D	RN/LPNM TA	1		2	
Scan & File	L026A	Tech	1		1	
Review/read X-ray, lab, and pathology reports						
Prep. For MD review	L037D	RN/LPNM TA				
Check dressings & wound/ home care instructions						
/coordinate office visits /prescriptions						
Discharge day management 99238 –12 minutes						
Other Clinical Activity (please specify)						
End: Patient leaves office						
POST-SERVICE Period						
Start: Patient leaves office/facility						
Conduct phone calls/call in prescriptions						
Office visits						
List Number and Level of Office Visits						
99211 16 minutes		16				
99212 27 minutes		27				
99213 36 minutes		36				
99214 53 minutes		53				
99215 63 minutes		63				
Other						
Total Office Visit Time			0		0	
Other Activity (please specify)						
End. with last office visit before end of global period						
MEDICAL SUPPLIES						
Alcohol Pad	SJ053	Unit 1 pad	4		4	
Electrode	SJ019	1 pad	4		4	
Paper, laser printer	SK057	1 page	10		10	
pack, minimum multi-specialty visit	SA048	pack	1		1	
electrode adhesive disk	SJ019	item	4		4	
EQUIPMENT						
Equipment	CMS Code	Unit				
Cart	EF011	1	4		5	
Pacemaker Monitoring, System	CMS Code	1	6		8	
exam table	EF023	1	4		5	

AMA/Specialty Society RVS Update Committee Recommendation				
		93286		93287
April 2008	Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead pacemaker system	Pen-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead implantable cardioverter defibrillator system		
LOCATION	Non Facility	Facility	Non Facility	Facility
GLOBAL PERIOD				
TOTAL CLINICAL LABOR	19.0		21.0	N/A
TOTAL PRE-SERV	1.0		1.0	N/A
TOTAL SERVICE PERIOD	18.0		20.0	N/A
TOTAL POST-SERV	0.0		0.0	N/A
PRE-SERVICE				
Start: Following visit when decision for surgery or procedure made				
Telephone triage with patient, complete pre-service diagnostic & referral forms	1		1	
Coordinate pre-surgery services				
Schedule space and equipment in facility				
Provide pre-service education/obtain consent				
Follow-up phone calls & prescriptions				
End: When patient enters office/facility for surgery/procedure				
SERVICE PERIOD				
Start: When patient enters office/facility for surgery/procedure. Services Prior to Procedure				
Review charts	2		2	
Greet patient and provide gowning	3		3	
Obtain vital signs	1		1	
education/obtain consent	2		2	
supplies				
Setup scope (non facility setting only)				
monitor patient				
Sedate/apply anesthesia				
Intra-service				
Assist physician interrogating and obtaining information from device	5		7	
Post-Service				
Monitor pt. following service/check				
Clean room/equipment by				
Clean Scope				
Clean Surgical Instrument				
Package				
Complete diagnostic forms, lab & X-ray requisitions				
Print PaceArt Report	3		3	
Scan and File PaceArt Report	2		2	
Review/read X-ray, lab, and pathology reports				
Prepare report for physician review				
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
Discharge day management				
99238 –12 minutes				
Other Clinical Activity (please specify)				
End: Patient leaves office				

AMA/Specialty Society RVS Update Committee Recommendation		93286		93287	
April 2008	Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead pacemaker system	Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report, single, dual or multiple lead implantable cardioverter defibrillator system			
LOCATION	Non Facility	Facility	Non Facility	Facility	
POST-SERVICE PERIOD					
Start. Patient leaves office/facility					
Conduct phone calls/call in prescriptions					
Office visits					
List Number and Level of Office Visits					
99211 16 minutes					
99212 27 minutes					
99213 36 minutes					
99214 53 minutes					
99215 63 minutes					
Total Office Visit Time	0		0		
Other Activity (please specify)					
End: with last office visit before end of global period					
MEDICAL SUPPLIES					
Gloves, non-sterile 2 pair	1		1		
swab-pad, alcohol	4		4		
Paper	10		10		
Electrodes	5		5		
Electrode Adhesive Disk	5		5		
Pack, Minimum Multi-specialty visit	1		1		
EQUIPMENT					
Cart	5		7		
Pacemaker Monitoring, System	9		12		
exam table	5		7		

AMA/Specialty Society RVS Update Committee Recommendation		93293		
April 2008			Transtelephonic rhythm strip pacemaker evaluation(s) single, dual or multiple lead pacemaker system, includes recording with and without magnet application with report(s) up to 90 days	
LOCATION	CMS Code	Staff Type	Non-Facility	Facility
GLOBAL PERIOD				
TOTAL CLINICAL LABOR TIME			48.0	N/A
TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	N/A
TOTAL SERVICE PERIOD CLINICAL LABOR TIME			48.0	N/A
TOTAL POST-SERV CLINICAL LABOR TIME			0.0	N/A
PRE-SERVICE				
Start: Following visit when decision for surgery or procedure made				
Telephone triage with patient, complete pre-service diagnostic & referral forms				
Coordinate pre-surgery services				
Schedule space and equipment in facility				
Provide pre-service education/obtain consent				
Follow-up phone calls & prescriptions				
End: When patient enters office/facility for surgery/procedure				
SERVICE PERIOD				
Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
Review charts				
Greet patient and provide gowning				
Obtain vital signs				
Provide pre-service education/obtain consent				
Prepare room, equipment, supplies				
Setup scope (non facility setting only)				
Prepare and position patient/ monitor patient/ set up IV				
Sedate/apply anesthesia				
Intra-service				
Receipt and review of remote transmissions, preparation of report and distribution of results	L037A	Electrodiagnostic Technologist	39	
Patient enrollment, education on use of device/service, physician notification	LO37D	RN/LPN/MTA	9	
Post-Service				
Monitor pt following service/check tubes, monitors, drains				
Clean room/equipment by physician staff				
Clean Scope				
Clean Surgical Instrument Package				
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				
End: Patient leaves office				
POST-SERVICE PERIOD				
Start: Patient leaves office/facility				
Conduct phone calls/call in prescriptions				
Office visits None				
List Number and Level of Office Visits				
99211 16 minutes		16		
99212 27 minutes		27		
99213 36 minutes		36		
99214 53 minutes		53		
99215 63 minutes		63		
Total Office Visit Time			0	
Other Activity (please specify)				
End: with last office visit before end of global period				
MEDICAL SUPPLIES				
Printer paper	SK057	pages	10	
Equipment				
Pacemaker interrogation system	CMS Code	minutes	39	

AMA/Specialty Society RVS Update Committee Recommendation			93296		93294		93295	
April 2008			Interrogation device evaluation(s), (remote), per 90 days, pacemaker or implantable cardioverter defibrillator, remote data acquisitions), receipt of transmissions and technician review, technical support and distribution of results		Interrogation device evaluation(s) (remote), up to 90 days, single, dual or multiple lead pacemaker system with interim physician analysis and physician review and report(s)		Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead implantable cardioverter defibrillator system with interim physician analysis and physician review and report(s)	
LOCATION	CMS Code	Staff Type	Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility
GLOBAL PERIOD								
TOTAL CLINICAL LABOR TIME			0.0	N/A	0.0	N/A	0.0	N/A
TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	N/A	0.0	N/A	0.0	N/A
TOTAL SERVICE PERIOD CL TIME			28.0	N/A	0.0	N/A	0.0	N/A
TOTAL POST-SERV CLINICAL LABOR TIME			0.0	N/A	0.0	N/A	0.0	N/A
PRE-SERVICE								
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								
Provide pre-service education/obtain consent								
Follow-up phone calls & prescriptions								
Other Clinical Activity (please specify)								
End: When patient enters office/facility for surgery/procedure								
SERVICE PERIOD								
Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure								
Review charts								
Greet patient and provide gowning								
Obtain vital signs								
Provide pre-service education/obtain consent								
Prepare room, equipment, supplies								
Setup scope (non facility setting only)								
Prepare and position patient/monitor patient/ set up IV								
Sedate/apply anesthesia								
Intra-service								
Obtain information from IDTF server by fax or computer and prepare for physician review - 1 5 or times per 90 days	LO37D	RN/LPNMTA						
Obtain information from server, download and prepare for physician review - 2 2 times per 30 days	LO37D	RN/LPNMTA						
Obtain information from server, download and prepare for physician review - 2 times per 30 days	LO37D	RN/LPNMTA						
Receipt and review of remote transmissions, preparation of report and distribution of results - 1 5 transmission per 90 days	L037A	Electrodiagnostic Technologist	27					
Patient enrollment, education on use of device/service, physician notification	LO37D	RN/LPNMTA	1					
Post-Service								
Monitor pt following service/check tubes, monitors, drains								
Clean room/equipment by physician staff								
Clean Scope								
Clean Surgical Instrument Package								
Complete diagnostic forms, lab & X-ray requisitions								
Review/read X-ray, lab, and pathology reports								
Print PaceArt report & send	LO37D	RN/LPNMTA						
Scan & File	L026A	Tech						
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
Discharge day management 99238 –12 minutes								
Other Clinical Activity (please specify)								
End: Patient leaves office								
POST-SERVICE Period								
Start: Patient leaves office/facility								
Conduct phone calls/call in prescriptions								
Office visits NONE								
List Number and Level of Office Visits								
99211 16 minutes		16						
99212 27 minutes		27						
99213 36 minutes		36						
99214 53 minutes		53						
99215 63 minutes		63						
Other								
Total Office Visit Time			0		0		0	
End: with last office visit before end of global period								
MEDICAL SUPPLIES								
Paper, laser printer	SK057	1 page	10		0		0	
Equipment								
Pacemaker interrogation system	CMS Code	minutes	27		0		0	

AMA/Specialty Society RVS Update Committee Recommendation			93297	93298
April 2008			Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s)	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s)

AMA/Specialty Society RVS Update Committee Recommendation		93228		
April 2008			Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report	
	CMS Code			
LOCATION		Staff Type	Non-Facility	Facility
GLOBAL PERIOD				
TOTAL CLINICAL LABOR TIME			0.0	N/A
TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	N/A
TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	N/A
TOTAL POST-SERV CLINICAL LABOR TIME			0.0	N/A
PRE-SERVICE				
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				
Provide pre-service education/obtain consent				
Follow-up phone calls & prescriptions				
Other Clinical Activity (please specify)				
End: When patient enters office/facility for surgery/procedure				
SERVICE PERIOD				
Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
Review charts				
Greet patient and provide gowning				
Obtain vital signs				
Provide pre-service education/obtain consent				
Prepare room, equipment, supplies				
Setup scope (non facility setting only)				
Prepare and position patient/ monitor patient/ set up IV				
Sedate/apply anesthesia				
Intra-service				
Post-Service				
Monitor pt following service/check tubes, monitors, drains				
Clean room/equipment by physician staff				
Clean Scope				
Clean Surgical Instrument Package				
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				
End: Patient leaves office				
POST-SERVICE PERIOD				
Start: Patient leaves office/facility				
Conduct phone calls/call in prescriptions				
Office visits NONE				
List Number and Level of Office Visits				
99211 16 minutes		16		
99212 27 minutes		27		
99213 36 minutes		36		
99214 53 minutes		53		
99215 63 minutes		63		
Other				
Total Office Visit Time				
0				
Other Activity (please specify)				
End with last office visit before end of global period				
MEDICAL SUPPLIES				
Unit				
Equipment				

**AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Day Global Period
Non Facility Direct Inputs**

CPT Long Descriptor: 93299: Interrogation device evaluation(s), (remote), per 30 days, implantable cardiovascular monitor or implantable loop recorder, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

Sample Size: 1 Response Rate: (%): 100 Global Period: XXX

Geographic Practice Setting %: Rural Suburban Urban

NA: Respondents provide services nationally

Type of Practice %: Solo Practice
 Single Specialty Group
 Multispecialty Group
 Medical School Faculty Practice Plan

100% - Independent Diagnostic Testing Facility

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Only one of the Remote Cardiac Services Provider Group (RCSPG)'s nine members provides this service and only with respect to implantable loop recorders. None of the RCSPG members provide interrogation of implantable cardiovascular monitors. The company whose data is presented below has been furnishing the service since October 2007 and currently has 46 patients receiving the service.

Description of the Clinical Service

An implantable loop recorder (ILR) is an implantable device that continuously records ECG rhythm triggered automatically by rapid and slow heart rates or by the patient during asymptomatic episode. It is designed to detect transient symptoms, most significantly syncope, which may not be detected by other types of cardiac monitoring. After implantation, the device automatically stores ECG segments when the R-R interval falls outside of predetermined limits or the patient can trigger storage him or herself, when symptoms are experienced.

A patient with an ILR is referred by the physician to the monitoring center or IDTF for ECG monitoring. The IDTF enrolls the patient and educates the patient on the use of the service. An assessment of the underlying signal strength is made and if sensing is inadequate instructions are given to the patient for further follow-up and potential reprogramming. The device used by the RCSPG facility furnishing this service uses blue tooth technology which allows data to be transmitted if the patient is within range of the blue tooth modem. Interrogated data received by the monitoring center, which includes automatically recorded rhythm episodes (based on previously programmed detection parameters) as well as patient-activated rhythm episodes, are

reviewed by the electrodiagnostic technician (a certified cardiographic technician) for device alerts and compared to physician directed parameters for communication to the physician. The interrogated data is transmitted to the physician for review with the urgency of delivery determined by the physician. The monitoring center providing this service reports that there are typically 6 trending samples received each day (i.e. every four hours) in addition to about 300 asymptomatic transmissions per month and approximately 4 symptomatic transmissions which are patient-generated.

The company furnishing this service has done so only since October 1, 2007 and has approximately 50 patients enrolled. All patient services, including enrollment and patient education are performed by the electrodiagnostic technician. Monitoring is provided on a 24/7 attended basis through the use of 3.6 FTEs. Because the company provides other 24/7 remote monitoring services, only a percentage of technician time is allocated to this service. Currently four technicians whose time is allocated 80% to ILR furnish services during the daytime shifts. Two technicians allocated 20% to ILR provide nighttime service.

Recommendations for Technician Time

When the total technician time is calculated based on comparing technician time to total services provided, using the methodology explained in the discussion of 93X15 and 93X18, the technician time per service was approximately 450 minutes. Since this seemed high, we checked it by comparing it to the actual technician minutes it takes the facility to perform each specific task over the 30-day period. The result was very similar – 490 minutes. Although this describes the reality of current operations, we are still concerned that it is too high.

The company furnishing the service believes that this high number of minutes of technician time is largely attributable to the significant amount of artifact or asymptomatic data captured by the ILR and transmitted to the monitoring center. The company is working with the device manufacturer to make technological improvements that will reduce this and expects that this will occur in the near future, likely by 2009 when this code will take effect. Assuming these efforts are successful, it is anticipated that technician time will decrease significantly though exactly how much is not known. Nevertheless, in an effort to value this code reasonably on an interim basis, we have attempted to estimate technician time based on expected improvements in the technology. Consequently, we are not, at this time, recommending that clinical labor time be calculated based on the methodology used for other remote cardiac services which compares the number of technicians to total services.

Recommendations for Technician Time

1. ECG Monitoring

We recommend technician time for ECG monitoring time of 220 minutes calculated as follows:

Event Type	Recording Duration	Frequency/per month	Tech Time (review, edit, analysis, reporting)	Total Time month/mi
Patient Trigger	7 minutes	3	10 minutes each event	30

Auto Trigger (asymptomatic)	1 minute	100	1 minute each event	100
Trend	10 seconds	180	30 seconds each event	90

As noted above, these recommendations are based on anticipated reduction in technician time due to expected improvements in the technology which will reduce the number of asymptomatic transmissions. Currently, technicians spend 300 minutes per patient per month reviewing auto-triggered asymptomatic transmissions. It is anticipated that technology improvements will reduce this by two-thirds to 100 minutes.

Given that ILR interrogation is still an evolving technology and accurate practice expense data is limited, these recommendations should be considered interim and we urge that any values established for this service be re-evaluated as soon as more robust data is available.

2. Other Services Performed by Technicians

In addition to the monitoring services described above, technicians perform other services which are described below and on the attached spreadsheet. Enrollment and education of the patient takes 25 minutes but is only done when the patient is first signed up for the service. Once on the service, the patient is monitored every 30 days for as long as the physician considers it necessary to diagnose the patient's condition. The company furnishing the service has only been doing so since October of 2007 so it does not yet have data on the typical number of months a patient is monitored. Information provided by the device manufacturer indicates that eight months is a reasonable expected time frame. Therefore, we suggest allocating the 25 minutes of up-front time across 8 services for a total of 3 minutes per service. Once additional data becomes available, this can be reevaluated.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

NA

Intra-Service Clinical Labor Activities:

- Patient enrollment and education on use of device.
- Review and analysis of ECG data from trending samples transmitted to monitoring center and determine if physician notification is required.
- Prepare monthly report and distribute to physician.
- Review and analysis of patient symptomatic transmissions.

- Notification to physician if criteria are met.
- Review and analysis of patient asymptomatic transmissions.

Post-Service Clinical Labor Activities:

NA

Equipment

All of the technician ECG analysis and reporting services described above are accomplished through computer software and hardware which was specifically developed by the monitoring center providing this service. We have identified this equipment as the “ILR Interrogation system” for ease of reference. However this is not an off-the-shelf item that can be purchased from a third party vendor. It consists of software developed in-house as well as hardware such as servers and computer workstations.

For these reasons, pricing of equipment for this service as well as other remote cardiac services is a complex undertaking. Furthermore, it necessarily involves the disclosure of confidential and proprietary company data. Therefore, we recommend that the pricing of the ILR Interrogation System as well as the systems used to furnish other remote cardiac services be undertaken directly with CMS in accordance with prior precedent. Under that approach, the RCSPG would submit recommendations based on the facility’s equipment cost data supported by invoices, where applicable, and other company financials.

	1	2	3	4	5
1				93299	
2	Apr-08	CMS Code		Interrogation device evaluation(s), (remote), per 30 days, implantable cardiovascular monitor or implantable loop recorder, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	
3	LOCATION		Staff Type	Non Facility	Facility
4	GLOBAL PERIOD				
5	TOTAL CLINICAL LABOR TIME			114.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			114.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	End: When patient enters office/facility for surgery/procedure				
12	SERVICE PERIOD				
13	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
14	Intra-service				
15	Patient enrollment and education on use of device	L026A	MTA	3	
16	Review and analysis of ECG data from trending samples transmitted to the monitoring center and determine if physician notification is required	L026A	MTA	25	
17	Prepare monthly report and distribute to physician	L026A	MTA	3	
18	Review and analysis of patient symptomatic transmissions	L026A	MTA	5	
19	Notification to physician if criteria are met	L026A	MTA	18	
20	Review and analysis of asymptomatic transmissions	L026A	MTA	60	
21	Post-Service				
22					
23	Other Clinical Activity (please specify)				
24	End: Patient leaves office				
25					
26	Start: Patient leaves office/facility				
27	Other Activity (please specify)				
28	End: with last office visit before end of global period				
29	MEDICAL SUPPLIES				
30					
31	Equipment				
33	ILR Interrogation System (software and hardware)				
34					

**AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs**

CPT Long Descriptor:

Mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center without patient intervention for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed transmission of daily and emergent data reports

Sample Size: 2 Response Rate: (%): 100% Global Period: XXX

Geographic Practice Setting %: N/A Rural _____ Suburban _____ Urban _____

Type of Practice %: _____ Solo Practice
 _____ Single Specialty Group
 _____ Multispecialty Group
 _____ Medical School Faculty Practice Plan
 XXX Independent Diagnostic Testing Facility (IDTF)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Survey Process

This is a new technical component service that has never been reported using a specific CPT code. There are two providers of this service in the United States who report the service using an unlisted CPT code; both are IDTFs. The professional interpretation component is reported separately using a different CPT (that will also be new in 2009).

The two providers of this service are direct competitors and for legal and business reasons we had to create a process for collecting practice expense (PE) inputs from each of them that would completely mask each provider from the competitor's inputs. For this reason we hired a credible, independent third party, The Moran Company, to be the repository of PE input data submitted separately by each provider and to prepare calculations based on that data.

Representatives for each provider developed a common data collection tool that described the various clinical activities performed in connection with the service (based on the CPT description of service), the supplies used to perform the service and capital equipment. Each provider completed the tool and their representatives met to assure that the description of clinical labor activities, the description of supplies and of capital equipment was identical and that those descriptions accurately described staff activities, supplies and capital equipment. For a number of

items the data collection process was iterative as the providers had difficult collecting data in the format required by the PERC.

Once the data was collected and the provider's representatives determined that the line items were comparable and accurate – the tools were submitted separately to the Moran Company. The Moran Company determined the mean staff time for the two staff types used and developed a list of supplies and capital equipment used by both manufacturers that was not duplicative. If any supply or piece of capital equipment was used by only one company the other provider was notified to determine whether the item was included elsewhere on the tool and if it was not then it was deleted.

Description of the Service

Following is a description of how the technical component of Mobile Cardiovascular telemetry (MCOT) is performed. This is the same description that was included in the CPT application for this code. Per CMS convention, all activities are considered to be intra-service activities.

- The physician sends a prescription for mobile cardiovascular telemetry to the surveillance center. The prescription includes the types of reports requested and emergency notification criteria.
- The monitoring center contacts the patient and obtains clinical information from the patient relevant to providing the service (e.g, allergies to electrode patches). An appointment is made with the patient for education and to connect the monitor which may be done by telephone or in person, by a nurse or other appropriate licensed or credentialed healthcare professional.
- The monitor is uniquely configured by linking the sensor to the monitor, and by linking the monitor to both the patient and patient's record. This enables the monitor to transmit electrocardiographic data directly to the appropriate patient record. The monitor, sensor, base, electrodes, assorted accessories, and education materials are sent to the patient.
- The monitoring center educates the patient and facilitates the connection. This includes instruction on monitor set up and care, the wireless technology (how the monitor works and automatically transmits electrocardiographic data without patient intervention), electrode placement and care, how to record symptomatic events, and the meaning of and response to alert messages. A baseline electrocardiographic transmission is sent to the monitoring center to ensure the electrodes are connected properly.
- During the monitoring period, the monitor automatically transmits ECG data to the monitoring center when the algorithm identifies asymptomatic arrhythmias or when the patient triggers a symptomatic ECG segment. The surveillance technician reviews and analyzes each ECG segment and if the arrhythmia meets the notification criteria, the ordering physician is called immediately and an urgent report is prepared and sent.
- During the monitoring period, the monitor transmits comprehensive ECG data each day that is permanently stored and used to construct a comprehensive daily report which includes a heart rate trend graph and, if applicable, atrial fibrillation burden graph and other recorded ECG data. The daily report is transmitted to the ordering physician. The monitor records and analyzes all heartbeats and stores greater than 24 hours of the most recent recorded heartbeats. The stored ECG data are available to the ordering physician upon request.

- The patients typically contact the monitoring center a number of times to ask questions about the electrodes, or an alert message on the monitor screen or for other technical issues. The monitoring center typically contacts patients for issues such as artifact transmission, and lack of transmitted ECG segment data due to removal of a lead or a possible break in service. A summary report is generated by the monitoring center that is sent to the ordering physician. The monitoring center transmits the summary report to the ordering physician.
- The patient removes the electrodes, unhooks and packages all the equipment in a pre-paid return box and ships the material to the monitoring center. If the patient is unable to ship the box, arrangements are made by the monitoring center to pick up the equipment.

Following return of the device to the center, the center cleans and services the device and prepares it for use by the next patient.

In addition to the technical component of this service there is a professional, interpretation component which is coded separately and reported by the interpreting physician.

Electrodiagnostic Technician Time

Methodology

ED staffing must comply with Medicare requirements for IDTF's that perform remote cardiac monitoring. These include requirements for ED qualifications, training and experience as well as an absolute requirement to remain open 24 hrs/d, 7 days/wk, 52 wks/yr. This means that the IDTF must be staffed by EDs 24/7.

The mean number of days that a patient remains on the service is fifteen.

Not only is there a shortage of ED's, but the training and qualification requirements mean that ED's are not fungible and can not be hired or let go on short notice. Training takes several weeks and during that time trainees cannot perform services independently. Therefore providers of remote cardiac monitoring services must anticipate service volume and hire staff in advance of an increase in service levels. The providers attempt to maintain a constant number of patients being monitored per ED over time. However, daily fluctuations in service volume, absence from work and ED experience level result in fluctuations of this ratio on a day to day basis. However, irrespective of the number of patients being monitored on any given day, the providers must staff their facilities 24/7 and have an adequate number of ED's on staff.

This service is the only service one of the providers performs – therefore all staff are completely dedicated to monitoring MCOT patients (i.e., the provider does not perform event monitoring or any other services). The other provider does perform other remote monitoring services but the ED's performing MCOT are 100% dedicated to MCOT and do not perform any other services. Therefore, 100% of the ED time is allocated to this code and the IDTF must be staffed 24/7.

Consequently, as described in recommendations for 93X15 and 93X18, instead of using the usual PERC methodology of adding up the number of minutes per task, for calculating staff time per service, we employed a different methodology that took into account the fact that the providers must furnish services on a 24/7 basis regardless of the number of patients being monitored. CMS has previously accepted this methodology for calculating ED minutes/service for cardiac event monitoring (93271 and 93012) and pacemaker monitoring (93733 and 93736).

We calculated the ED time per service for the most recent twelve month period for which complete data was available (either 7/1/06 through 7/1/07 or 1/1/07 through 12/31/07). FTE EDs for the 12-month period were calculated by each provider and that number was multiplied by the number of hours an FTE is expected to work (2080) and then by 60 (the number of minutes in an hour) to determine the total number of ED minutes/yr. We then divided that number by the total number of services performed for the twelve month period to determine the number of ED minutes/service. The recommendation reflects the mean for the two providers.

Please note that these are the number of minutes for which the providers must pay ED's irrespective of how many minutes are actually spent on patient care or how many services are being provided at any point in time.

Although it is possible to calculate ED minutes/service using various methods, the following factors make it very unlikely that any one method would be more accurate than any other: (1) staffing levels change (generally increasing) over time on an irregular basis making it practically impossible to know for sure how many completely trained ED's are working on any given night or in any particular month; (2) the number of services provided per day changes daily and is generally increasing over time and does not perfectly match the number of ED FTE's; (3) the length of each service has changed over time (going up a day or two per service over the last 18 months); and (4) the number of trainees working on any given night is unknown. Therefore, it is not possible to determine an "average" number of ED's or an "average" number of services performed per day or per month.

Technician Activities

Each day the ED reviews up to 15 (or sometimes more) transmissions per patient from the monitor. The time it takes to review and analyze these transmissions is typically between 1 to 1.5 minutes though this time can be longer depending on the length and complexity of the event. In no case would it take less than 0.75 minutes. In addition some of these transmissions require the preparation of an urgent report and immediate notification of the physician. When this occurs, the time required to prepare the report, call and reach the physician by phone and send the report can take 15 – 30 minutes. Depending on how many times this occurs during a monitoring period this can add a few minutes of ED time per day when spread across 15 days. In addition, the ED reviews the heart rate and atrial fibrillation burden graphs and prepares a daily report which includes those graphs, other data and appropriate rhythm strips. It takes 1-3 minutes to prepare this report and assure it is correct, depending on the amount of data and whether or not it contains any abnormalities. These activities alone add up to approximately 15-16 minutes per patient per day, on average. This does not take into account any other activities that are performed once or intermittently throughout the service period.

Medical/Technical Assistant Time

This was calculated using the usual PERC methodology of summing the minutes per task to arrive at a total number of minutes per service for services provided by the MTA staff type because these individuals are not staffed on a 24/7 basis. One provider staffs these individuals 20 hr/day and the other staffs 16 hr/day).

Our recommendation reflects the mean number of minutes spent by this staff type per service.

Pre-Service Clinical Labor Activities:

N/A

The following is a description of all intra-service activities for both the RN/LPN/MTA and the ED.

Intra-Service Clinical Labor Activities:

- The MTA calls the patient to obtain clinical information, arrange for the device kit to be delivered, and sets up an appointment for education and to connect to the monitor
- The MTA scans, tests and configures the device for the patient per physician orders
- The MTA prepares the device for shipping complete with education materials and supplies
- The MTA educates the patient on use of the device and service including instruction on the monitor set up and care, how wireless technology works, electrode placement and care, how to record symptomatic events; the meaning of and response to alert messages; and connection of the device
- The MTA confirms that a baseline EG transmission has been accepted into the monitoring center
- After the device begins transmitting, the MTA receives and responds to patient questions by telephone and contacts the patient to address issues such as break in service, problem with service, electrode irritation, electrode artifact and other device issues
- The electrodiagnostic technician (ED) reviews and analyzes patient ECG data transmitted to the monitoring center via patient or auto-trigger and determines if MD notification is required. These transmissions occur several times per day.
- If MD notification criteria are met, the ED calls the physician and prepares an urgent report sent by fax or email.
- The ED reviews ECG data of the past 24 hours, identifies any abnormalities in the data, and prepares and transmits a daily report.
- At the end of the service, the MTA creates a summary report and transmits it to the physician

CPT Code: 93229

- The MTA makes and end of service call to the patient to alert them to the pending discharge
- The MTA contacts the patient to arrange for return of the monitor
- An MA cleans, downloads data, services and restocks units returned by the patient

Post-Service Clinical Labor Activities:

N/A

Supplies

- **Electrodes:** Three sensors (electrodes) are placed on the chest to collect heart rhythm data. The sensors come in packages of three and are changed daily. If any electrodes are returned they are usually unusable because the package seal has been broken or they are damaged. The providers can not risk sending damaged electrodes to patients who are being monitored continuously so they do not attempt to reuse returned electrodes.
- **Batteries:** The remote monitor requires one AA battery to function. The monitor is on continually and the battery must be replaced each day.
- **Delivery and Return:** The monitor is shipped to the patient by Federal Express or UPS and charges directly attributable to the patients are incurred.
- **Wireless Communication:** The monitor contains a wireless communication device specific to the monitor. The reason why the unit of use is “1” is because the provider incurs a fixed flat rate fee for wireless communications that is negotiated with the wireless service provider. The fee is the same irrespective of the number of transmissions sent, the number of minutes required to send transmissions, or the number of days the monitor is in use. Therefore it is inappropriate to use minutes, days or transmissions as the unit of supply for this item. The unit is “the wireless service” which is similar to the fixed rate most people pay for their cell phone plan every month irrespective of the number of calls or minutes of use. In practice, the wireless device is turned on when the monitor is shipped to the patient and turned off when the monitor is returned to the provider. The wireless device is uniquely configured for each patient so that the telemetry data transmitted to the IDTF is linked to the patient’s IDTF record and can not be mixed-up with telemetry data from any other patient. The fixed fee for the wireless device includes configuration, turn-on, turn-off and the monitoring service.
- **Dedicated Patient Communication 800 Line:** The Providers must maintain an 800 number (or toll free line) for patients to contact the IDTF and for the IDTF to contact the patient. This is because a single IDTF monitors patients all over the country and any other method of making long-distance calls could deter patients from making necessary calls because of cost. Patients typically contact the center several times with questions about the electrodes, or an alert message on the monitor screen or other technical issues. These communications are directly related to the clinical service and are separate from phone calls related to billing or other non-clinical matters which are not made over the dedicated 800 line. Likewise, the monitoring center typically contacts patients for issues such as artifact transmission, and lack of transmitted ECG segment data due to removal of a lead or a possible break in service. The providers incur a monthly fixed fee for the 800 line irrespective of the number of calls made or the minutes of use. The 800 line is not used for any other communications.

Equipment

Equipment used to provide this service consists of

- A portable cardiac telemetry monitoring device furnished to the patient. This consists of a monitor, sensor, base, electrodes, a wireless communication device, software for cardiac rhythm analysis and various accessories. The wireless device is used to transmit the patient's ECG data;
- Computer hardware and software systems located at the IDTF which are necessary to receive the data, convert it into usable clinical information, make it available to the clinical staff for review and analysis, transmit it to the physician (e.g., by secure email, fax etc.), and create daily and summary reports;
- A technician workstation (computer, monitor, telephone);
- A webserver system (separate from the servers that collect telemetry information) which allows for secure web-based access of the physician to telemetry data;
- Dedicated call recording system which provides a record of all patient communications to the monitoring center.

The software used to provide the service has been either developed or customized by each provider in-house. One of the providers also provides other remote monitoring services and some of the hardware and software used to provide the service is shared with other services and costs are allocated to this service based on utilization.

Establishing provider costs for this equipment necessarily involves review of confidential and proprietary data. As noted above, because the two providers are competitors, it is essential that the confidentiality of this information be protected. Consequently, we recommend that for purposes of valuing equipment costs for this service, we use the same approach as was used by the RCSPG in 2006 in connection with revaluing of other remote cardiac services. Under that approach, at CMS' request, the RCSPG submitted recommendations based on data from a representative sample of companies, supported by invoices, where applicable, and other company financials using a process in which no company was able to view the data submitted by any other company. This documentation was identified as confidential and proprietary and is protected from disclosure under the federal FOIA and Privacy Acts.

	1	2	3	4	5
1				93229	
2	Meeting Date: April 2008		Mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center without patient intervention for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed transmission of daily and emergent data reports		
3	LOCATION	Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD				
5	TOTAL CLINICAL LABOR TIME			325.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			325.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
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	SERVICE PERIOD				
19	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
20	Intra-service				
21	Call patient to obtain clinical information, arrange for kit to be delivered, and set up appt for education and to connect to monitor	L026A	MTA	8	
22	Scan, test and configure the device for patient per physician orders	L026A	MTA	19	
23	Prepare device for shipping complete with education materials and supplies	L026A	MTA	5	
24	Education patient on use of device and service (instruction on monitor set up and care, how wireless technology works, electrode placement and care, how to record symptomatic events, and meaning of and response to alert messages, connection of device)	L026A	MTA	22	
25	Confirm baseline transmission (EKG) has been accepted into monitoring center	L026A	MTA	3	
26	Receive and respond to patient questions by telephone, contact patient to address issues such as break in service, problem with service, electrode irritation, electrode artifact, device issues	L026A	MTA	33	
27	Review ECG data transmitted to the monitoring center via patient or autotrigger, determine if MD notification is required, review and post MD notification, prepare report for MD notification, call to MD to notify, confirm criteria, send report by fax or email, review all transmitted ECG data and identify abnormalities for report, review heart rate and A-fib burden graph, follow up to get signed report if criteria changed by MD, call patient and emergency medical services if necessary, prepare and send report	L037A	ED	214	
28	Creation of summary report and transmission to ordering physician	L026A	MTA	3	
29	End of service call to alert patient to pending discharge	L026A	MTA	3	
30	Contact patient for monitor return	L026A	MTA	3	
31	Clean, download data, service and restock units returned by patients	L026A	MTA	12	
32	Post-Service				
33	End: Patient leaves office				
34	POST-SERVICE Period				
35	Start: Patient leaves office/facility				
36	Conduct phone calls/call in prescriptions				
37	Office visits: NONE				
44	Other				
45	Other Activity (please specify)				
46	End: with last office visit before end of global period				
47	MEDICAL SUPPLIES		Unit		
48	Batteries (AA)			14	
49	Wireless Communication per service			1	
50	Electrodes, single	SD053		42	
51	patient instruction book			1	
52	delivery cost for mailing and return of device			2	
53					
54	Equipment		Unit		

AMA Specialty Society Recommendation

	1	2	3	4	5
1				93229	
2	Meeting Date: April 2008		Mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center without patient intervention for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed transmission of daily and emergent data reports		
3	LOCATION	Code	Staff Type	Non Facility	Facility
55	Cardiac Telemetry Monitoring Device				
56	Cardiac Telemetry System (software and hardware)				
57	MCOT System Tech Workstation				
58	MCOT System Webserver				
59	Call Recording System				

AMA/Specialty Society RVS Update Committee

September 2007

Echocardiography

Background

For the 2005 Five Year Review, CMS originally requested review of CPT Code 93325 *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)* (work RVU = 0.07, ZZZ global) as it had not been reviewed by the RUC. The American College of Cardiology (ACC) surveyed the code and recommended an increased work RVU to the RUC. During that meeting, the RUC reviewed the specialty's survey results and rationale and noted that code 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete* (work RVU = 0.92, XXX global period) was almost always billed with 93325. The RUC recommended code 93325 be referred to the CPT Editorial Panel for consideration for bundling with 93307.

During the October 2006 RUC meeting, the RUC was informed that CPT code 93325, had not yet been reviewed by the CPT Editorial Panel following the most recent Five-Year Review. The specialty society had indicated to CPT that it did not intend to submit a CPT code proposal. Although the RUC indicated an interest in bundling the service with other cardiology services, ACC argued that bundling is inappropriate due to the service's varied utilization pattern with a wide variety of other services. Since ACC did not develop a bundled coding proposal and the CPT Panel Executive Committee did not discuss it, the RUC would need to examine the code again.

The specialty presented their 2005 survey data results for 93325 at the February 2007 RUC meeting. The RUC also reviewed data from the 2005 Medicare Utilization files for 93325 and other services in this family of codes. The RUC discussed the inherent nature of providing the services described in 93325, 93307, and 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* on the same day by the same physician, as illustrated in the following table:

Same Day Occurrences for 93325 with Codes Billed Together at Least 90% of the Time

Produced from the 2005 5% Sample File

CPT Code 1	CPT Code 2	Code 1 Services	Same Day Billed Occurrences	% of Time Code 1 Billed with Code 2
93325	93320	138,398	136,433	98.58%
93325-TC	93320-TC	23,039	22,645	98.29%
93325-26	93320-26	211,640	206,755	97.69%
93325	93307	13,8398	130,949	94.62%
93325-TC	93307-TC	23,039	22,298	96.78%
93325-26	93307-26	211,640	197,093	93.13%

The RUC discussed its policy for other services that are inherent in the provision of physician services. For example, when conscious sedation is inherent to procedures it is included within the valuation of the procedure and not reported separately. Likewise, the CPT Editorial Panel has moved to an approach of including radiological guidance within a new CPT code if it is inherent to the procedure. The RUC understood that the American College of Cardiology is taking a long-term, broad review of their services and welcomed this approach. However, the data for 93320, 93325, and 93307 is clear and the RUC recommended a coding proposal be prepared by the specialty society to immediately address this as one service versus three distinct services.

In June 2007, the CPT Editorial Panel edited four codes and created a new code that reflects the work of CPT codes 93307, 93320 and 93325 when performed together. The panel created new code 93306 *Echocardiography, transthoracic real-time with image documentation (2D), including M-mode recording if performed, with spectral Doppler echocardiography, and with color flow Doppler echocardiography* which combined the following three codes into one service:

- 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete* (work RVU = 0.92)
- 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU = 0.38)
- 93325 *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)* (work RVU = 0.07)

This CPT code revision was in response to changes in clinical practice that have generally made the performance of spectral and color flow Doppler an integral part of a complete transthoracic echocardiogram. The introduction of the new code serves to maintain 93307 CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(two dimensional echocardiography) and to preempt coding confusion for the instance when imaging without color flow or velocity information is requested. In addition, the CPT Editorial Panel made necessary editorial changes in the introductory language of Echocardiography to accommodate the new code.

RUC Review and Recommendation

In September 2007, the RUC reviewed the specialty society's survey results of the physician work for new code 93306 from a random sample of 597 physicians. The specialty received a response rate of 16.4% (nearly 100 respondents) that indicated the physician work was believed to approximate the sum of its inherent procedure codes (93307+93320+93325). The median survey results indicated a work RVU of 1.44 which is slightly more than the sum of its parts ($0.92+0.38+0.07 = 1.37$). The specialty society indicated that the majority of echocardiography laboratories have shifted from image recording on videotape to digital image recording. While the physician is now able to review recorded images and associated flow velocity waveforms in a shorter period of time due to the use of digital technology, the interpreting physician actually reviews more data (and provides more complex analyzes) in a shorter period of time. The specialty society's RUC Advisory Committee believed that the intensity of the physician work had increased, and compared the work to several other codes as reference points, including:

- 76485 *Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification* (Work RVU = 1.46, 2005 Five Year Review Code)
- 78708 *Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing* (Work RVU = 1.19, RUC Multi-specialty Points of Comparison Listed)
- 93975 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (Work RVU = 1.48, 2000 Five Year Review Code)
- 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (Work RVU = 1.48)

The specialty society's RUC Advisory Committee understood that although the intensity of the service had increased with imaging technological advances, the overall physician work may have decreased. This same committee reviewed the distribution of the survey results and noted that survey median physician time (31.50 minutes) is less than the building block time of 43 minutes and that there was a tight spread between the 25th and 75th percentiles (1.30 – 1.76). The specialty acknowledged that although the survey respondents indicated the physician work was slightly more (1.44) than the sum of its parts (1.37), the total physician time was lower by 11.5 minutes. The specialty therefore acknowledged that there are economies of scale when these services are provided together and recommended the 25th percentile survey results (Work RVU = 1.30) would provide the proper valuation of this new code.

The RUC reviewed the specialty recommendation for new code 93306 and believed that the specialty survey results provided an accurate depiction of the typical patient. The RUC reviewed the new bundled code in relation to code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; A detailed examination; 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.* (Work RVU = 1.34, 20 minutes of intra-service time). The RUC believed that the rationale provided by the specialty was consistent with efficiency gains associated with performing these services together and their proposed physician work value of 1.30 is appropriate in relation to other services among and across specialties.

The RUC recommends a physician work relative value of 1.30 for code 93306.

Practice Expense

The RUC reviewed the direct practice expense which was an additive approach from existing inputs (93307+93320+93325) which were reviewed and recommended by the RUC in March 2002. The RUC, understanding that the issue originated from the most recent Five Year Review, believed that the addition of these existing clinical labor, medical supplies, and equipment, provided an accurate set of direct inputs. The RUC did, however, believe that a reduction in the clinical staff time was appropriate due to efficiencies in performing these services together. The RUC recommends a total clinical labor time of 82 minutes rather than the sum of its parts totaling 91 minutes, and no change to the medical supplies and equipment (other than a reduction in equipment time). The specialty society contended that the Echocardiography is now digitally recorded and a revision of the equipment for these services should be made. The RUC suggested this discussion should more appropriately be discussed either through formal request from CMS or as part of a Five Year Review of practice expense. An Excel spreadsheet is attached with these recommendations for the facility and non facility settings.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Echocardiography includes obtaining ultrasonic signals from the heart and great arteries, with two-dimensional vessels, with real time image and/or Doppler ultrasonic signal documentation, and with interpretation and report. When interpretation is performed separately use modifier 26.</p> <p>Echocardiography is an ultrasound examination of the cardiac chambers and valves, the adjacent great vessels, and the pericardium. A complete transthoracic echocardiogram (93307-93306) is a comprehensive procedure that includes 2-dimensional, spectral Doppler, color flow Doppler and selected M-mode examination of the left and right atria, left and right ventricles, the aortic, mitral, and tricuspid valves, the pericardium, and adjacent portions of the aorta. These structures are assessed using multiple views as required to obtain a complete functional and anatomic evaluation, and appropriate measurements are obtained and recorded. Despite significant effort, identification and measurement of some structures may not always be possible. In such instances, the reason that an element could not be visualized must be documented. Additional structures that may be visualized (eg, pulmonary veins, pulmonary artery, pulmonic valve, inferior vena cava) would be included as part of the service. Color and/or spectral Doppler may also be used in conjunction with other base echocardiography codes (exclusive of 93306 and 93307) when flow and velocity information is needed.</p> <p>A follow-up or limited echocardiographic study (93308) is an examination that does not evaluate or document the attempt to evaluate all the structures that comprise the complete echocardiographic exam. This is typically performed in follow-up of a complete echocardiographic examination when a repeat complete exam is unnecessary due to the more focused clinical concern. In some emergent clinical situations, a limited echocardiographic study may be performed primarily.</p> <p>Report of an echocardiographic study, whether complete or limited, includes an interpretation of all obtained information, documentation of all clinically relevant findings including quantitative measurements obtained, plus a description of any recognized abnormalities. Pertinent images, videotape, and/or digital data are archived for permanent storage and are available for subsequent review. Use of echocardiography not meeting these criteria is not separately reportable.</p> <p>Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation and final, written report, is not separately reportable.</p>				
●93306	G1	<p>Echocardiography, transthoracic real-time with image documentation (2D), including M-mode recording if performed, with spectral Doppler echocardiography, and with color flow Doppler echocardiography</p> <p>(For transthoracic echocardiography without color flow or velocity, use 93307)</p>	XXX	1.30
▲93307		Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete	XXX	0.92

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Do not report 93307 in conjunction with 93320, 93321 or 93325)		(No Change)
▲+93320		Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete (Use 93320 in conjunction with 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350)	ZZZ	0.38 (No Change)
▲+93321		Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging) (Use 93321 in conjunction with 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350)	ZZZ	0.15 (No Change)
▲+93325		Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography) (Use 93325 in conjunction with 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350)	ZZZ	0.07 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93306 Tracking Number G1 Specialty Society Recommended RVU: **1.30**
Global Period: XXX RUC Recommended RVU: **1.30**

CPT Descriptor: Echocardiography, transthoracic real-time with image documentation (2D), including M-mode recording if performed, with spectral Doppler echocardiography, and with color flow Doppler echocardiography

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old man with a history of coronary artery disease and hypertension presents with exertional shortness of breath and progressive exercise intolerance. On clinical evaluation, blood pressure is 140/90 mmHg, heart rate is regular at 90 bpm, and respirations are elevated at 20 per minute. Examination is notable for rales in the lung fields, and a systolic murmur is heard. Cardiomegaly and pulmonary congestion are noted on chest X-ray, and LVH is noted on ECG.

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? 86 %

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews existing information (e.g. request for an echocardiographic evaluation) and relevant clinical records to clarify the indications for the procedure and to determine the clinical questions that need to be answered.

Description of Intra-Service Work: A sequence of real-time tomographic images of cardiac structure and dynamics is obtained from multiple views and recorded on videotape or digitally. Selected M-mode (time-motion) recordings may be made to facilitate dimensional measurement. Using color Doppler flow imaging, blood flow velocity patterns are viewed and recorded across the cardiac valves and along the atrial and ventricular septae, as well as in the great arteries and veins. When abnormal findings indicate valvular regurgitation or an intracardiac or extracardiac shunt, additional views are recorded. Using spectral Doppler (by means of pulsed and/or continuous wave techniques), flow velocities are recorded across the cardiac valves, and abnormal flow signals (such as with stenotic or regurgitant valves) are recorded usually from multiple transducer positions and orientations. The interpreting physician may verify the suitability of the images and Doppler flow data prior to the completion of the study, and may obtain additional views if necessary. The interpreting physician reviews videotaped or digitally recorded views of the heart, and analyzes and measures the structure and dynamics of the heart chambers, valves, and great vessels. In the context of the anatomic and dynamic findings, the presence of any abnormalities of the flow stream in the heart and great vessels is noted, and where appropriate measures of jet width, jet area, proximal flow convergence, and flow propagation velocity are made to help quantitate the severity of abnormalities noted. The interpreting physician also reviews spectral Doppler velocity recordings and makes or verifies quantitative measures. Doppler velocities are used for hemodynamic assessment of systolic and diastolic left ventricular function as well as pressures in the right atrium, right ventricle, pulmonary artery, and left atrium. When appropriate, calculations include pressure gradients and valve orifice areas in patients with stenotic valves, and regurgitant volumes, regurgitant fractions, and effective regurgitant orifice areas in patients with pathologic valvular regurgitation. From these anatomic and hemodynamic data, a complete interpretation is developed. Quantitative anatomic and functional measures such as left ventricular size, wall thickness, mass, ejection fraction, and regional wall motion are made, and the sizes of the left atrium, aorta, and right heart chambers are documented. Final interpretation typically also involves review of relevant tomographic views and hemodynamic data in comparison to previous study findings in order to determine if qualitative and quantitative changes have occurred.

Description of Post-Service Work: A report is then prepared, reviewed and corrected if necessary, and signed. The study findings may be reviewed in detail with the requesting physician in order to facilitate appropriate patient management decisions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		09/2007			
Presenter(s):	Thomas Ryan, MD, Michael Picard, MD, Benjamin Byrd, III, MD				
Specialty(s):	American College of Cardiology				
CPT Code:	93306				
Sample Size:	597	Resp N:	98	Response: 16.4 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	362.50	1000.00	2000.00	5000.00
Survey RVW:	0.90	1.30	1.44	1.76	4.50
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	0.00	10.00	20.00	25.00	60.00
Immediate Post Service-Time:	<u>6.50</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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			
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 93306	
	Specialty Recommended
Physician Work RVU:	
Pre-Service Evaluation Time:	
Pre-Service Positioning Time:	
Pre-Service Scrub, Dress, Wait Time:	
Intra-Service Time:	
Immediate Post Service-Time:	
Post Operative Visits	Total Min** CPT Code and Number of Visits
Critical Care time/visit(s):	<u>0.0</u> 99291x 99292x
Other Hospital time/visit(s):	<u>0.0</u> 99231x 99232x 99233x
Discharge Day Mgmt:	<u>0.0</u> 99238x 99239x
Office time/visit(s):	<u>0.0</u> 99211x 12x 13x 14x 15x
Prolonged Services:	<u>0.0</u> 99354x 55x 56x 57x

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93307	XXX	0.92	RUC Time

CPT Descriptor Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
78465	XXX	3,013,393	1.46	RUC Time

CPT Descriptor 1 Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
78494	XXX	6293	1.19	RUC Time

CPT Descriptor 2 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing

Other Reference CPT Code Global Work RVU Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 42 **% of respondents:** 42.8 %

TIME ESTIMATES (Median)

	CPT Code: 93306	Key Reference CPT Code: 93307	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	20.00	18.00	
Median Immediate Post-service Time	6.50	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	31.50	28.00	
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	4.24	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.36
Urgency of medical decision making	3.90	3.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.16	3.52
Physical effort required	2.18	2.14

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.78	2.57
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	4.31	3.98
Estimated risk of malpractice suit with poor outcome	3.72	3.38

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.07	2.07
Intra-Service intensity/complexity	3.82	3.24
Post-Service intensity/complexity	2.98	2.86

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 was reviewed by a consensus panel of the specialty society's RUC committee.

Compelling Evidence for Change: The surveyed code is a new code. This is its initial valuation.

The specialty society expert consensus panel members reviewed the survey. They noted the large number of respondents (98), the high response rate (16%), and the relatively tight spread between 25th and 75th percentiles (1.30 – 1.76). The expert panel agreed that the survey median of 1.44 RVU and total time of 31.5 minutes were appropriate.

Building Block Method

The components of the new code include the following

Code	RVU	RUC Intra-time	RUC Total Time
93307	.92	18	28
93320	.38	15	15
93325	.07	---	---
TOTAL	1.37	33 + +	43 + +

The expert panel noted that the survey median (1.44) was close to the building block method total RVU of 1.37. The expert panel noted that the specialty society survey of 93325 during the 5 year review produced a survey median of RVU .30 and that clinicians uniformly agree that the current value of .07 for 93325 is a significant under-valuation. If the 5 year review survey of .30 for 93325 is used in the building block method, the total is 1.6, higher than the current survey median.

The expert panel noted that the survey median time of 31.5 minutes is less than the building block time of > 43 minutes. The panel believes that this is due to the fact that since the previous RUC values for intra-service time were established for the component codes, the majority of echocardiography laboratories have shifted

from image recording on videotape to digital image recording. While this does not save time in the recording of the study, it does facilitate review of the recorded images by the interpreting physician. This same phenomenon is undoubtedly true for many other diagnostic imaging modalities.

The expert panel made specific note of two points that they believe are relevant to echocardiography services. First, while the physician is now able to review recorded images and associated flow velocity waveforms in a shorter period of time due to use of digital technology, the interpreting physician actually reviews more data (and provides more complex analysis) in that shorter period of time; hence the intensity of physician work has increased as the time needed to perform this work has decreased. Second, as noted explicitly in the description of intra-service work, “final interpretation typically also involves review of relevant tomographic views and hemodynamic data in comparison to previous study findings in order to determine if qualitative and quantitative changes have occurred”. The panel noted that this descriptor was not available to survey respondents. In estimating the time needed to review the bundled study now described in CPT 933xx, many respondents likely focused exclusively on the review and interpretation of the current study, and did not include the additional 5-10 minutes needed to call up the prior study images, review them side by side with the current study images, and include that information in the final report. The panel agreed that the typical patient undergoing a complete transthoracic echo study in 2007 has had a prior study, and that the time needed to make careful comparisons for serial changes is important to consider.

Cross-Walk to Cardiology Codes

The expert panel noted that the survey median of 1.44 is in the same range as other cardiology imaging codes, such as the MPC codes listed above (78465, Myocardial perfusion imaging; tomographic (SPECT), 1.46 RVU and 78494, Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, 1.19 RVU. The current survey median is similar to other cardiology imaging codes such as – stress echo (CPT 93350 – 1.48 RVU’s, 40 minutes intra-service).

Cross-Walk to other Non-Cardiology Codes

The expert panel also noted that the current survey median was similar to other non-cardiology imaging codes; these include: abdominal arterial and venous ultrasound (93975 – 1.8 RVU’s, 41 minutes intra-service), Brain MRI (70551 – 1.48 RVU’s, 25 minutes intra-service), 78708 (kidney flow and function, with pharm stress, single study – 1.21 RVU’s, 32 minutes intra-service time) this latter service involves stress, but far fewer possible diagnoses and CT Throat with Contast (71260 – 1.24 RVU’s, 15 minutes intra-service).

IWPUT analysis

IWPUT analysis was not undertaken since it is not validated or accepted for imaging services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93307, 93320 and 93325

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Internal Medicine How often? Sometimes

Specialty IDTF How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 15,500,000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Previously 93307, 93320 and 93325 were performed approximately 95 % of the time with the base code 93307. These services will now be reported with the new 933XX code. No comprehensive claims data is available for the non-Medicare population, however, our clinical experts estimate a bit more than double the Medicare utilization.

Specialty Cardiology Frequency 12087014 Percentage 77.98 %

Specialty Internal Medicine Frequency 2015000 Percentage 13.00 %

Specialty IDTF Frequency 420,000 Percentage 2.70 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,495,586 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Previously 93307, 93320 and 93325 were performed approximately 95 % of the time with the base code 93307. These services will now be reported with the new 933XX code. These numbers are based on 2005 Medicare data and extrapolating the frequency out.

Specialty Cardiology Frequency 5066557 Percentage 77.99 %

Specialty Internal Medicine Frequency 844426 Percentage 12.99 %

Specialty IDTF Frequency 175897 Percentage 2.70 %

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 Update Process
PERC Summary of Recommendation
XXX Global Period
Non - Facility Direct Inputs

CPT Long Descriptor: Echocardiography, transthoracic real-time with image documentation (2D), including M-mode recording if performed, with spectral Doppler echocardiography, and with color flow Doppler echocardiography

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 College of Cardiology (ACC) convened representatives of both the ACC and the American Society of Echocardiology (ASE) to discuss practice expense inputs. These groups convened a 16 member consensus panel to collect and refine practice expense data. The panel included both physicians practicing echocardiography and cardiac sonographers. Physicians were split equally between those in private practice and those in faculty practice plans. Solo practice, single specialty group practice, and multispecialty group practice were all represented. Panel members were geographically diverse and represented both large and small practices, as well as both rural and urban practice settings. Panel members worked closely with their practice administrators.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service period an Cardiac Sonographer typically performs the following activities:

- Review/read x-ray, lab, and pathology reports

Intra-Service Clinical Labor Activities:

During the intra-service period a Cardiac Sonographer typically performs the following activities:

- Greet patient and provide gowning
- Obtain vital signs
- Prepare room, equipment and supplies
- Prepare and position patient/ monitor patient/ set up IV
- Acquire ultrasound data
- Process data, measure and record preliminary findings

Post-Service Clinical Labor Activities:

During the post-service period a Cardiac Sonographer typically performs the following activities:

- Conduct phone calls/call in prescriptions
- Other Activity (please specify) *QA documentation required for accreditation*

	A	B	C	D	E
1				93306	
2	Meeting Date: September 2007 AMA/Specialty Society RUC Recommendation			Echocardiography, transthoracic real-time with image documentation (2D), including M mode recording if performed, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD			XXX	XXX
5	TOTAL CLINICAL LABOR TIME for service		all staff types	82.0	0.0
6	TOTAL CLINICAL LABOR TIME	L050A	Cardiac Sonographer	70.0	
7	TOTAL CLINICAL LABOR TIME	LD037E	RN/LPN/MTA	12.0	
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L050A	Cardiac Sonographer	3.0	
9	TOTAL PRE-SERV CLINICAL LABOR TIME	LD037E	RN/LPN/MTA	5.0	
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	LD037E	RN/LPN/MTA	7.0	
11	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L050A	Cardiac Sonographer	63.0	
12	TOTAL POST-SERV CLINICAL LABOR TIME	L050A	Cardiac Sonographer	4.0	
13	PRE-SERVICE - total			8	
14	Start: Following visit when decision for surgery or procedure made				
15	Other Clinical Activity (please specify) Review prior echo studies	L050A	Cardiac Sonographer	3	
16	Complete pre-service diagnostic and referral forms (pre-certification)	L037D	RN/LPN/MTA	5	
17	End: When patient enters office/facility for surgery/procedure				
18	SERVICE PERIOD - total			70	0
19	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
20	Review charts (document clinical elements - patient history)	L037D	RN/LPN/MTA	1	
21	Greet patient and provide gowning	L037D	RN/LPN/MTA	3	
22	Obtain vital signs	L037D	RN/LPN/MTA	3	
23	Prepare room, equipment, supplies	L050A	Cardiac Sonographer	3	
24	Prepare and position patient/ monitor patient/ set up IV	L050A	Cardiac Sonographer	3	
25	Intra-service				
26	Acquire ultrasound data	L050A	Cardiac Sonographer	42	
27	Process data; measure & record preliminary findings	L050A	Cardiac Sonographer	10	
28	Post-Service				
29	Clean room/equipment	L050A	Cardiac Sonographer	3	
30	Other Clinical Activity (please specify) patient education, instruction, and counseling	L050A	Cardiac Sonographer	2	
31	End: Patient leaves office				
32	POST-SERVICE Period - total			4	0
33	Start: Patient leaves office/facility				
34	Conduct phone calls/call in prescriptions	L050A	Cardiac Sonographer	0	
35	Other Activity (please specify) QA documentation required for accreditation	L050A	Cardiac Sonographer	4	
36	End: with last office visit before end of global period				
37	MEDICAL SUPPLIES	CMS Code	Unit	Unit Cost	
38	drape, non-sterile, sheet 40in x 60in	SB006	1 item	\$ 0.220	
39	pack, minimum multispecialty visit	SA048	1 item	\$ 1.140	
40	Sanitizing cloth - wipe (echo ultrasound)	SM022	3 wipes	\$ 0.140	
41	ultrasound transmission gel	SJ062	180	\$ 2.340	
42	Video tape, VHS	SK086	0 2 item	\$ 0.410	
43	ECG electrode single	SD053	3 items	\$ 0.090	
44	Computer media, optical disk 128mb	SK015	0 2 item	\$ 2.400	
45	EQUIPMENT	CMS Code	Unit		
46	Computer, desktop with monitor	ED021	1	42 minutes	
47	video SVHS, VCR (medical grade)	ED034	1	10 minutes	
48	video printer, color (Sony medical)	ED036	1	42 minutes	
49	stretcher	EF018	1	42 minutes	
50	ultrasound, echocardiography analyzer software (ProSolv)	EQ252	1	10 minutes	
51	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec)	EQ253	1	42 minutes	
52	ultrasound, echocardiography w-4 transducers (Sequoia C256)	EQ254	1	42 minutes	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Stress Echo with ECG Monitoring

The CPT Editorial Panel created two new codes to describe continuous electrocardiographic monitoring and the use of contrast agents for left ventricular opacification for endocardial border visualization with stress echocardiography.

93351 Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision, with interpretation and report

The RUC reviewed the specialty society survey physician time for code 93351. The RUC determined that 5 minutes pre-time, 20 minutes intra-service time and 10 minutes post service time for 93351 is appropriate to perform this service.

This RUC determined that the physicians' mental effort, judgment and technical skill required to perform this service is similar to the physician work required to perform 70496 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75; 8 minutes pre-time, 20 minutes intra-service time, 10 minutes post-service time) and recommends a work RVU of 1.75 for 93351. Additionally, code 70496 is on the RUC's Multi-Specialty Points of Comparison list.

The RUC agreed that a work RVU of 1.75 appropriately takes into account that this service was previously reported with codes 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (work RVU = 1.48) and 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* (work RVU = 0.75). The RUC agreed that an increment of work above 93350 is appropriate to maintain rank order among this family of

codes. A work RVU of 1.75 is the mid-point between the survey 25th percentile of 1.50 and the median of 2.00. **The RUC recommends a work RVU of 1.75 for code 93351.**

The RUC recognizes that the physician time for 93350 (40 minutes) is currently higher than the new survey data for 93351 (37 minutes). There are potential anomalies in the work and/or time data for 93350. **The RUC recommends that 93350 be surveyed and reviewed at the October 2008 RUC meeting.**

93352 Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to codes for stress echocardiography)

The RUC agrees with the survey median physician intra-service time and recommends 5 minutes for this add-on service, code 93352. The RUC determined that the 25th percentile work RVU of 0.19 from the specialty society survey is appropriate as it is similar to CPT code 90774 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 0.18). **The RUC recommends a work RVU of 0.19 for 93352.**

Practice Expense

The direct practice expense inputs have been modified to address concerns of the RUC and practice expense subcommittee and the RUC agrees that the inputs are appropriate.

PLI Crosswalk

The PLI for 93352 has been corrected to be cross walked to the reference service 90774.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>Echocardiography includes obtaining ultrasonic signals from the heart and great arteries, with two-dimensional¹ vessels, with real time¹ image and/or Doppler ultrasonic signal documentation, and with interpretation and report. When interpretation is performed separately use modifier 26.</p> <p>Echocardiography is an ultrasound examination of the cardiac chambers and valves, the adjacent great vessels, and the pericardium.² A complete transthoracic echocardiogram without spectral or color flow Doppler² (93307; 93306)^{1,3} is a comprehensive procedure that includes 2-dimensional and selected M-mode examination of the left and right atria, left and right ventricles, the aortic, mitral, and tricuspid valves, the pericardium, and adjacent portions of the aorta. Multiple views are required to obtain a complete functional and anatomic evaluation, and appropriate measurements are obtained and recorded.² These structures are assessed using multiple views as required to obtain a complete functional and anatomic evaluation, and appropriate measurements are obtained and recorded.² Despite significant effort, identification and measurement of some structures may not always be possible. In such instances, the reason that an element could not be visualized must be documented. Additional structures that may be visualized (eg, pulmonary veins, pulmonary artery, pulmonic valve, inferior vena cava) would be included as part of the service. Color and/or spectral Doppler may also be used in conjunction with other base echocardiography codes (exclusive of •93306 and 93307) when flow and velocity information is needed.⁺²</p> <p>A complete transthoracic echocardiogram with spectral and color flow Doppler (93306) is a comprehensive procedure that includes spectral Doppler and color flow Doppler in addition to the 2-dimensional and selected M-mode examinations. Spectral Doppler (93320, 93321) and color flow Doppler (93325) provide information regarding intracardiac blood flow and hemodynamics.</p> <p>A follow-up or limited echocardiographic study (93308) is an examination that does not evaluate or document the attempt to evaluate all the structures that comprise the complete echocardiographic exam. This is typically limited to, or in follow up of, a complete echocardiographic examination when a repeat complete exam is unnecessary due to the more focused clinical concern. In some emergent clinical situations, a limited echocardiographic study may be performed primarily.²</p> <p>In stress echocardiography, echocardiographic images are recorded from multiple cardiac windows before, after, and in some protocols, during stress. The stress is achieved by 1) walking on a treadmill, 2) using a² bicycle (supine or upright), or 3) the administration of pharmacological agents that either simulate exercise (by increasing heart rate, blood pressure or myocardial contractility) or alter coronary flow (vasodilation). The patient's ECG, heart rate and blood pressure are monitored at baseline, throughout the procedure and during recovery. Reports are prepared to evaluate 1) the duration of stress, the reason for stopping, and the hemodynamic response to stress; 2) the electrocardiographic response to stress; and 3) the echocardiographic response to stress.</p> <p>Code 93350 is used to report the performance and interpretation of a stress echocardiogram only, with the components of the cardiovascular stress test reported separately using the appropriate codes (93016–93018). When a stress echocardiogram is performed combined with a complete cardiovascular stress test (continuous electrocardiographic monitoring, physician supervision, interpretation and report), use 93351. When different providers perform the separate components of a stress echocardiogram— Code 93350 is used to report the performance and interpretation of a stress echocardiogram only, with the components of the cardiovascular stress test reported separately using the appropriate codes (93016–93018).</p>		

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>When left ventricular endocardial borders cannot be adequately identified by standard echocardiographic imaging, echocardiographic contrast may be infused intravenously both at rest and with stress to achieve that purpose. CPT +93352 is used to report the administration of echocardiographic contrast agent in conjunction with stress echocardiography (CPT 93350 or 93351).</p> <p>Report of an echocardiographic study, whether complete or limited, includes an interpretation of all obtained information, documentation of all clinically relevant findings including quantitative measurements obtained, plus a description of any recognized abnormalities. Pertinent images, videotape, and/or digital data are archived for permanent storage and are available for subsequent review. Use of echocardiography not meeting these criteria is not separately reportable.</p> <p>Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation and final, written report, is not separately reportable.</p> <p>The services listed do not include pharmaceuticals or drugs. These items supplied by the physician should be reported separately using the appropriate supply code(s), in addition to the procedure code.</p> <p>(For fetal echocardiography, see 76825-76828)</p>				
93303		Transthoracic echocardiography for congenital cardiac anomalies; complete	XXX	1.30 (No Change)
93304		follow-up or limited study	XXX	0.75 (No Change)
●93306 (Reviewed at the September 2007 RUC Meeting)		<p>Echocardiography, transthoracic real-time with image documentation (2D), includes M-mode recording, when performed, with spectral Doppler echocardiography, and with color flow Doppler echocardiography</p> <p><u>(For transthoracic echocardiography without color flow or velocity, use 93307)</u></p>	XXX	1.30 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
93307		Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed; complete (Do not report 93307 in conjunction with 93320, 93321 or 93325)	XXX	0.92 (No Change)
93308		follow-up or limited study	XXX	0.53 (No Chnage)
Ⓢ93312		including probe placement, image acquisition, interpretation and report	XXX	2.20 (No Change)
✚93320		Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete (Use 93320 in conjunction with 93303, 93304, 93307 , 93308, 93312, 93314, 93315, 93317, 93350, 93351)	ZZZ	0.38 (No Change)
✚93321		Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging) (Use 93321 in conjunction with 93303, 93304, 93307 , 93308, 93312, 93314, 93315, 93317, 93350, 93351)	ZZZ	0.15 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
✚93325		Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography) (Use 93325 in conjunction with 76825, 76826, 76827, 76828, 93303, 93304, 93307 , 93308, 93312, 93314, 93315, 93317, 93320, 93321 , 93350, 93351)	ZZZ	0.07 (No Change)
▲93350	GG1	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; (The appropriate stress testing code(s) from the 93016-93018 series should be reported in addition to 93350 to capture the exercise stress portion of the study.	XXX	1.48 (No Change)
●93351 ²	GG2	including performance of continuous electrocardiographic monitoring, with physician supervision (Do not report 93351 in conjunction with 93350, 93015, 93016, 93017, or 93018)	XXX	1.75
●✚93352 ²	GG3	Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to codes for stress echocardiography) (Use 93352 in conjunction with 93350 or 93351)	ZZZ	0.19

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93351 Tracking Number GG2

Specialty Society Recommended RVU: **2.0**

Global Period: XXX

RUC Recommended RVU: **1.75**

CPT Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision, with interpretation and report

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old woman with non-diagnostic chest pain concerned about a family history of coronary artery disease presents to the office for a stress echocardiogram.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 3%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 3%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the request for stress echocardiography and relevant clinical records to clarify the indications for the procedure and to determine the clinical questions that need to be answered. The physician provides direct supervision of the patient in the stress testing laboratory.

A nurse takes a history to assure that there are no contra-indications to stress testing, locates the necessary anatomical landmarks, prepares the patient for precordial electrode placements, hooks up the electrodes and takes the patient's blood pressure, ECG and heart rate (supine and standing).

Description of Intra-Service Work: The sonographer hooks up a three lead ECG for gating and places the patient in left lateral decubitus position and obtains a baseline echocardiogram at rest, including assessment of ventricular function, chamber sizes, wall thicknesses, wall motion, aortic root, and valves. Images are acquired from multiple cardiac windows including the parasternal long axis, parasternal short axis, apical four chamber, and apical two chamber views.

The physician reviews the resting echocardiographic images to be sure there is adequate visualization of all LV segments.

The nurse initiates the stress protocol by having the patient begin exercise on the treadmill. The heart rate, blood pressure, and ECG are continuously monitored. A staged stress protocol is followed with blood pressure, pulse and ECG recordings made at the end of each stage. The patient's response to stress is watched for the appearance of any indicators requiring cessation of stress test (e.g., 1) severe symptoms, 2) significant ventricular arrhythmia, 3) hypotension and 4) echocardiographic evidence of new regional LV wall motion abnormality). If no such indicators appear, stress continues until exercise cannot be continued or target heart rate is achieved during a pharmacologic stress test. The patient is monitored until all symptoms have resolved.

The sonographer records echocardiographic images for assessment of left ventricular wall motion immediately after exercise ends. In the case of treadmill exercise, the patient must be moved onto the examination table and placed in the left decubitus position. The sonographer organizes acquired selected images in a side-by-side format for review and interpretation by the physician.

The physician reviews the sequence of tomographic images, recorded both at baseline and again immediately following completion of treadmill exercise. Global and regional ventricular performance is evaluated carefully. Other cardiac causes of chest pain are also assessed. Where appropriate, measurements of cardiac structure and function are made. When available, prior studies are retrieved and reviewed side-by-side with the current images. A diagnostic interpretation is developed. The physician also reviews and analyzes the stress electrocardiogram which includes starting and ending hemodynamics, arrhythmias, symptoms (especially chest pain), ST segment changes, functional capacity and any other elements that are relevant to the interpretation of a stress electrocardiogram examination.

Description of Post-Service Work: The physician discusses the test result with the patient. The physician dictates a report, which specifies results of the resting echocardiogram, the stress echocardiogram, and the EKG/physiologic response to stress. Results are transmitted to the ordering physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	James Maloney, MD, FACC; Benjamin Byrd, MD, FACC, Thomas Ryan, MD FACC				
Specialty(s):	American College of Cardiology				
CPT Code:	93351				
Sample Size:	243	Resp N:	59	Response: 24.2 %	
Sample Type: Panel					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	100.00	200.00	400.00	1000.00
Survey RVW:	0.75	1.50	2.00	2.37	6.10
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	2.00	15.00	20.00	30.00	60.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.0	99291x	99292x		
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x	
Discharge Day Mgmt:	0.0	99238x	99239x		
Office time/visit(s):	0.0	99211x	12x	13x	14x 15x
Prolonged Services:	0.0	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	93351	Recommended Physician Work RVU: 2.00				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:		5.00	7.0	-2.0		
Pre-Service Positioning Time:		0.00	0.0	0.0		
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0		
Intra-Service Time:		20.00				
Immediate Post Service-Time:	10.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	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 0.0	99239x 0.0			
Office time/visit(s):	0.0	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93015	XXX	0.75	RUC Time

CPT Descriptor 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

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78465	XXX	1.46	RUC Time	3,013,393

CPT Descriptor 1 Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic), with or without quantification

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93312	XXX	2.20	RUC Time	204,600

CPT Descriptor 2 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
75559	XXX	2.95	RUC Time

CPT Descriptor Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 18.0 %

TIME ESTIMATES (Median)

	CPT Code: 93351	Key Reference CPT Code: 93015	Source of Time RUC Time
Median Pre-Service Time	5.00	2.00	
Median Intra-Service Time	20.00	15.00	
Median Immediate Post-service Time	10.00	4.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Total Time	35.00	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	3.73	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.45
Urgency of medical decision making	3.82	3.73

Technical Skill/Physical Effort (Mean)

Technical skill required	4.45	4.00
Physical effort required	3.45	3.36
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.00	3.82
Outcome depends on the skill and judgment of physician	4.45	4.00
Estimated risk of malpractice suit with poor outcome	4.27	4.18

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	2.91
Intra-Service intensity/complexity	3.73	3.18
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.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93350 and 93015

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 300000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Specific data on total national utilization of stress echocardiography are not available. We estimate that Medicare patients comprise somewhat more than half of those who will receive 93351 (see estimate of Medicare utilization below).

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? 186,824 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that approximately 40% of the current Medicare claims for 93350 (467,062) will shift to 93351. Note that a portion of claims for 93015 will also shift to 93351.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93352 Tracking Number GG3

Specialty Society Recommended RVU: **0.39**

Global Period: ZZZ

RUC Recommended RVU: **0.19**

CPT Descriptor: Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to codes for stress echocardiography)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An overweight 60 year old man with non-diagnostic chest pain presents for a stress echocardiogram. Resting images of the left ventricle are inadequate to fully assess wall motion and contractility. Preparations for contrast administration are made; contrast is then administered at rest and again during stress to provide adequate left ventricular images.

Instructions: This is an add-on service. Estimate only the work and time related to the contrast use, i.e., only work and time beyond what is typical for a non-contrast enhanced stress echocardiogram in a patient who does not require contrast.

(Do not report 933X2 more than once per stress echocardiogram.)

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 2%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician provides direct supervision of the entire stress echocardiography procedure. The physician reviews the resting echocardiographic images while the patient is on the table, and notes poor visualization of more than one LV wall segment requiring contrast opacification to improve endocardial border definition. The physician reviews patient history to assure there is no contraindication to contrast administration such as previous adverse reaction, unstable or worsening heart failure, acute myocardial infarction, serious ventricular arrhythmias, respiratory failure, or severe emphysema. Pros and cons of contrast injection are discussed with the patient, including the risks of anaphylactic/anaphylactoid reaction. Consent for contrast is obtained, and intravenous access is acquired. Arrangements are made for 30 minutes of post-recovery monitoring.

Description of Intra-Service Work: The physician oversees and directs the prescribed dose of contrast that is administered intravenously. The physician is available to answer questions for the sonographer or review components of the study. The physician verifies completeness and adequacy of study and may request additional images as necessary.

A nurse injects echocardiographic contrast agent intra-venously. The dose is titrated through an iterative process to achieve adequate LV opacification and pre-stress contrast-enhanced echocardiographic images are obtained by the sonographer to provide optimal definition of the LV endocardium. At peak stress or immediately post-stress, the nurse administers a second infusion of echocardiographic contrast and the sonographer obtains post-stress images. Dose adjustments may be required. The patient is monitored until heart rate has returned to baseline, all symptoms have

resolved and 30 minutes have passed since contrast administration. The intravenous catheter is removed and hemostasis achieved.

The physician reviews and interprets the contrast enhanced echocardiographic images.

Description of Post-Service Work: The physician documents decision to administer contrast based on initial review of resting images and documents that all FDA requirements for patient monitoring were met.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	James Maloney, MD, FACC, Benjamin Byrd, MD, FACC, Thomas Ryan, MD, FACC				
Specialty(s):	American College of Cardiology				
CPT Code:	93352				
Sample Size:	249	Resp N:	36	Response: 14.4 %	
Sample Type: Panel					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	25.00	50.00	150.00	300.00
Survey RVW:	0.02	0.19	0.39	0.93	3.02
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	0.00	3.00	5.00	10.50	60.00
Immediate Post Service-Time:	4.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.0	99291x	99292x		
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x	
Discharge Day Mgmt:	0.0	99238x	99239x		
Office time/visit(s):	0.0	99211x	12x	13x	14x 15x
Prolonged Services:	0.0	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

Select Pre-Service Package

CPT Code:	93352	Recommended Physician Work RVU: 0.39			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		0.00	0.0	0.0	
Pre-Service Positioning Time:		0.00	0.0	0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0	
Intra-Service Time:		5.00			
Immediate Post Service-Time:	0.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.0	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 0.0	99239x 0.0		
Office time/visit(s):	0.0	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90761	ZZZ	0.09	RUC Time

CPT Descriptor INTRAVENOUS INFUSION, HYDRATION; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78478	XXX	0.50	RUC Time	

CPT Descriptor 1 Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93320	XXX	0.38	RUC Time	

CPT Descriptor 2 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96411	ZZZ	0.20	RUC Time

CPT Descriptor Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 % of respondents: 30.5 %

TIME ESTIMATES (Median)

	CPT Code: 93352	Key Reference CPT Code: 90761	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	5.00	3.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	5.00	3.00
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.91	1.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.45	1.45
Urgency of medical decision making	2.91	1.82

Technical Skill/Physical Effort (Mean)

Technical skill required	2.55	1.73
Physical effort required	2.09	1.55

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.82	1.82
Outcome depends on the skill and judgment of physician	2.82	1.55
Estimated risk of malpractice suit with poor outcome	2.73	1.73

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.82	1.27
Intra-Service intensity/complexity	2.45	1.64
Post-Service intensity/complexity	2.09	1.27

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time	Total Time
4.	93351	XXX	2.0	5	20	10	35
5.	93352	ZZZ	0.39	5	5	4	14
6.							
7.	93350	XXX	1.48		40		40
8.	93352	ZZZ	0.39	5	5	4	9
9.							

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Contrast administrations (93352) is performed with 93350, but there is currently no reimbursement for the additional physician work.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 30000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. Based on current use of contrast, we estimate that fewer than 10 percent of stress echocardiograms will be performed with contrast.

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?
 24,300 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that between 10 and 15 percent of stress echocardiograms provided to Medicare patients will be performed with contrast. Medicare-aged patients are more likely than younger patients to have poor quality echocardiographic images.

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

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. 90774

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs**

CPT Long Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision, with interpretation and report.

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A panel of ACC and ASE member physicians, practice administrators, and cardiac sonographers met several times by phone to review clinical labor, medical supplies, and equipment inputs for 933X1. The inputs were developed based on direct experience in several panel members' individual practices. The panel represented a mix of academic and private practices and diverse geographic locations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Registered Nurse: Calls patient day prior to procedure to review cardiac history, identify allergies to medications, relay clinical rationale for test, and to explain test procedure. Provides instructions on test location, arrival time, diet on test day, clothing to wear, medication usage (e.g., hold beta-blockers). Reviews prior ECG. Files pre-authorization paperwork.

Intra-Service Clinical Labor Activities:

Cardiac Sonographer: Escorts patient from registration area to stress echo lab and provides instructions for gowning. Reviews patient record, including available prior echocardiographic images. Positions patient for study and connects 3 lead ECG system for gating of images. Acquires resting echo images and performs baseline measurements. Formats gated quad-screen resting images for physician review prior to initiation of stress test. Reviews resting image adequacy with physician. Remains in the room while the RN performs the stress test (1) to assist in the event of an emergency and (2) to be immediately available for rapid acquisition of stress images when patient reaches stress test endpoint. (Note that duration of exercise or heart rate response to pharmacologic agents is not predictable.). Acquires post-stress echo images within 1 minute of cessation of exercise. Confers privately with RN to make preliminary assessment of test results (normal results: patient dresses prior to physician review, then is discharged; abnormal results: study reviewed by MD before patient dresses, patient remains until abnormalities are resolved, discharge occurs and referring physician notified). Processes echo images, selecting 4 best images with highest heart rate, and matches those with corresponding baseline images for MD review.

Enters image and text data from echo system to final report system. Transfers digital image set to media or central server. All paperwork is transferred to physician for interpretation. Proofreads final report.

Registered Nurse: Reviews clinical information, instructs patients on equipment and procedure, answers questions, and has patient sign consent. Preps patient, does 12 lead ECG hook-ups baseline vital signs. ECG performed at baseline: supine, standing, and with hyperventilation. Reviews and compares with prior ECG to ensure there has been no intervening event. Supervises the treadmill portion of the exam, takes average of 4.75 vital signs, monitors ECG, pulse oximetry and records patients Relative Perceived Exertion (RPE) at each stage of the exercise protocol. Prints an ECG at each stage. Stops exercise based on heart rate response or symptoms. Moves patient to echocardiography examination table.

Continues recovery monitoring with vital signs for 8 minutes. Prints a recovery ECG. Disconnects patient from ECG. Fills out remainder of treadmill worksheet and records preliminary comments (this form will be combined with stress echo form). Gives patient post test instructions and escorts patient to reception area. Cleans the room (exam table & BP cuff wiped with Clorox wipe; table paper & pillow case changed; checks ECG printer paper and changes when needed; stocks room with supplies as needed). Provides discharge instructions such as what to do if symptoms return, primary care physician followup, and proper medication usage (e.g., nitroglycerin)

Post-Service Clinical Labor Activities:

Cardiac Sonographer: Performs Q/A activity required for accreditation.

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
ZZZ Global Period
Non Facility Direct Inputs**

CPT Long Descriptor: Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to codes for stress echocardiography)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A panel of ACC and ASE member physicians and cardiac sonographers met several times by phone to review clinical labor, medical supplies, and equipment inputs for 93351. The inputs were developed based on direct experience in several panel members' individual practices. The panel represented a mix of academic and private practices and diverse geographic locations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Registered Nurse: Reviews patient history to assess patient for suitability for use of contrast. Performs comprehensive checklist evaluation, identifying exclusions for contrast administration that have been mandated by FDA. Presents information to physician for review. Obtains patient consent and physician approval for contrast administration.

Intra-Service Clinical Labor Activities:

Cardiac Sonographer: Following review of resting images and decision to use contrast, prepares contrast agent for administration.

Registered Nurse: Starts IV for contrast administration. Injects contrast intravenously. Titrates dose through an iterative process to achieve adequate LV opacification. *Supervises the treadmill portion of the exam, takes average of 4.75 vital signs, monitors ECG, pulse oximetry and records patients Relative Perceived Exertion (RPE) at each stage of the exercise protocol. Stops exercise based on heart rate response or symptoms (Note: these activities are part of 933X1 and are include here only for reference).* Injects second dose of contrast for immediate post stress images. Dose adjustment may be required. Monitors patient per FDA requirements (total of 30 minutes after last contrast exposure). Discontinues IV and dresses site.

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			93351		93352	
	Meeting Date: April 2008			Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision, with interpretation and report		Use of contrast agent during stress echocardiography (list separately in addition to code for stress echocardiography)	
2							
4	LOCATION	CMS Code	Staff Type	Non-facility	Facility	Non-facility	Facility
5	GLOBAL PERIOD						
6	TOTAL CLINICAL LABOR TIME			111.0		30.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME			3.0		0.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			108.0		30.0	
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0		0.0	
10	TOTAL CLINICAL LABOR TIME RN/LPN/MA	L037D	RN/LPN/MA	9.0		0.0	
11	TOTAL CLINICAL LABOR TIME RN	L051A	RN	38.0		21.0	
12	TOTAL CLINICAL LABOR TIME CARDIAC SONOGRAPHER	L050A	Cardiac sonographer	64.0		9.0	
13	PRE-SERVICE						
14	Start: Following visit when decision for surgery or procedure made						
18	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	3			
19	Follow-up phone calls & prescriptions						
20	End: When patient enters office/facility for surgery/procedure						
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure						
23	Review charts, prior ECG, determines type of stress	L051A	RN	2			
24	Review history, prior echocardiogram	L050A	Cardiac sonographer	2			
25	Greet patient and provide gowning	L050A	Cardiac sonographer	3			
26	Obtain vital signs	L037D	RN/LPN/MA	3			
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	3			
28	Prepare room, equipment, supplies	L037D	RN/LPN/MA	2			
29	Prepare chest for 12 lead ECG, place ECG leads, BP cuff	L037D	RN/LPN/MA	2			
	Prepare and position patient for echocardiogram and 3 lead						
30	ECG for gating	L050A	Cardiac sonographer	2			
31	Intra-service						
	Perform baseline supine and standing ECG, compare with						
32	previous ECGs and review with physician	L051A	RN	7			
	Acquire resting echocardiographic images and perform						
33	baseline measurements	L050A	Cardiac sonographer	20			
34	Acquire gated quad screen resting images	L050A	Cardiac sonographer	7			
35	Review resting echo images with MD	L050A	Cardiac sonographer	3			
36	Assess eligibility for contrast	L051A	RN			2	
37	Obtain consent for contrast	L051A	RN			2	
38	Start IV	L051A	RN			2	
39	Prep contrast agent	L050A	Cardiac sonographer			2	
	Inject contrast at baseline and adjust dosing as needed during						
40	resting image acquisition	L051A	RN			7	
	Obtain resting echocardiographic images post contrast						
41	injection	L050A	Cardiac sonographer			7	
42	Present during exercise stress test	L050A	Cardiac sonographer	10			
43	Supervise exercise stress test	L051A	RN	10			
44	Inject contrast post stress	L051A	RN			1	
45	Perform post stress ECG	L051A	RN	1			
46	Acquire post stress echo images	L050A	Cardiac sonographer	6			
47	Post-Service						
48	Monitor pt following service/check tubes, monitors, drains	L051A	RN	8		7	
49	Preliminary review of results with sonographer						
50	Preliminary review of results with RN						
51	Clean room/equipment by physician staff	L051A	RN/LPN/MA	3			
54	Select and format echo images, review with MD	L050A	Cardiac sonographer	4			
	Check dressings & wound/ home care instructions /coordinate						
57	office visits /prescriptions	L037D	RN/LPN/MA	3			
	Enter ECG and echo report elements into stress echo						
59	computer report system, archive images	L050A	Cardiac sonographer	7			
60	Quality assurance activities required for accreditation	L050A	Cardiac sonographer	0			
61	End: Patient leaves office						
74	MEDICAL SUPPLIES	CMS Code	Unit				
75	electrode, ECG (single)	SD053	item	13			
76	paper, recording (per sheet)	SK059	item	15			
77	sandpaper (per sheet)	SK072	item	1			
78	swab-pad, alcohol	SJ053	item	1			
79	bandage, strp 0 75in x 3in (Bandaids)	SG021	item	1		1	
80	drape, non-sterile, sheet 40in x 60in	SB006	item	1			
81	glutaraldehyde 3 4% (Cidex, Maxicide, Wavicide)	SM018	oz	1			
82	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item	3			
83	pack, minimum multi-specialty visit	SA048	pack	1			
84	computer media, optical disk 128mb	SK015	item	1			
85	patient education booklet	SK062	item	1			
86	ultrasound transmission gel	SJ062	ml	60			
87	sodium chloride 0 9% inj bacteriostatic (30ml uou)	SH068	1 item			1	
88	Interlink vial access	SC015	1 item			1	
89	syringe 10-12ml	SC051	1item			2	
90	stop cock, 3-way	SC049	1 item			1	
91	tourniquet, non-latex 1in x 18in	SD124	1 item			1	
92	swab-pad, alcohol	SJ053	1 item			1	
93	angiocatheter 14g-24g	SC001	1 item			1	
94	dressing, 4in x 4 75in (Tegaderm)	SG037	1 item			1	
95	tape, porous-hypoallergenic 2in (Scanpore)	SG077	1 inch			1	
96	gauze, non-sterile 2in x 2in	SG050	1 item			1	
97	swab, patient prep, 1 5 ml (chloraprep)	No code	1 item			1	
98	alcohol isopropyl 70%	SJ001	1ml			1	
99	EQUIPMENT	CMS Code	Price	Minutes Used		Minutes Used	
100	Siemens Sequoia C512 Ultrasound machine	No code	\$ 325,000	64		0	
101	Philips Xcelera, Digital Image Management system	No code	\$ 173,059	64		0	
102	Echo exam Table	No code	\$ 11,095	64		0	

	A	B	C	D	E	F	G
2	Meeting Date: April 2008			Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision, with interpretation and report		Use of contrast agent during stress echocardiography (list separately in addition to code for stress echocardiography)	
4	LOCATION	CMS Code	Staff Type	Non-facility	Facility	Non-facility	Facility
103	Laser Printer	ED032		1		0	
108	Cardiac Monitor with treadmill (12 lead PC based)	EQ078		20		0	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Actigraphy Sleep Assessment

Actigraphy was given a Category III CPT tracking code, 0089T, for new technology in 2004. Since 2004 there has been increased documentation in peer reviewed literature as well as development of a new standard of practice parameter paper that supports the change to a Category I CPT code. In February 2008, the CPT Editorial Panel agreed that a category I CPT code was warranted and created code 95803 *Actigraphy testing, recording, analysis, interpretation and report (minimum of 72 hours to 14 consecutive days of recording)*.

The RUC reviewed the survey results from 93 physicians regarding the physician work, time, intensity, and complexity of code 95803, in comparison to the survey's key reference procedure code 95806 *Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist* (work RVU = 1.66). The survey results indicated the total work of code 95803 was similar in physician intensity and complexity to 95806, but required less time, urgency, and stress. However, the physician time in the pre-service and post-service periods in the survey data appeared high for the work described and the RUC agreed with the specialty society's downward adjustments (from 15 minutes to 5 in both pre and post service time periods). The RUC the typical intra-service time would be 20 minutes and that the survey median of 1.00 reflected the work value for 95803.

The RUC also reviewed the physician work of a level three (99213 (work value = 0.92)) and level four (99214 (work value = 1.42)) established office visits in relation to new code 95803 and agreed that a 95803 should be valued between the two services. In addition, although code 95806 required more overall physician time (45 minutes for 95806 vs. 30 minutes for 95803), 95803 typically is more complex and requires more physician technical skill. The RUC agreed with the specialty society's median survey results and work relative value recommendation. **The RUC recommends a relative work value of 1.00 for CPT code 95803.**

Practice Expense: The RUC reviewed the direct practice expense inputs for new code 95803 and made minor edits from the specialty recommendation.

New Technology:

The RUC recommends that code 95803 be added to the new technology list as this procedure utilizes new techniques.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●95803	HH1	Actigraphy testing, recording, analysis, interpretation and report (minimum of 72 hours to 14 consecutive days of recording) (Do not report 95803 more than once in any 14 day period) (Do not report 95803 in conjunction with 95806-95811)	XXX	1.00
Category III				
D 0089T		Actigraphy testing, recording, analysis and interpretations (minimum of three day recording) (0089T has been deleted. For actigraphy testing use 95803)		N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95803 Tracking Number HH1

Specialty Society Recommended RVU: **1.00**

Global Period: XXX

RUC Recommended RVU: **1.00**

CPT Descriptor: Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)

(Do not report 9580X more than once in any 14 day period)

(Do not report 9580X in conjunction with 95806-95811)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 29-year-old male complained of excessive sleepiness, including difficulty maintaining wakefulness while driving. No history of snoring, abnormal breathing while sleeping, cataplexy, hypnagogic hallucinations, sleep paralysis, unusual behaviors during sleep, drug abuse, or psychiatric illness. He reported difficulty falling asleep until late at night and struggling to get out of bed most mornings. Actigraphy monitoring is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 3%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review actigraphy request from ordering physician and patient medical records. Identify the clinical questions/concerns being asked. Determine appropriateness of test to the clinical problem(s). Determine the length of testing appropriate to the issues.

Description of Intra-Service Work: Review the technician printout and raw data to determine if the test was conducted in an overall valid manner. Edit the raw data for sections that need to be excluded, adjust lights out and on times to stated times according to sleep diary data. Correlate the objective data from the printout with the subjective data of the sleep diary provided by patient and initial history from the patient record. The sleep diary consists of a standardized form covering a week at a time with separate entries for each 24 hour segment. It is an integral part of the test. The diary consists of patient's recording of lights out and lights on times, awakenings including when they were experienced during the sleep period and their estimated duration, perception of the total sleep time, sleep episodes and their estimated durations during the regular wake period, and perception of alertness across the day. This allows objective correlation with the patient's subjective report of such essential elements as total sleep time, awakening numbers, naps, etc. The final technical data report is created, consisting of a graphic activity plot, epoch by epoch data printout classified as wake or sleep, and summary data table of sleep latency, total, sleep time, etc. An interpretation of the data is completed and diagnosis established.

Description of Post-Service Work: The formal interpretation report is created.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008				
Presenter(s):	Gregory Barkley, MD (AAN); Sam Fleishman, MD (AASM); Burt Lesnick, MD (ACCP); Scott Manaker, MD (ACCP); Gerald B. Rich, MD (AASM)				
Specialty(s):	American Academy of Neurology, American Academy of Sleep Medicine, American College of Chest Physicians, American Thoracic Society				
CPT Code:	95803				
Sample Size:	3671	Resp N:	93	Response: 2.5 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	11.00	25.00	500.00
Survey RVW:	0.10	0.67	1.00	1.50	5.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	0.00	10.00	20.00	30.00	90.00
Immediate Post Service-Time:	<u>15.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	_____	99291x	99292x		
Other Hospital time/visit(s):	_____	99231x	99232x	99233x	
Discharge Day Mgmt:	_____	99238x	99239x		
Office time/visit(s):	_____	99211x	12x	13x	14x 15x
Prolonged Services:	_____	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23), 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	95803	Recommended Physician Work RVU: 1.00			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		5.00	0.00	5.00	
Pre-Service Positioning Time:		0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00	
Intra-Service Time:		20.00			
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95806	XXX	1.66	RUC Time

CPT Descriptor Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99213	XXX	0.92	RUC Time	107,236,268

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99214	XXX	1.42	RUC Time	62,901,327

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A 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>	<u>Time Source</u>
93230	XXX	0.52	Harvard Time

CPT Descriptor Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 30.1 %

TIME ESTIMATES (Median)

	CPT Code: 95803	Key Reference CPT Code: 95806	Source of Time RUC Time
Median Pre-Service Time	5.00	10.00	

Median Intra-Service Time	20.00	25.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	30.00	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	3.75	3.61
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.57
Urgency of medical decision making	2.68	3.21

Technical Skill/Physical Effort (Mean)

Technical skill required	3.54	3.46
Physical effort required	2.54	2.68

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.75	3.00
Outcome depends on the skill and judgment of physician	3.57	3.50
Estimated risk of malpractice suit with poor outcome	2.54	3.14

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.11	3.19
Intra-Service intensity/complexity	3.32	3.68
Post-Service intensity/complexity	3.21	3.68

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The four surveying societies convened a panel of physicians representing broad geographic settings as well as a range of practice types. The panel felt the survey data was strong, based on 93 respondents from the AAN, AASM, ACCP, and ATS. The survey sample type was a combination of random (from AASM) and panel (from AAN, ACCP, and ATS). The reviewing physicians were comfortable with the intra-service time on the survey, but felt the pre-service and post-service times were overstated and adjusted them to a more reasonable number of minutes. The panel believed the median RVW was appropriate and recommends 1.00 RVUs for the service. Survey respondents chose 95806 as the key reference service. Code 95806 takes more time and has a higher RVU than the new code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0089T and 95999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Sometimes

Specialty Pulmonary How often? Sometimes

Specialty Sleep Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 25000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Since sleep medicine is composed of mostly neurologists and pulmonologists, we have grouped them into one specialty.

Specialty Sleep Medicine	Frequency 25000	Percentage 100.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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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? 5,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Since sleep medicine is composed of mostly neurologists and pulmonologists, we have grouped them into one specialty.

Specialty Sleep Medicine	Frequency 5000	Percentage 100.00 %
--------------------------	----------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? 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
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs**

CPT Long Descriptor: Actigraphy testing, recording, analysis, interpretation, and report
(minimum of 72 hours to 14 consecutive days of recording)

(Do not report 95803 more than once in any 14 day period)
(Do not report 95803 in conjunction with 95806-95811)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

AAN, AASM, ACCP, and ATS convened a consensus panel of experts from across the country and representing diverse practice settings and types to develop the practice expense inputs.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The technician performs the following activities:

- Fill out a pre-diagnostic questionnaire.
- Review the history and any other previous exam results.
- Review the physician orders and confirm the period of time ordered for monitoring.
- Schedule the patient for the study and address any follow-up phone calls.
- Turn on the designated computer, open the actigraphy software program, and place the monitoring device on the interface.
- Check the battery power, enter the demographic/clinical information for the patient, calibrate the monitoring device, and configure and set parameters for the monitoring period for each patient.
- Provide pre-testing education including the appropriate use of the device and how to record the subjective diary data, and then obtains consent.

Intra-Service Clinical Labor Activities:

The technician performs the following activities:

- Review charts.
- Place the device on the patient.
- Answer phone calls from the patient regarding use of the device/follow-up call to patient
- Review paperwork and sleep diaries for accuracy, interview patient regarding subjective data, and address any issues that may have arisen over the monitoring period.
- Open the monitoring device software program on the dedicated computer, set up the interface for the monitoring device, and confirm data acquisition.
- Download data to the computer, make comparisons between subjective and objective data, set the rest/activity markers, review the event markers and review light exposure data.
- Generate raw data summaries and graphic representation of the data along with comments regarding technical concerns or issues.

Post-Service Clinical Labor Activities:

The technician performs the following activities:

- Disinfect and clean the equipment.
- Transfer data to the reading station/file server for archiving and review.
- Confer with the physician verbally about the results of the test and about specifics in reference to quality and scoring of the study.

	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation			95803	
	Meeting Date: April 2008			Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	
2					
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD			XXX	XXX
5	TOTAL CLINICAL LABOR TIME			50.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			11.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			39.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms	L047B	REET	3	
12	Review the history and any other previous exam results	L047B	REET	3	
13	Review the physician orders and confirm the period of time ordered for monitoring	L047B	REET	2	
14	Coordinate pre-surgery services				
15	Schedule space and equipment in facility				
16	Provide pre-service education/obtain consent	L047B	REET	3	
17	Follow-up phone calls & prescriptions				
18	Other Clinical Activity (please specify) - configure device for patient use - turn on the designated computer, open the actigraphy software program, place the monitoring device on the interface, check the battery power, enter the demographic/clinical information for the patient, calibrate the monitoring device, and configure and set parameters for the monitoring period for each patient	L047B	REET	0	
19	End: When patient enters office/facility for surgery/procedure				
20	SERVICE PERIOD				
21	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
22	Review charts	L047B	REET	2	
23	Greet patient and provide gowning				
24	Obtain vital signs				
25	Place the device on the patient	L047B	REET	1	
26	Provide pre-service education/obtain consent			7	
27	Prepare room, equipment, supplies			5	
28	Setup scope (non facility setting only)				
29	Prepare and position patient/ monitor patient/ set up IV				
30	Sedate/apply anesthesia				
31	Intra-service				
32	Answer phone call(s) from the patient regarding use of the device	L047B	REET	2	
33	Assist physician in performing procedure				
34	Post-Service				
35	Review paperwork and sleep diaries for accuracy, interview patient regarding subjective data, address any issues that may have arisen over the monitoring period	L047B	REET	3	
36	Open the monitoring device software program on the dedicated computer, set up the interface for the monitoring device, and confirm data acquisition	L047B	REET	2	
37	Download data to the computer, make comparisons between subjective and objective data, set the rest/activity markers, review the event markers and review light exposure data	L047B	REET	14	
38	Transfer data to the reading station/file server and for archiving and review	L047B	REET	2	
39	Generate raw data summaries and graphic representations of the data, make comments regarding technical concerns or issues. Confer with the physician verbally about the results of the test and about specifics in reference to quality and scoring of the study	L047B	REET	1	
40	Clean room/equipment by physician staff	L047B	REET		
41	Clean Scope				
42	Clean Surgical Instrument Package				
43	Complete diagnostic forms, lab & X-ray requisitions				
44	Review/read X-ray, lab, and pathology reports				
45	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
46	End: Patient leaves office				
47	POST-SERVICE Period				
48	Start: Patient leaves office/facility				
49	Conduct phone calls/call in prescriptions				
50	Other Activity (please specify)				
51	End: with last office visit before end of global period				
52	MEDICAL SUPPLIES	CMS Code	Unit		
53	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item	2	
54	paper, laser printing (each sheet)	SK057	item	14	
55	computer media, dvd	SK013	item	1	
56	patient education booklet	SK062	item	1	
57	Equipment	CMS Code			
58	Actigraphy device (pricing info attached)			1	
59					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Gastric Neurostimulator Reprogramming

In February 2008, the CPT Editorial Panel deleted temporary Category III code 0162T *Electronic analysis and programming, reprogramming of gastric neurostimulator (ie, morbid obesity)*. As a result of this deletion, it has been assumed that those reporting this procedure would now use CPT codes 95980 – 95982. Code 0162T had been typically non-covered by most Medicare contractors and its deletion will shift the reporting to codes 95980 – 95982 and initiate coverage by Medicare. The specialty society indicated that gastric neurostimulators received FDA approval as a humanitarian use device that may make patients feel full with less food. Small clinical trials have reported positive outcomes in weight loss and maintenance of weight loss along with minimal complications. However, due to the lack of long term outcomes from well-designed randomized clinical trials, conclusions cannot be made concerning the safety and efficacy of chronic gastric stimulation in morbidly obese individuals. While the use of gastric pacing has been proposed for use in morbidly obese patients, the use of a gastric pacing device for this indication remains under investigation. The specialty society and the RUC agreed that the projected volume for these services was unlikely to change at this time and for the foreseeable future, but should be reviewed as planned under the RUC's new technology list.

The RUC agreed that the physician work relative values for codes 95980 – 95982 be maintained and that these services remain on the RUC's new technology list.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
43882		Revision or removal of gastric neurostimulator electrodes, antrum, open (For laparoscopic approach, see 43647, 43648) (For insertion of gastric neurostimulator pulse generator, use 64590) (For revision or removal of gastric neurostimulator pulse generator, use 64595)	YYY	Carrier Priced (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(For electronic analysis and programming of gastric neurostimulator pulse generator, use 95999 see 95980-95982)		
Neurology and Neuromuscular Procedures Neurostimulators, Analysis Programming				
95980	JJ1	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	XXX	0.80 (No Change)
95981	JJ2	subsequent, without reprogramming	XXX	0.30 (No Change)
95982	JJ3	subsequent, with reprogramming	XXX	0.65 (No Change)
Category III				
D 0162T		Electronic analysis and programming, reprogramming of gastric neurostimulator (ie, morbid obesity) (Code 0162T has been deleted. To report, see 95980–95982)		N/A



April 1, 2008

William L. Rich, III, MD
Chair, AMA / Specialty Society Relative Value Update Committee
515 N. State Street
Chicago IL 60610

RE: Deletion of code 0162T

Dear Dr. Rich:

On behalf of the American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE), we are pleased to provide the following clarification regarding the request to delete code 0162T, and the potential effect, if any, on patient type and procedure volume for codes 95980-95982.

The description of code 0162T is Electronic analysis and programming, reprogramming of gastric neurostimulator (ie, morbid obesity). When this code was established by the CPT Editorial Panel in 2006, the request to establish this code by the Society of American Gastroenterological Endoscopic Surgeons (SAGES) was vague as to whether this described initial or subsequent programming of the gastric neurostimulator for morbid obesity. As will be seen subsequently, the work of this service is described by, and identical to, codes 95980-95982.

When performed for initial, intraoperative programming of a gastric neurostimulator, the physician would report code 95980, Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming. As code 95980 specifically refers to initial analysis and programming of the implanted gastric neurostimulator, this code does not distinguish between gastric neurostimulators placed on the greater versus the lesser curvature of the stomach.

When electronic analysis is performed for a previous implanted gastric neurostimulator, the physician will determine whether reprogramming is required, or not. If no reprogramming is required, the physician reports code 95981, Electronic analysis of

implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator / transmitter; subsequent, without reprogramming. If reprogramming is required, the physician reports code 95982, Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator / transmitter; subsequent, with reprogramming. For both codes 95981 and 95982, the physician work of the electronic analysis is the same regardless of the location of the implanted gastric neurostimulator pulse generator.

Currently, there is only one gastric electrical stimulator that has received approval from the U.S. Food and Drug Administration (FDA). The Enterra™ Therapy System (formerly named Gastric Electrical Stimulation (GES) System) manufactured by Medtronic is approved for treatment of chronic refractory gastroparesis. The Enterra™ is an implanted device that delivers electrical stimulation to the gastric muscles by means of two unipolar intramuscular stomach leads, or electrodes. These are controlled by a pulse generator that is programmed. The leads are implanted in the muscle tissue of the greater curvature of the stomach either by laparotomy or laparoscopy, and connected to the pulse generator. The generator, including the programmed stimulator and power supply, is then implanted subcutaneously, usually in the abdominal area. When the device is activated it delivers electrical stimulation according to the parameters programmed by the physician who is treating the patient. The default parameters for the gastric stimulation create a gastric stimulation rate of 12 cpm. This type of stimulation is thought to enhance gastric emptying, although it does not induce a normal gastric muscular contraction wave at the physiologic rate of approximately 3 cpm.

The GES (Enterra™) System received FDA approval through a "humanitarian device exemption." This regulatory category was established in 1996 and only applies to devices intended to benefit less than 4,000 patients. The Enterra Therapy System (Medtronic Inc., Minneapolis, MN) received FDA marketing approval as a Class III medical device under the Humanitarian Device Exemption (HDE) on March 31, 2000, for the treatment of chronic, intractable (drug refractory) nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology.

According to the FDA, a humanitarian use device (HUD) is a device that is intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 4000 individuals in the United States per year. "An HUD application is not required to contain the results of scientifically valid clinical investigations demonstrating that the device is effective for its intended purpose. The application, however, must contain sufficient information for FDA to determine that the device does not pose an unreasonable or significant risk of illness or injury, and that the probable benefit to health outweighs the risk of injury or illness from its use, taking into account the probable risks and benefits of currently available devices or alternative forms of treatment. Additionally, the applicant must demonstrate that no comparable devices are available to treat or diagnose the disease or condition, and that they could not otherwise bring the device to market" (FDA, 2003).

“An approved HDE authorizes marketing of the HUD. However, an HUD may only be used after Institutional Review Board (IRB) approval has been obtained for the use of the device for the FDA approved indication. The labeling for an HUD must state that the device is a humanitarian use device and that, although the device is authorized by Federal Law, the effectiveness of the device for the specific indication has not been demonstrated” (FDA, 2003).

The available intermediate and long-term data indicate that gastric electrical stimulation may be associated with improvements in gastrointestinal symptom scores, nutrition and quality-of-life for patients with intractable nausea and vomiting secondary to gastroparesis of diabetic or idiopathic origin with failure, contraindication or intolerance of pharmaceutical therapy, and that these improvements are sustained over time.

Gastric electrical stimulation has also been investigated as a treatment of obesity as a technique to increase a feeling of satiety with subsequent reduced food intake and weight loss. The exact mechanisms resulting in changes in eating behavior are uncertain but may be related to neuro-hormonal modulation and/or stomach muscle stimulation. Gastric stimulation may make patients feel full with less food. Small clinical trials have reported positive outcomes in weight loss and maintenance of weight loss along with minimal complications. Studies cited include:

Favretti F, De Luca M, Segato G, et al. Treatment of morbid obesity with the Transcend Implantable Gastric Stimulator (IGS): a prospective survey. *Obes Surg* 2004;14(5):666-70;

Shikora SA. Implantable gastric stimulation for the treatment of severe obesity. *Obes Surg* 2004;14(4):545-8;

Cigaina V. Gastric pacing as therapy for morbid obesity: preliminary results. *Obes Surg* 2002;12 Suppl 1:12S-16S;

De Luca M, Segato G, Busetto L, et al. Progress in implantable gastric stimulation: summary of results of the European multi-center study. *Obes Surg* 2004;14(Suppl.1):S33-9.

Liu S, Hou X, Chen JD. Et al. Therapeutic potential of duodenal electrical stimulation for obesity: acute effects on gastric emptying and water intake. *Am J Gastroenterol*. 2005;100(4):792-796.

Yao S, Ke M, Wang Z, et al. Retrograde gastric pacing reduces food intake and delays gastric emptying in humans: A potential therapy for obesity? *Dig Dis Sci*. 2005;50(9):1569-1575.

Jensen MD. Potential role of new therapies in modifying cardiovascular risk in overweight patients with metabolic risk factors. *Obesity* (Silver Spring). 2006;14 Suppl 3:143S-149S.

Due to the lack of long term outcomes from well-designed randomized clinical trials, conclusions cannot be made concerning the safety and efficacy of chronic gastric stimulation in morbidly obese individuals. While the use of gastric pacing has been

proposed for use in morbidly obese patients, the use of a gastric pacing device for this indication remains under investigation.

The AGA and ASGE believe that the typical patient for codes 95980 – 95982, and the projected volume for these services, is unlikely to change at this time and for the foreseeable future. While our survey of Medicare contractor LCDs indicate that code 0162T is a non-covered service for Medicare beneficiaries, CMS may wish to address whether deletion of this code would need to be addressed under CAG-00250R, Decision Memo for Bariatric Surgery for the Treatment of Morbid Obesity, see <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=160>. Commercial payors will need to address similar issues for their patients when code 0162T is deleted effective January 1, 2009.

In the meantime, Medicare contractors can issue LCDs, and commercial payors can issue clinical / coverage policy bulletins that identify the ICD-9-CM codes for which they believe gastric stimulation to be a covered service. ICD-9 codes can be identified as those that support medical necessity, based on the current ICD-9-CM codes that are effective at the time of LCD / clinical policy publication.

We anticipate the following ICD-9 code would be covered if selection criteria for gastroparesis are met:

536.3	Gastroparesis
787.01-787.03	Nausea and vomiting

ICD-9 codes that would not be covered for diagnosis of obesity:

278.00	Obesity, unspecified
278.01	Morbid obesity
V85.35	Body Mass Index 35.0-35.9, adult
V85.36	Body Mass Index 36.0-36.9, adult
V85.37	Body Mass Index 37.0-37.9, adult
V85.38	Body Mass Index 38.0-38.9, adult
V85.39	Body Mass Index 39.0-39.9, adult
V85.4	Body Mass Index 40 and over, adult

The AGA and ASGE look forward to tracking the volume of and indications for these procedures during calendar years 2008- 2010, and providing an update to the RUC on codes 95980-95982 when they are scheduled for review in September 2011.

Sincerely



Joel V. Brill, MD
AGA representative to
the CPT/RUC Advisory
Committee's



Nicholas Nickl, MD
ASGE representative to
the RUC Advisory
Committee

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Canalith Repositioning

The CPT Editorial Panel created a new code to describe therapeutic maneuvering of the patients' body and head designed to use the force of gravity. By using this type of maneuvering, the calcium crystal debris that is in the semi-circular canal system is re-deposited into a neutral part of the end organ where it will not cause vertigo.

95992 Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day

The specialty society indicated that the vast majority of patients do not have this treatment repeated. The RUC reviewed the survey results for code 95992 in which 101 respondents indicated a median performance rate of 55 times in the last year. The RUC determined that the median physician time from the specialty society survey was appropriate. The specialty societies indicated that the physician or qualified health care professional will spend 30 minutes total with the patient: 20 minutes has been defined to be in the intra-service period, while 10 minutes has been defined to be in the post-service period.

This service is currently reported with two units of 97112 *Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities* (work = 0.90-[0.45 x 2]; total time = 36 minutes [18 x 2]). Therefore, the RUC agreed that the survey median of 0.75 was appropriate. **The RUC recommends a work RVU of 0.75 for 95992.**

Practice Expense

The RUC determined that the direct practice expense inputs, as revised, are appropriate.

PLI Crosswalk

The PLI crosswalk was revised to 99213.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Ø●95992	II1	Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day (Do not report 95992 in conjunction with 92531, 92532)	XXX	0.75

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95992 Tracking Number

Specialty Society Recommended RVU: **0.75**

Global Period: XXX

RUC Recommended RVU: **0.75**

CPT Descriptor: Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day

(Do not report 95992 in conjunction with 92531, 92532)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year old man reports brief attacks of position related vertigo. He has been diagnosed as having benign paroxysmal positional vertigo and the appropriate, involved canal has been determined. The decision is made to perform a canalith repositioning procedure.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: The physician or other qualified health care provider instructs the patient in the canalith repositioning procedure. He is counseled that during the repositioning maneuver he may experience dizziness, nausea and may vomit, but that dizziness is expected and is not cause for alarm.

Position 1-2: The patient is rapidly moved from the sitting upright to the head hanging right position. The head is held at about 45 degrees to the right in the supine position with the neck slightly hyperextended. The nystagmus evoked is observed and once it subsides the patient is moved to position 3.

Position 3: From the head hanging right position, the head is then turned about 90 degrees to the left so that the head is in the head hanging left position.

Position 4: The patient rolls over to his/her left side about 90 degree turn toward the opposite ear.

Position 5: From this position, the patient is moved in a manner that allows the head to turn nearly facing the floor and held in that position for 1-30 seconds.

Position 6: From position 5, the patient is taken en bloc to a seated position. The patient's head is straightened and they remain seated upright for posterior canal debris to settle in the vestibule. The entire process (positions 1-5) is then repeated at least once.

Description of Post-Service Work: After the maneuver is performed, the patient is asked to remain in the office for observation to avoid brief episodes of vertigo as otoliths reposition themselves immediately after the procedure. The physician or other qualified healthcare professional instructs the patient regarding his/her ability to drive home. The patient is provided education materials and information on what to expect when they return home.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2008			
Presenter(s):	Gregory L. Barkley, MD; Leo Bronston, DC; Jane Dillon, MD; Terry Fife, MD; Robert C. Fifer, PhD; Erik van Doorne, DPT				
Specialty(s):	Neurology, Otolaryngology, Audiology, Chiropractic, Physical Therapy				
CPT Code:	95992				
Sample Size:	247	Resp N:	101	Response: 40.8 %	
Sample Type: Panel					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	16.00	55.00	150.00	3000.00
Survey RVW:	0.25	0.50	0.75	1.00	5.50
Pre-Service Evaluation Time:			10.0		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	4.00	15.00	20.00	30.00	60.00
Immediate Post Service-Time:	<u>10.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x	99292x		
Other Hospital time/visit(s):	<u>0.0</u>	99231x	99232x	99233x	
Discharge Day Mgmt:	<u>0.0</u>	99238x	99239x		
Office time/visit(s):	<u>0.0</u>	99211x	12x	13x	14x 15x
Prolonged Services:	<u>0.0</u>	99354x	55x	56x	57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	95992	Recommended Physician Work RVU: 0.75			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		0.00	0.0	0.0	
Pre-Service Positioning Time:		0.00	0.0	0.0	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.0	0.0	
Intra-Service Time:		20.00			
Immediate Post Service-Time:	<u>10.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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 0.0	99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
97112	XXX	0.45	RUC Time

CPT Descriptor Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93307	XXX	0.92	RUC Time	4,548,649

CPT Descriptor 1 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-code recording; complete

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99433	XXX	0.62	RUC Time	1

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>	<u>Time Source</u>
99203	XXX	1.34	RUC Time

CPT Descriptor: Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care 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.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 30.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 95992	<u>Key Reference CPT Code:</u> 97112	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	20.00	15.00	
Median Immediate Post-service Time	10.00	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
Prolonged Services Time	0.0	0.00
Median Total Time	30.00	18.00
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.71	3.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.16
Urgency of medical decision making	3.19	2.71

Technical Skill/Physical Effort (Mean)

Technical skill required	3.87	3.61
--------------------------	------	------

Physical effort required	3.35	3.10
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.39	2.19
Outcome depends on the skill and judgment of physician	4.00	3.55
Estimated risk of malpractice suit with poor outcome	2.10	2.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.74	2.52
Intra-Service intensity/complexity	3.58	3.23
Post-Service intensity/complexity	2.52	2.45

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The submitting societies conducted a survey that yielded 101 responses; and the experts from the submitting societies reviewing the survey data are pleased with its strength and consistency. A vast majority of survey respondents from six different societies found the vignette to be typical (79.21%).

When compared with the key reference service 97112 (Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities), the new code was identified as more complex and intense in every surveyed area, including mental effort and judgment, technical skill/physical effort, psychological stress, and time segments.

Because the expert panel of the submitting societies acknowledges that this service is typically performed with an E/M service on the same day, the experts reviewing the survey data elected to remove all pre-service time. The submitting societies are comfortable with the survey median of 20.0 minutes of intra-service time and recommend 10.0 minutes of post service time.

The IWPOT of the new code, when calculated with the new times and recommended RVW of 0.75, is 0.026: a value that is very close—but slightly higher—than that of the reference code, 97112 (IWPOT of 0.025). This result is consistent with survey responses indicating greater complexity and intensity for the new code as well as our recommendation of a higher RVW for this new code.

It is the conclusion of the experts from each of the submitting societies that the above factors strongly support median value from the survey of 0.75 RVWs for this new code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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)

It is typical for the same physician or other qualified health care provider to provide both of these services; the first is performed to determine the need to perform the canalith repositioning procedure.

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each; summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

CPT Code	Global Period	Recommended Work RVU	Pre-service	Intra-service	Post-service	Total Time
99213	XXX	0.92	3	15	5	23
959XX	XXX	0.75	0	20	10	30
Total		1.67	3	35	15	53

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT codes 92700, 95999, 97110, 97112, 97140, 97530, S9092

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology	How often? Commonly
Specialty Audiology	How often? Commonly
Specialty Otolaryngology	How often? Sometimes
Specialty Physical Therapy	How often? Commonly
Specialty Chiropractic	How often? Rarely
[Others] Primary care	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 16700

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We combined information from Neuhauser et al (2005) and Nedselski et al. (1986) and estimated the incidence of BPPV at approximately 0.001 % of the adult population. We then multiplied 0.001 % times the US adult population (using 2005 census data) and estimated that approximately 10 % of the 167,000 total cases per year (i.e., 16,700) would be referred for the canalith repositioning procedure.

Specialty Neurology	Frequency 3674	Percentage 22.00 %
Specialty Audiology	Frequency 3674	Percentage 22.00 %
Specialty Otolaryngology	Frequency 2505	Percentage 15.00 %
Specialty Physical Therapy	Frequency 3674	Percentage 22.00 %
Specialty Chiropractic	Frequency 668	Percentage 4.00 %
[Others] Primary Care	Frequency 2505	Percentage 15.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,700 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We reduced the national estimate to reflect the prevalence in the 65+ years of age population.

Specialty Neurology	Frequency 1474	Percentage 22.00 %
Specialty Audiology	Frequency 1474	Percentage 22.00 %
Specialty Otolaryngology	Frequency 1005	Percentage 15.00 %
Specialty Physical Therapy	Frequency 1474	Percentage 22.00 %

Specialty Chiropractic	Frequency 268	Percentage 4.00 %
Others] Primary Care	Frequency 1005	Percentage 15.00 %

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. The PLI for the selected reference CPT code, 97112, is 0.01. Since the surveyed code was found by respondents to be more complex and intense than the reference code, a more reasonable reference for the PLI crosswalk is our second key reference CPT code, 99213, with a PLI of 0.03.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			95992			
2	Meeting Date: April 2008			Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day			
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility		
4	GLOBAL PERIOD			XXX			
5	TOTAL CLINICAL LABOR TIME			4.0	0.0		
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0		
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			4.0	0.0		
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0		
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure made						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity (please specify)						
17	End: When patient enters office/facility for surgery/procedure						
18	SERVICE PERIOD						
19	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure						
20	Review charts						
21	Greet patient and provide gowning						
22	Obtain vital signs						
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies						
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2			
27	Sedate/apply anesthesia						
28	Intra-service						
29	Assist physician in performing procedure						
30	Post-Service						
31	Monitor pt. following service/check tubes, monitors, drains						
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	2			
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, 99239 –15 minutes						
39	Other Clinical Activity (please specify)						
40	End: Patient leaves office						
41	POST-SERVICE/Period						
42	Start: Patient leaves office/facility						
43	Conduct phone calls/call in prescriptions						
44	Office visits						
45	List Number and Level of Office Visits						
46	99211 16 minutes		16				
47	99212 27 minutes		27				
48	99213 36 minutes		36				
49	99214 53 minutes		53				
50	99215 63 minutes		63				
51	Other						
52	Total Office Visit Time			0	0		
53	Other Activity (please specify)						
54	End: with last office visit before end of global period						
55	MEDICAL SUPPLIES	CMS Code	Unit				
56	Patient Education Booklet	SK062	Item	1			
57	gloves, non-sterile	SB022	Item	1			
58	towel, paper (Bounty) (per sheet)	SK082	Item	2			
59	disinfectant, surface (Envirocide, Sanizide)	SM013	Item	1			
60	towel, non-sterile	SB042	Item	1			
61	basin, emesis	SJ010	Item	1			
62							
63	Equipment	CMS Code					
64	Table	EF023	Furniture	1			
65							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2008

Pediatric Intensive Care

In June 2008, the CPT Editorial Panel created new global bundled critical care codes for children over the age of 2 years who meet the definition of critically ill or injured with single or multiple organ failure where physician presence is required to reassess the patient frequently and supervise the health care team over a 24 hour period. These new CPT codes capture the repetitive evaluation of the patient's status, adjustments to therapy, review of laboratory results, monitoring and review of imaging data as well as the supervision of the health care team. These services are bundled critical care codes because these evaluations occur in brief and longer encounters throughout the day and cannot reasonably be counted or documented at each patient contact, which often represents a dozen or more per day.

The RUC reviewed the specialty society's survey of over 50 pediatric specialists regarding the physician work valuation for neonatal and pediatric intensive care codes 99475 and 99476.

99475 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

The RUC reviewed the specialty society survey work RVU for 99475 and determined that the specialty recommended RVU of 15.00 was too high compared to the reference service code 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* (work RVU=15.98) as 99293 requires more time and physician work (240 total minutes).

The RUC used a building block of the adult critical care codes 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU = 4.50) and 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes* (work RVU = 2.25) to develop the appropriate work RVU for code 99475. The RUC equated the physician work of this new code to one 99291 and three 99292 [$4.50 + (2.25 \times 3) = 11.25$]. The maximum total physician time for this building block approach is 164 minutes (74+30+30+30). The building block derived adult critical care total physician time is similar to the specialty society survey total time of 165 minutes, which further supports the building block method approached used by the RUC. The RUC also believed that the intensity of this service is slightly higher than that for the adult critical care codes and that the service is provided throughout the day.

The RUC recommends a work RVU of 11.25 for code 99475 and the specialty society surveyed physician time of 30 minutes pre-service, 105 intra-service and 30 minutes post-service.

99476 Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

The RUC reviewed the specialty society survey work RVU for 99476 and determined that the specialty recommended RVU of 7.77 was too high compared to the reference service code 99294 *Subsequent 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* (work RVU = 7.99 and 140 minutes total physician time), as 99294 requires more time and physician work.

The RUC used a building block approach of the adult critical care codes 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU = 4.50) and 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes* (work RVU = 2.25) to develop the appropriate work RVU for code 99475. The RUC believed the physician work equated to one 99291 and one 99292 ($4.50 + 2.25 = 6.75$). The total physician time for these blended codes is 104 minutes ($74 + 30$). The blended adult critical care total physician time is similar to the specialty society survey time of 105 minutes, which further supports the building block approach as proposed by the RUC. The RUC also believed that the intensity of this service is slightly higher than that for the adult critical care codes and that the service is provided throughout the day.

The RUC recommends a work RVU of 6.75 for code 99476 and the specialty society surveyed physician times of 20 minutes pre-service, 65 intra-service and 20 minutes post-service.

Practice Expense:

The specialty and the RUC recommend no direct practice expense inputs for codes 99475 and 99476, since these services are provided only in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Inpatient Pediatric Critical Care When critical care services are provided to neonates or pediatric patients less than 24 months of age at two separate institutions by a physician from a different group on the same date of service, the physician from the referring institution should report their critical care services with the hourly critical care codes (99291, 99292) and the receiving institution should report the appropriate global admission code (99293,99295) for the same date of service. <u>Critical care services to a pediatric patient beyond 5 years of age are reported with the hourly critical care codes (99291,99292).</u> <u>Critical care services to a neonate or pediatric patient provided in an outpatient environment are reported with the hourly critical care codes (99291-99292)</u> Critical care services provided by a second physician of a different specialty not reporting a 24-hour global code can be reported with the hourly critical care codes 99291-99292.				
•99475	M1	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	XXX	11.25
•99476	M2	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	XXX	6.75

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 99475 Tracking Number M1 Specialty Society Recommended RVU: **15.00**
 Global Period: XXX RUC Recommended RVU: **11.25**

CPT Descriptor: Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 4-year-old child is admitted to the PICU from the ER with impending respiratory failure due to asthma that has failed management in the emergency department. Treatment included continuous bronchodilator therapy and complex pharmacologic support. Blood gases define respiratory failure and the child is sent to the PICU for close cardiovascular, respiratory and blood gas monitoring and possible mechanical ventilation.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician speaks to the emergency department and the referring physician in preparation of the admission to the PICU. They travel to the bedside, speak to the nurse; review the pre-hospital/emergency room summary, therapy that has been provided, laboratory and imaging obtained in the emergency department.

Description of Intra-Service Work: The physician completes a history with the family of the child and undertakes a complete physical examination of the child. Lines are placed, laboratory work and blood gases ordered, imaging ordered, the child is sedated and paralyzed and intubated and placed on the ventilator due to deteriorating respiratory and mental status. Ventilator settings are varied based upon the initial blood gas results. The child's initial orders are written and treatment is initiated at the bedside.

Description of Post-Service Work: The physician completes the documentation of the admission history and physical examination and speaks with the family and referring physician. The chest radiograph and initial laboratory work is reviewed, ventilator settings and pharmacologic therapy is adjusted.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008			
Presenter(s):	Steve Krug, MD, FAAP and David Jaimovich, MD, FAAP				
Specialty(s):	American Academy of Pediatrics (AAP)				
CPT Code:	99475				
Sample Size:	750	Resp N:	66	Response: 8.8 %	
Sample Type: Panel					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate					
Survey RVW:	12.50	15.00	15.98	15.98	28.00
Pre-Service Evaluation Time:			30.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	25.00	68.13	105.00	146.25	390.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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			
Prolonged Services:	<u>0.0</u>	99354x 0.0 55x 0.0 56x 0.0 57x 0.0			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99475	
	<u>Specialty Recommended</u>
Physician Work RVU:	15.00
Pre-Service Evaluation Time:	30.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	105.00
Immediate Post Service-Time:	<u>30.00</u>
Post Operative Visits	Total Min** CPT Code and Number of Visits
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 0.0 99239x 0.0
Office time/visit(s):	<u>0.0</u> 99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	<u>0.0</u> 99354x 0.0 55x 0.0 56x 0.0 57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99293	XXX	15.98	RUC Time

CPT Descriptor 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

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
99291	XXX	3,310,355	4.50	RUC Time

CPT Descriptor 1 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 63 % of respondents: 95.4 %

TIME ESTIMATES (Median)

	<u>CPT Code: 99475</u>	<u>Key Reference CPT Code: 99293</u>	<u>Source of Time RUC Time</u>
Median Pre-Service Time	30.00	30.00	
Median Intra-Service Time	105.00	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	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	165.00	240.00
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	4.06
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.27	4.24
Urgency of medical decision making	4.82	4.79

Technical Skill/Physical Effort (Mean)

Technical skill required	4.42	4.50
Physical effort required	4.05	4.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.59	4.52
Outcome depends on the skill and judgment of physician	4.67	4.56
Estimated risk of malpractice suit with poor outcome	4.27	4.17

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.59	3.55
Intra-Service intensity/complexity	4.70	4.68
Post-Service intensity/complexity	3.56	3.55

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel was convened. After thorough review of the work survey results, the panel agreed to recommend the survey median of 15.98.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99291-99292

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 9000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. There are approximately 200,000 PICU admits per year and 4.5% would qualify for this service.

Specialty Pediatrics	Frequency 9000	Percentage 100.00 %
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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? 150

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. There are very few pediatric patients who are Medicare beneficiaries.

Specialty Pediatrics	Frequency 150	Percentage 100.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? 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: 99476 Tracking Number M2 Specialty Society Recommended RVU: **7.77**
Global Period: XXX RUC Recommended RVU: **6.75**

CPT Descriptor: Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 3-year-old child is receiving continued care, including cardiovascular support and monitoring in the PICU after admission for fever, neutropenia and circulatory shock following a diagnosis of bacteremia and sepsis, during chemotherapy for acute lymphocytic leukemia

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician speaks with the bedside nurse and reviews the laboratory information, pharmacologic support, imaging data, vital signs and monitoring data.

Description of Intra-Service Work: The physician completes an interval exam, makes changes with the management and discusses the changes in management with the bedside care team. The child is re-examined and laboratory, imaging and monitoring values are interpreted and changes in therapy ordered multiple times during the day.

Description of Post-Service Work: The physician completes the documentation of the admission history and physical examination and updates the current daily information and documents the management changes and speaks with the family and child's oncologist. The initial laboratory work and monitoring data is reviewed and therapy is adjusted.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2008			
Presenter(s):	Steve Krug, MD, FAAP & David Jaimovich, MD, FAAP				
Specialty(s):	American Academy of Pediatrics (AAP)				
CPT Code:	99476				
Sample Size:	750	Resp N:	55	Response: 7.3 %	
Sample Type: Panel					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate					
Survey RVW:	5.50	7.77	7.99	8.00	9.60
Pre-Service Evaluation Time:			20.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	15.00	60.00	65.00	105.00	310.00
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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			
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99476	
	Specialty Recommended
Physician Work RVU:	7.77
Pre-Service Evaluation Time:	20.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	65.00
Immediate Post Service-Time:	20.00
Post Operative Visits	Total Min** CPT Code and Number of Visits
Critical Care time/visit(s):	0.0 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 0.0 99239x 0.0
Office time/visit(s):	0.0 99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0 99354x 0.0 55x 0.0 56x 0.0 57x 0.0

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99294	XXX	7.99	RUC Time

CPT Descriptor Subsequent 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

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
99291	XXX	3,310,355	4.50	RUC Time

CPT Descriptor 1 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 53 % of respondents: 96.3 %

TIME ESTIMATES (Median)

	<u>CPT Code: 99476</u>	<u>Key Reference CPT Code: 99294</u>	<u>Source of Time RUC Time</u>
Median Pre-Service Time	20.00	20.00	
Median Intra-Service Time	65.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	105.00	140.00
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	4.42	4.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	4.49
Urgency of medical decision making	4.45	4.45

Technical Skill/Physical Effort (Mean)

Technical skill required	4.42	4.45
Physical effort required	4.00	3.93

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.65	4.56
Outcome depends on the skill and judgment of physician	4.56	4.47
Estimated risk of malpractice suit with poor outcome	4.16	4.13

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.60	3.55
Intra-Service intensity/complexity	4.56	4.51
Post-Service intensity/complexity	3.56	3.56

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPOT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel was convened. After thorough review of the work survey results, the panel agreed to recommend the survey median of 7.99.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:-No-

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99291-99292

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 9000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. There are approximately 200,000 PICU admits per year and 4.5% would qualify for this service.

Specialty Pediatrics Frequency 9000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 250

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. There are very few pediatric patients who are Medicare beneficiaries.

Specialty Pediatrics Frequency 250 Percentage 100.00 %

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? 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

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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Tampa, FL

January 8, 2008

William Rich, MD

Chair, AMA/Specialty Society RVS Update Committee

American Medical Association

Department of Physician Payment Policy and Systems

515 North State Street

Chicago, IL 60610

Re: Direct Practice Expense Inputs for Codes 99475 and 99476 (Tracking Codes M1 and M2)

Dear Dr Rich:

Codes 99468 (*Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 25 months through 71 months of age*) and 99469 (*Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 25 months through 71 months of age*) are among the codes being considered during the February 2008 RUC meeting.

The American Academy of Pediatrics (AAP) has conducted a physician work survey for codes 99468 and 99469 and developed work RVU recommendations based on the survey results. However, since the services described by codes 99475 and 99476 typically occur in the facility setting, the AAP recommends no direct practice expense inputs for codes 99475 and 99476.

If you have any questions, please contact Linda Walsh, AAP staff, at 800/433-9016 ext 7931 or lwalsh@aap.org. Thank you.

Sincerely,

Steve Krug, MD

Steven E. Krug, MD, FAAP
AAP RUC Advisor

**AMA/Specialty Society RVS Update
Committee**

**Remaining RUC & HCPAC
Recommendations for 2009 Medicare
Physician Payment Schedule**

October 2008

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October 13, 2008

Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: Remaining RUC Recommendations for 2009 Medicare Physician Payment Schedule

Dear Mr. Weems:

The American Medical Association/Specialty Society RVS Update Committee (RUC) met on October 2-5, 2008 to consider recommendations related to several Centers for Medicare and Medicaid Services (CMS) requests including those initially identified by the RUC's Five-Year Review Identification Workgroup. We understand that CMS is currently in the process of preparing the *Final Rule* on the 2009 Medicare Physician Payment Schedule. We urge CMS to consider these recommendations in the publication of this *Final Rule*, expected to be published in the *Federal Register* on November 1, 2008.

CMS Requests

At the October 2008 RUC Meeting, several services, identified by the Site of Service Anomaly, High Volume Growth and High IWP/UT screens, as well as services in which CMS requested a review of the practice expense inputs, were reviewed by the RUC. Attached are documents including work relative value recommendations, direct practice expense (PE) inputs, utilization estimates, and suggested Professional Liability Insurance (PLI) relative value crosswalks for the following issues:

- Skin Tissue Rearrangement (14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061 & 14300)
- Skin Pedicle Flaps (15570, 15572, 15574 & 15576)
- Destruction of Skin Lesions (17106, 17107 & 17108)
- Treat Thigh Fracture (27244 & 27245)
- Interventional Radiology Procedures (36481, 37183, 47382 & 50200)
- Change Biliary Drainage Catheter (47525)
- Cystourethroscopy (52214 & 52224)
- Cryoablation of Prostate (55873)
- Microvolt T-Wave Assessment (93025)
- Audiology Services (92620, 92621, 92625, 92626, 92627 & 92640)
- Stress Echo with ECG Monitoring (93025)

Kerry Weems
October 13, 2008
Page Two

Cost estimates for medical supplies and equipment not listed on the "CMS Labor, Supply, and Equipment List for the Year 2008" 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 that may alter the cost estimates. The RUC shares this information with CMS without making specific recommendations on the pricing for supplies and equipment.

Fastest Growing Procedures

In the *Proposed Rule*, regarding the 2009 Physician Payment Schedule published on July 1, CMS provided a list of the 114 fastest growing procedures. CMS was supportive of the RUC's role in the identification and review of potentially misvalued services. CMS compiled this list based on codes that grew at least 10% per year over the course of three previous years to be reviewed. This generated a list of 114 services, for which approximately a third have already been identified by the RUC. Seventy-nine additional high volume growth codes were identified under this method. To begin the review of these services, AMA staff requested specialties to provide action plans that would detail the reason for the growth, if any, and a timeline for the review of the procedure or any other special concerns related to the valuation of these services or other services within their respective coding families.

The Five-Year Review Identification Workgroup discussed each code individually and made several different recommendations – to re-review (potentially by survey), refer to CPT, draft CPT Assistant article, request more data, review in 3 years, or remove from this screen. It is expected that any changes to coding descriptors will be made within the CPT 2010 cycle. For those services that may need to be re-reviewed, the Workgroup recommends that they not be immediately referred for survey, but, be discussed further and prioritized by this Workgroup in February 2009, with surveys to potentially begin thereafter. RUC staff will be performing the prioritization by utilization and forwarding the list to all specialties for review and comment prior to the February 2009 meeting. Specialties are asked to confirm that the correct family of services is included with the potentially misvalued service. Attached is the report from the Five-Year Review Identification Workgroup listing all of the RUC approved Workgroup recommendations pertaining to this screen.

Harvard Valued Codes

CMS indicated in the July 2008 *Proposed Rule* that it will request the RUC to review the 2,856 codes valued by Harvard only. The RUC, in its comments to the *Proposed Rule*, informed CMS that reviewing all 2,856 Harvard-valued codes would require an inordinate amount of time and financial resources, possibly spanning a decade. In the *Proposed Rule*, CMS states that the focus of the RUC review should give priority to high volume and low intensity services. As such, the RUC analyzed the list with a threshold for high volume of 10,000 per year. The resulting list was 296 services, which accounts for more than \$4.5 billion or 86% of the slightly more than \$5.2 billion in allowable charges for all Harvard-valued services that CMS cites in the *Proposed Rule*.

The Workgroup discussed the list in light of the amount of work that it will place on the specialty societies. The Workgroup noted that while a list of 296 codes appears, at its face, to be manageable, the list does not account for the additional codes that would be reviewed within the

Kerry Weems
October 13, 2008
Page Three

families of those 296. In order to initiate the review, the RUC will limit its current review to the top 9 services, which have a volume of one million or more. These services include:

- 88305 - Level IV - Surgical pathology, gross and microscopic examination
- 73510 - Radiologic examination, hip, unilateral; complete, minimum of two views
- 73630 - Radiologic examination, foot; complete, minimum of three views
- 90935 - Hemodialysis procedure with single physician evaluation
- 93042 - Rhythm ECG, one to three leads; interpretation and report only
- 88312 - Special stains; Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each
- 88304 - Level III - Surgical pathology, gross and microscopic examination
- 88313 - Special stains; Group II, all other (eg, iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each
- 73610 - Radiologic examination, ankle; complete, minimum of three views

The RUC will ask specialty societies to identify the related families of codes for these 9 high volume services to be discussed at the February 2009 meeting.

Review of Practice Expense Relative Value Units

In the *Proposed Rule*, CMS asked the RUC to review the direct practice expense inputs for high-volume codes where the practice expense payments are significantly increasing during the transition to the new practice expense methodology. The RUC staff prepared an analysis, which is attached, which illustrates that the services increasing under the transition have little to do with the direct inputs assigned to the codes. Rather, the increases are attributed to those specialties for which CMS has accepted supplemental survey data. It is important to realize the cause and effect of the underlying data in the practice expense methodology designed by CMS. The transition to the "bottom-up" practice expense methodology occurred at the same time CMS was implementing supplemental survey data from several specialties. The analysis illustrates that for 82% of the codes increasing by 20% or more during the transition to this methodology, the dominant specialty is one that conducted a supplemental survey or is crosswalked to a specialty that conducted such a survey.

The RUC reviewed this CMS request further at the October 2008 meeting and agreed that the increase in PE RVUs is most likely due to CMS acceptance of indirect practice expense supplemental surveys. While using the particular review criteria of codes that increase during the practice expense transition may be flawed, the RUC does agree that practice expense data should be refined going forward. The RUC has previously asked CMS to indicate if a particular year would be designated to conduct a Five-Year Review of practice expense. From recent meetings with CMS staff, the RUC understands that CMS prefers a rolling review of this data, rather than a large scale review. Understanding this preference, the Practice Expense Subcommittee of the RUC will continue to work with CMS to conduct an ongoing review of PE inputs.

RUC Request to Review a Potentially Misvalued Service

In addition to these recommendations and notifications, the RUC requests that CPT code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical*

Kerry Weems
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Page Four

probe placement) (Work RVU=20.25) be evaluated at the February 2009 RUC Meeting. The RUC, upon reviewing the practice expense inputs for this service, determined that the intra-service time for this procedure, 200 minutes, seemed to be inappropriate. When this service was originally reviewed, this intra-service time may have been appropriate but as the utilization of the service has increased, this intra-service time now seems not to be reflective of the work being performed. The RUC requests that 55873 be reviewed by CMS to determine if they believe that this service should be added to the RUC agenda.

We appreciate your consideration of these RUC recommendations. If you have any questions regarding the attached materials, please contact Sherry Smith at (312) 464-5604.

Sincerely,



William L. Rich, III, MD, FACS

cc: Gaysha Brooks
Rick Ensor
Edith Hambrick, MD
Whitney May
Ken Simon, MD
Pam West, DPT
RUC participants

Attachments

AMA/Specialty Society RVS Update Committee & HCPAC - Summary of CMS Requested Services

CPT Code	Descriptor	Current Value	RUC Recommended Value	Change in Value	PE Only Issue
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	6.83	6.19	Yes	
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm	9.60	8.58	Yes	
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less	7.66	7.02	Yes	
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	11.18	10.16	Yes	
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	8.44	8.44	No	
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck,	12.67	10.63	Yes	
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10	9.07	9.07	No	
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1	13.67	11.25	Yes	
14300	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area	13.26	Referral to CPT	No	
15570	Formation of direct or tubed pedicle, with or without transfer; trunk	10.00	10.00	No	
15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs	9.94	9.94	No	
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet	10.52	10.52	No	
15576	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral	9.24	9.24	No	
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique);	4.62	3.61	Yes	
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique);	9.19	4.68	Yes	
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique);	13.22	6.37	Yes	
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric	17.08	18.00	Yes	
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	21.09	18.00	Yes	

CPT Code	Descriptor	Current Value	RUC Recommended Value	Change in Value	PE Only Issue
36481	Percutaneous portal vein catheterization by any method	6.98	Tabled to February 2009 RUC Meeting	No	Yes
37183	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)	7.99	7.99	No	Yes
47382	Ablation, one or more liver tumor(s), percutaneous, radiofrequency	15.19	15.19	No	Yes
47525	Change of percutaneous biliary drainage catheter	5.55	1.54	Yes	
50200	Renal biopsy; percutaneous, by trocar or needle	2.63	2.63	No	Yes
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	3.70	3.70	No	Yes
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or	3.14	3.14	No	Yes
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)	20.25	Postponement until Review of Entire Code	No	Yes
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	0.86	Postponement until Review of Entire Code	No	
92620	Evaluation of central auditory function, with report; initial 60 minutes	0.00	1.50	Yes	
92621	Evaluation of central auditory function, with report; each additional 15 minutes	0.00	0.35	Yes	
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	0.00	1.15	Yes	
92626	Evaluation of auditory rehabilitation status; first hour	0.00	1.40	Yes	
92627	Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure)	0.00	0.33	Yes	
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour	0.00	1.76	Yes	
93025	Microvolt T-wave alternans for assessment of ventricular arrhythmias	0.75	0.75	No	Yes
93350	Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	1.48	1.46	Yes	

**RUC Recommended Physician Time for CMS Requests
October 2008**

CPT Code	Pre Service Evaluation Time	Pre Service Positioning Time	Pre Service Dress Scrub and Wait Time	Intra Service Time	Immediate Post Service	99231	99232	99233	99238	99212	99213	99214	Total Time
14000	25			64	22						3.5		191.5
14001	34		15	105	26				0.5		4		272
14020	29			78	24						4		223
14021	37		15	116	28						4		288
14040	15	10	5	90	25					2	2		223
14041	34		15	135	27						4		303
14060	15	10	5	60	15					2	2		183
14061	38		15	157	28						4.5		341.5
14300	44		25	102	34	2.5			1		4.5		396.5
15570	40	13	20	100	30	1			1	1	2	1	363
15572	40	13	20	90	30				0.5	1	3		297
15574	40	10	20	110	30				0.5	1	3		314
15576	40	10	20	90	30				0.5	1	2		271
17106	7			30	10					1	1		86
17107	7			40	10					2	1		112
17108	7			60	10					3	1		148
27244	40	30	20	75	30	2	2		1	1	3		438
27245	40	30	20	80	30	2	2		1	1	3		443
47525	19	1	5	20	10								55
92620	7			60	10								77
92621				15									15
92625	7			40	10								57
92626	7			60	10								77
92627				15									15
92640	4			60	5								69
93350	3			20	5								28

**Summary of Direct Practice Expense Changes
RUC Recommendations for CMS Requests
October 2008**

Practice Expense Physician Time Components Recommended October 2008 RUC Meeting							Practice Expense Physician Time Components prior to the October 2008 RUC Meeting							Change in Post Op Visit Info										
CPT Code	Intra- Service	Clinical Labor Assist	99238	99211	99212	99213	99214	Current Intra Time	Change in intra time	New Clinical Labor Assist	Staff Type	99238	99211	99212	99213	99214	Change in Clinical Labor Time Excluding Post-Op Visits	99238	99211	99212	99213	99214	Change in Post Op Visits	Change in Clinical Labor Time from Change in Post Op Visits
14000	64	64				3.5		64			Blend	0.5			3.5		-0.5						Yes	-6
14001	105	105	0.5			4		105			Blend	1			4		-0.5						Yes	-6
14020	78	78				4		78			Blend	0.5			4		-0.5						Yes	-6
14021	116	116	0.5			4		116			Blend	1			4		-0.5						Yes	-6
14041	135	135				4		135			Blend	1			4		-1						Yes	-12
14060	60	60			2	2		60			Blend			2	2								No	0
14061	157	157				4.5		157			Blend	1			4.5		-1						Yes	-12
15570	100	100	1		1	2	1	105	-5	100	Blend	1		1	2		-5					1	No	53
15572	90	90	0.5		1	3		90			Blend	1		1	2		-0.5				1		Yes	30
15574	110	110	0.5		1	3		120	-10	110	Blend	0.5	1	1	1		-10		-1		2		Yes	56
15576	90	90	0.5		1	2		90			Blend	0.5		1	2								No	0
17106	30	30			1	1		20	10	30	Blend			2			10			-1	1		Yes	9
17107	40	40			2	1		30	10	40	Blend			2			10				1		Yes	36
17108	60	60			3	1		45	15	60	Blend			2			15			1	1		Yes	63
27244	75	NA	1		1	3		79		NA	Blend	1		4						-3	3		Yes	27
27245	80	NA	1		1	3				NA	Blend	1		3	1					-2	2		Yes	18
47525	20	20						28	-8	20	Blend	0.5		0.5			-8	-0.5		-0.5			Yes	-19.5
92620	60	0						0	60	0	Audiologist						-84						No	0
92621	15	0						0	15	0	Audiologist						-18						No	0
92625	40	0						0	40	0	Audiologist						-83						No	0
92626	50	0						0	50	0	Audiologist						-82						No	0
92627	15	0						0	15	0	Audiologist						-18						No	0
92640	60	0						0	60	0	Audiologist						-60						No	0

Members Present: Barbara Levy, MD (Chair), James Anthony, MD, Michael Bishop, MD, James Blankenship, MD, Dale Blasier, MD, Katherine Bradley, PhD, RN, Norm Cohen, MD, Thomas Felger, MD, Gregory Kwasny, MD, William J. Mangold, Jr., MD, Lawrence Martinelli, MD, Geraldine McGinty, MD, Maurits Weirsema, MD, Robert Zwolak, MD

Doctor Levy welcomed the Workgroup, thanked them for their work and reiterated that the mandate of this Workgroup is to identify potentially misvalued services for possible review by the RUC.

June 19, 2008 CMS Request for Review of 114 Services

Review of Specialty Society Action Plans

In the NPRM regarding the 2009 Physician Payment Schedule published on July 1, CMS provided a list of the 114 fastest growing procedures. CMS was supportive of the RUC's role in the identification of and review potentially misvalued services. CMS compiled this list based on codes that grew at least 10% per year over the course of three previous years to be reviewed. This generated a list of 114 services, for which approximately a third have already been identified by the RUC. Seventy-nine additional high volume growth codes were identified under this method. To begin the review of these services, AMA staff requested specialties to provide action plans that will detail the reason for the growth, if any, and a timeline for the review of the procedure or any other special concerns related to the valuation of these services or other services within their respective coding families.

The Five-Year Review Identification Workgroup discussed each code individually and made several different recommendations – to survey, refer to CPT, draft CPT Assistant article, request more data, review in 2 years, or remove from this screen. For those services that may need to be surveyed, the Workgroup recommends that they not be immediately referred for survey, but, because of the number of codes, be prioritized by this Workgroup in February 2009, with surveys to potentially begin thereafter. RUC staff will be performing the prioritization by utilization and forwarding the list to all specialties for review and comment prior to the February 2009 meeting. Specialties are asked to confirm that the correct family of services is included with the potentially misvalued service discussed below. **The RUC approved the following actions recommended by the Workgroup.**

Code	Recommendation to the RUC
10022	The specialty indicated that imaging should always be reported with this service. In its recommendations, the specialty indicated that utilization of more invasive procedures has decreased commensurate with the increase in 10022. However, those services were not listed in the specialty's action plan. Because of the potential of creating bundled services rather than surveying the code as is, the Workgroup requests additional data regarding the imaging procedures that are inherent and the relevant codes that have experienced a decrease in utilization due to the increase in utilization of this service. The Workgroup requests that the specialty return in February 2009 with this additional data.
13121	The Workgroup noted that 13121 is performed in conjunction with a excision of lesion service more than 70% of the time. The Workgroup agrees that the creation of a bundled service is most appropriate and requests that the specialty come back to the workgroup with data regarding the services that are most commonly performed with this family (13120, 13121 and 13122) to recommend the development of a bundled code.
19295	The Workgroup accepted the specialty society's rationale for the growth in volume and agreed with the recommendation to remove this service from the volume growth screen. The only actual resource cost in this service is the clip; there is no physician work.
20551	The Workgroup agreed with the specialty society's request for additional data from CMS. Specifically, the data requested is the number of units of 20551 and 20550 billed on the same day by the same provider as well as the number and level of evaluation and management services reported at the same time as the 20551 and 20550.
20926	The Workgroup agreed with the specialty society's request for additional data from CMS. Specifically, the data requested are the other services billed on the same day by the same surgeon.
22214	<p>The Workgroup noted that this service has never been reviewed by the RUC. In combination with the growth in volume, the Workgroup agreed that the service was potentially misvalued and may need to be surveyed along with 22210, 22212, and 22216 of the same family.</p> <p>The RUC delayed action on this service while staff researches why the RUC database indicates RUC time, but with no available survey data. The RUC requests that the Five-Year Review Identification Workgroup review this service again with all available data from the previous RUC recommendation.</p>
22533	The Workgroup accepted the specialty society's rationale for the growth in volume and agreed with the recommendation to draft a CPT Assistant article. The article should include the other services in the family, 22532 and 22534.

22843	<p>The Workgroup noted that this service has never been reviewed by the RUC. In combination with the growth in volume, the Workgroup agreed that the service was potentially misvalued and may need to be surveyed with 22840, 22841, 22842, 22844, 22845, 22846, 22847, 22848, and 22851.</p> <p>The RUC delayed action on this service while staff researches the previous RUC recommendation. The RUC requests that the Five-Year Review Identification Workgroup review this service again with all available data from the previous RUC recommendation.</p>
22849	<p>The Workgroup noted that this service has never been reviewed by the RUC. In combination with the growth in volume, the Workgroup agreed that the service was potentially misvalued and may need to be surveyed.</p> <p>The RUC delayed action on this service while staff researches the source of data within the RUC database. The RUC requests that the Five-Year Review Identification Workgroup review this service again with all available data from the previous RUC actions.</p>
22851	<p>The Workgroup reviewed the service and noted that it may be appropriate to develop a bundled service or may need to re-survey the service because of the growth in the add-on code. The Workgroup agreed that this service was potentially misvalued and asks that either the service be revised at CPT to bundle with the base code or may need to be resurveyed. The Workgroup also supported the request to obtain data on the number of times it is reported per operative session.</p>
23430	<p>The Workgroup noted that this service has never been reviewed by the RUC. In combination with the growth in volume, the Workgroup agreed that the service was potentially misvalued and may need to be surveyed.</p>
23472	<p>The Workgroup accepted the specialty society's rationale for the growth in volume and agreed with the recommendation to remove this service from the volume growth screen. This service was recently reviewed by the RUC.</p>
26480	<p>The Workgroup noted that this service has never been reviewed by the RUC. In combination with the growth in volume, the Workgroup agreed that the service was potentially misvalued and may need to be surveyed.</p>
29822	<p>The Workgroup noted that the specialty society's explanation that the open procedure has decreased is correct. The relevant open codes have decreased over the same period. However, the service is Harvard-valued. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed. Lastly, the Workgroup commented that this procedure may also be done on the same day with other procedures, which should be taken into account at the time of re-evaluation.</p>
29827	<p>The Workgroup agreed with the specialty society's explanation that the laparoscopy procedure has increased in volume and the open procedure has decreased, offsetting the overall growth. The Workgroup recommends that this service be removed from the screen. This service was also recently reviewed by the RUC.</p>

31579	The Workgroup accepted the specialty society's rationale for the growth in volume and agreed with the recommendation to remove this service from the volume growth screen. The specialty noted that while the typical patient is not a Medicare patient, the service is still commonly performed in the Medicare population and the number of patients requiring this procedure has increased.
32663	The Workgroup noted that this procedure was recently reviewed during the Third Five-Year Review. The specialty society provided a very detailed analysis of the total number of lobectomies performed showing that while 32663 has increased, utilization has merely shifted and total number of lobectomies is static. The Workgroup accepted the specialty society's rationale for the growth in volume and agreed with the recommendation to remove this service from the volume growth screen.
33213	The Workgroup found that this service was billed 76% of the time with the removal code, despite the fact that 33213 describes an insertion or replacement. The Workgroup agrees that this is inappropriate and recommends that the service be referred to CPT for revision of the descriptor and/or instructions.
35470	The Workgroup agreed that this service is currently structured as component coding and, consistent with previous recommendations, should be referred to CPT to create bundled services.
35474	The Workgroup agreed that this service is currently structured as component coding and, consistent with previous recommendations, should be referred to CPT to create bundled services.
36248	The Workgroup agreed that this service is currently structured as component coding and, consistent with previous recommendations, should be referred to CPT to create bundled services.
36516	The Workgroup noted that this was a new service in 2002 and has relatively low volume. The Workgroup agreed with the specialty society and recommends development of a CPT Assistant article to clarify coding.
38571	The specialty society indicated that several new codes are being developed to describe the robotic procedure. The Workgroup noted that 38571 may also need to be surveyed at that same time and should not be used as the base code or reference code for the new codes.
43236	The Workgroup agreed with the specialty society and recommends development of a CPT Assistant article. Further, the Workgroup noted that utilization should be reviewed again in three years to assess the effectiveness of the article.
43242	The Workgroup agreed with the specialty society and recommends development of a CPT Assistant article. Further, the Workgroup noted that utilization should be reviewed again in three years to assess the effectiveness of the article.

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43259	The Workgroup agreed with the specialty society and recommends development of a CPT Assistant article. Further, the Workgroup noted that utilization should be reviewed again in three years to assess the effectiveness of the article.
44205	The Workgroup agreed with the specialty society's rationale for the increase in volume that open procedures have decreased commensurate with the increase in the laparoscopic procedure. The comparison reveals that overall colectomies have decreased. The Workgroup agreed with the specialty's recommendation to remove this service from the screen.
44207	The Workgroup agreed with the specialty society's rationale for the increase in volume that open procedures have decreased commensurate with the increase in the laparoscopic procedure. The comparison reveals that overall colectomies have decreased. The Workgroup agreed with the specialty's recommendation to remove this service from the screen.
44970	The Workgroup agreed with the specialty society's rationale for the increase in volume that open procedures have decreased commensurate with the increase in the laparoscopic procedure. The comparison reveals that overall appendectomies have decreased. The Workgroup agreed with the specialty's recommendation to remove this service from the screen.
45381	The Workgroup agreed with the specialty society's rationale for volume growth and recommended that a CPT Assistant article be drafted to discuss the gastroenterology services. Further, the Workgroup noted that utilization should be reviewed again in three years to assess the effectiveness of the article.
47490	The Workgroup noted that this was a relatively low volume procedure, but that it is still Harvard-valued. In combination with the recent growth in volume, the Workgroup agreed that the procedure is potentially misvalued and recommends that the procedure may need to be surveyed.
50542	The Workgroup agreed with the specialty society that this was a new code in 2003 and the growth in volume is not excessive for a newer code. The Workgroup recommended removing it from the screen.
50548	The Workgroup agreed with the specialty society's rationale that the increase in utilization of 50548 is offset by a reduction in the open procedure. The Workgroup recommended removing this service from the screen. This service was recently reviewed by the RUC.
50605	The Workgroup agreed that this service should be referred to CPT for revision of the descriptor. Urologists are not typically the primary physician and are not performing the opening or closing, and descriptor of physician work should reflect this.
61793	This service has been deleted from CPT.

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61795	The Workgroup noted that this is a relatively high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and should be surveyed in the future.
63056	The Workgroup noted that this is a relatively high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future. Further, the Workgroup agrees with the specialty society that a CPT Assistant article and a CCI edit be created in the interim. The survey should also include the family of codes indicated by the specialty, 63055 and 63057.
63655	The Workgroup noted that while this is a low volume procedure, it has never been surveyed by the RUC and in combination with the growth in volume, the Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future. This service is also migrating to the outpatient setting.
64415	The Workgroup noted that this is a volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future. The family of injection codes should be addressed with this code.
64445	The Workgroup noted that this is a volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
64447	The Workgroup commented that the vignette for this service indicated that it is performed in conjunction with another procedure, but there are 25 minutes of pre-time. As such, the Workgroup agreed that the service is potentially misvalued and may need to be resurveyed.
64483	The specialty society commented that imaging guidance is absolutely necessary in this procedure. However, the procedure is only reported with an imaging service little more than 50% of the time. The Workgroup agreed that lesser injection codes may be incorrectly reported using this coded. The Workgroup recommended that this service along with the other codes in its family (64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484) be referred to CPT to be bundled with the appropriate guidance procedure(s).
64484	The specialty society commented that imaging guidance is absolutely necessary in this procedure. However, the procedure is only reported with an imaging service little more than 50% of the time. The Workgroup agreed that lesser injection codes may be incorrectly reported using this coded. The Workgroup recommended that this service along with the other codes in its family (64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484) be referred to CPT to be bundled with the appropriate guidance procedure(s).

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64561	The Workgroup agreed that had the New Technology list been in existence at the time this procedure was developed, it would have been included. As such, the Workgroup would like to continue to monitor this procedure and review the change in volume in two years. Further, the Workgroup will review the utilization of 64581 and 64590 indicated by the specialty.
65780	The Workgroup agreed with the specialty society recommendation to draft a CPT Assistant article to clarify correct reporting.
69100	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and should be surveyed in the future. The service may need to be surveyed with 69105 as indicated in the action plan. When the specialty reviews this, the Workgroup asks that it provide data regarding evaluation and management on the same date.
69801	The Workgroup noted that this service has migrated to being predominantly performed in the office-setting. In tandem with the growth in volume, the Workgroup agreed that it is potentially misvalued and may need to be surveyed.
71250	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
71275	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
72125	The Workgroup noted that this is a high volume procedure has been surveyed by the RUC, but that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
72128	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
72192	The Workgroup noted that this service is already under consideration to be bundled as part of the recommendations of the Joint Workgroup on Bundled Services. The Workgroup will defer any action on this service until the coding change proposal has been considered by CPT.
73200	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.

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73218	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
73700	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
74175	The Workgroup noted that this service is structured as a component code and agreed that that structure may not be appropriate. Further, the typical patient may have changed from the patient that is described in the vignette. The Workgroup agreed that this service is potentially misvalued, but requested that first be reviewed by the CPT to consider the appropriateness of component coding and other services it may be typically performed with.
76536	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
76880	The Workgroup accepted the specialty society's recommendation to survey this service.
77301	The Workgroup agreed with the specialty society recommendation to draft a CPT Assistant article to clarify correct reporting. Additionally, the Workgroup will review the change in volume again in 3 years to assess the effectiveness of the article.
77418	The Workgroup agreed with the specialty society recommendation to draft a CPT Assistant article to clarify correct reporting. Additionally, the Workgroup will review the change in volume again in 3 years to assess the effectiveness of the article.
77781	This service has been deleted from CPT
92135	The Workgroup commented that this service has increased in volume dramatically over the past 10 years, since it was reviewed by the RUC. The Workgroup agreed that it is potentially misvalued and recommends that it may need to be resurveyed.
92136	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
92285	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
92587	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.

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92986	The Workgroup accepted the specialty society recommendation to remove from the list. This was a low volume code and has not changed significantly in the last 20 years.
93308	The specialty society has developed guideline to reduce the inappropriate use of this code. Remove from this list.
93613	The Workgroup agreed that the increase in volume is appropriate and recommends that the service be removed from this screen. Advances in technology have allowed application of ablation for many previously untreatable and complex arrhythmias, such as atrial fibrillation and ventricular tachycardia. This requires use of 3-dimensional mapping to optimize the outcome. The increase in utilization is a reflection of an appropriate increase in the rate of use of this technology.
93652	The Workgroup commented that the service was last reviewed by the RUC in 1993. Further, the typical patient may be changing as indicated by the specialty. Lastly, the service contains seemingly excessive pre-service time, compared to more currently reviewed services. The Workgroup agreed that this service is potentially misvalued and that it and the others in the family – 93650 and 93651 may need to be surveyed.
93743	This service has been deleted from CPT
93922	The Workgroup noted that the existing data does not include any description of physician work as it was previously crosswalked to other services. The Workgroup agreed that it is potentially misvalued and recommends that it, and the other services in the family (93923, 93924, 93925, 93926, 93930, and 93931) may need to be surveyed. The Workgroup recommended a review a PE inputs for staff time as well.
93976	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
93990	The Workgroup accepted the recommendation of the specialty society to remove the code from the list because is has been reviewed by the RUC and the specialty's rationale is appropriate.
94762	The Workgroup noted that service is PE only, with IDTFs predominantly performing this procedure. The Workgroup recommends that this and the other codes in the family (94760 and 94761) be referred to the Practice Expense Subcommittee for review of the direct PE inputs.
95956	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and should be surveyed in the future along with the other services in the family – 95950, 95951, 95953, 95954, 95955, 95957, 95958, 95961, 95962, 95965, 95966, and 95967. The specialty also recommended a CPT Assistant article and the Workgroup agreed.

96920	The Workgroup noted that this service was new in 2002 and that volume should be reviewed again two years along with the other code in the family, 96921 and 96922.
G0179	The Workgroup agreed with the specialty society that the utilization of this service should actually be higher. Further, the Workgroup agreed that this service would be more appropriately reported with a CPT Category I code. The Workgroup accepted the specialty society's recommendation to remove this service from this screen and recommends that the specialty submit a coding change proposal to develop a CPT code for this service as well as G0180 and G0181.
G0181	The Workgroup agreed with the specialty society that the utilization of this service should actually be higher. Further, the Workgroup agreed that this service would be more appropriately reported with a CPT Category I code. The Workgroup accepted the specialty society's recommendation to remove this service from this screen and recommends that the specialty submit a coding change proposal to develop a CPT code for this service.
G0268	<p>The Workgroup noted that this service is indistinguishable from the CPT code 69210. The G code has never been reviewed by the RUC and CMS currently crosswalks the valuation to 69210. The Workgroup requests that CMS clarify the need for this service and, in the alternative, that they delete the G code.</p> <p>CMS provided the following information, which was originally given in response to a request for clarification to AAO-HNS:</p> <p>CMS has responded to the Academy's plea to correct the NCCI bundling of 69210 and audiometric testing by developing a new HCPCS II G code. "G0268 Removal of impacted cerumen (one or both ears) by physicians on same date of service as audiologic function testing." The RVUs for physician work, practice expense and malpractice will remain the same as CPT code 69210, removal impacted cerumen (separate procedure), one or both ears. It should be noted that this code should be billed only in those situations where a physician's expertise is needed to remove impacted cerumen on the same day as audiologic function testing performed by his employed audiologist. The two must share the same UPIN number. G0268 code cannot be billed by independent audiologists. Routine removal of cerumen, as defined by CMS, is the use of softening drops, cotton swabs and/or cerumen spoon) and is not paid separately. It is considered incidental to the office visit and cannot be reimbursed on the same day as the E&M service</p>

Review of Specialty Society Actions on Previously Reviewed Services

Thirty-five of the services identified by CMS were already identified through one of the various screens for potential misvaluation. A separate list of those services has been compiled and specialty societies, with the assistance of staff, have provided updates regarding the progress of the actions recommended by the RUC. The Five-Year Review Identification Workgroup reviewed the updates on each of the 35 services from the specialty societies and submits the following information and recommendations to the RUC for these services. **The RUC approved the following actions based on the Workgroup's recommendations:**

Code	Recommendation and/or Update to the RUC
14021	14021 is scheduled to be presented at the October 2008 RUC Meeting.
14300	The service was referred to CPT
15740	A coding change proposal regarding 15740 has been submitted and will be included in the October 2008 AMA CPT meeting agenda.
27245	27245 is scheduled to be presented at the October 2008 RUC Meeting
27370	The Workgroup agreed that due to the utilization of this service and fact that it has never been reviewed by the RUC, that it is potentially misvalued and may need to be surveyed.
37765	The Workgroup reviewed its previous recommendation and agreed that its decision to continue to monitor the service was appropriate in light of the fact that 37765 and 37766 were new codes in 2004. It reiterated that the growth in utilization was most likely because the codes were new. The Workgroup will review the services again in two years to determine the appropriateness of the utilization.
51772	The specialty society reported that it will submit coding change proposals to the CPT Editorial Panel to delete the 51772 as well as condense codes to include the Urethral Pressure Profile. The specialty indicated that the changes will be submitted in time for discussion at the February 2009 CPT Editorial Panel Meeting.
55866	The specialty society reported that it will submit coding change proposals to the CPT Editorial Panel to request new CPT codes. Code 55866 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing will remain. Additional CPT coding change proposals will be submitted for the following: 5586X <i>Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing; with total pelvic lymphadenectomy</i> and 5586X <i>Laparoscopy, robotic assisted surgical prostatectomy, retropubic radical, including nerve sparing, and 5586X, with total pelvic lymphadenectomy</i> , in time for discussion at the February 2009 CPT Editorial Panel Meeting.
63650	The RUC reviewed the potentially misvalued service at its February 2008 meeting and submitted recommendations to CMS in May 2008.
63660	The specialty societies submitted a coding change proposal for the October 2008 CPT Editorial Meeting to split the work previously described in 63660 into four separate codes.
63685	The RUC reviewed the potentially misvalued service at its February 2008 meeting and submitted recommendations to CMS in May 2008.

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64448	The Workgroup noted that 64448 was revised at the Feb 2008 CPT Panel meeting and presented at the April 2008 RUC meeting. Recommendation was to change the global from 10 to zero with 1.63 work RVUs. Descriptor was revised to read: <i>Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)</i> . The language regarding daily management was deleted per the Workgroup's recommendation.
64555	The specialty society indicated that two articles have appeared in their Health Policy Brief (May 2008 and August 2008) advising members of the proper coding of the percutaneous tibial nerve stimulation procedure using the 64999 unlisted nervous system code instead of the 64555. The specialty is also drafting a CPT Assistant Article with similar clarification.
64622 64626 64627	CPT Executive Committee addressed on May 1 and added parenthetical to instruct use of unlisted code for pulsed radiofrequency.
66982	The Workgroup previously recommended that 66984 and 66982 were not potentially misvalued because of pharmacologically induced Floppy Iris Syndrome. The impact of this new condition and its results on utilization of 66982 will be monitored and the Workgroup will review the service again in two years to assess changes in utilization.
67028	The Workgroup agreed that due to the utilization of this service and fact that it has never been reviewed by the RUC, that it is potentially misvalued and may need to be surveyed.
70496	The Workgroup agreed with its previous recommendation to review utilization of this service at a later date as the technology is currently shifting from 16 to 64 slice scanners. The Workgroup established a time-certain date for re-review in two years.
70498	The Workgroup agreed with its previous recommendation to review utilization of this service at a later date as the technology is currently shifting from 16 to 64 slice scanners. The Workgroup established a time-certain date for re-review in two years.
72191	The Workgroup agreed with its previous recommendation to review utilization of this service at a later date as the technology is currently shifting from 16 to 64 slice scanners. The Workgroup established a time-certain date for re-review in two years.
72194	The specialty society is in the process of developing a coding change proposal for CPT 2010.
73580	The Workgroup agreed that due to the utilization of this service and fact that it has never been reviewed by the RUC, that it is potentially misvalued and may need to be surveyed.
75635	The Workgroup agreed with its previous recommendation to review utilization of this service at a later date as the technology is currently shifting from 16 to 64 slice scanners. The Workgroup established a time-certain date for re-review in two years.

76513	CPT Executive Committee addressed on May 1 and added parenthetical to instruct not to report 76513 where 0187T is appropriate. The specialty society is currently engaged in an effort to develop a CPT Assistant article to clarify this.
77781 77782	Deleted in CPT 2009
90471	The RUC submitted its recommendations for changes to the PE for this code in its May 2008 recommendations to CMS. In its 2009 RBRVS proposed rule, CMS noted that it does not agree with the RUC-recommended clinical staff times related to "quality" activities. The AAP, AAFP, ACP, and RUC proposed rule comment letters will included clarification of the rationale for why CMS should include the RUC recommendations in the 2009 PE RVUs.
94681	The Workgroup commended the specialty society for the depth of the analysis they performed and the quality of their review of the growth in utilization. The Workgroup recommends that the RUC express its concern over the appropriateness of reporting of this procedure to CMS. The Workgroup will look at the change in utilization of this service again in two years.
95922	The Workgroup noted that a CPT Assistant article has been submitted to clarify coding of 95922.
96567	At the April 2008 meeting of the RUC, the specialty society presented the requested additional Practice Expense data. At that time the RUC agreed that the service was not potentially misvalued and no further action was required.
96921	The Workgroup agreed that this service as well as 96920 and 96922 should be assessed again in two years to review the change in utilization.
G0237 G0238	The change in site of service is a result of administrative regulations made by CMS and is not potentially misvalued based on this screen. The Workgroup requests that CMS review the current status of the impact on the SGR and make necessary changes to ensure funding. Further, the Workgroup recommends that the specialty society develop coding change proposals to add these codes as a Category I CPT Codes.
G0249	The Workgroup noted that the specialty society plans to include G0249 in its expanded review of anticoagulation management services in scheduled for April 2009.

CMS Request for Review of Services – Other Objective Criteria

Harvard Valued Codes

CMS indicated in the July 2008 NPRM that it will request the RUC to review the remaining 2,856 Harvard-valued codes. The RUC, in its comments to the NPRM, informed CMS that reviewing all 2,856 Harvard-valued codes would require an inordinate amount of time and financial resources, possibly spanning a decade.

In the NPRM, CMS states that the focus of the RUC review should give priority to high volume and low intensity services. As such, the RUC analyzed the list with a threshold for high volume of 10,000 per year. The resulting list was 296 services, which accounts for more than \$4.5 billion or 86% of the slightly more than \$5.2 billion in allowable charges for all Harvard-valued services that CMS cites in the NPRM.

The Workgroup discussed the list in light of the amount of work that it will place on the specialty societies. The Workgroup noted that while a list of 296 codes appears, at its face, to be manageable, the list does not account for the additional codes that would be reviewed within the families of those 296. The Workgroup agreed that though the task will be laborious, it should still take place.

In order to initiate the review, the RUC approved the recommendation of the Workgroup proposing the following:

- 1. Inform CMS that the RUC will limit its current review to the top 9 services, which have a volume of one million or more (as well as their respective families).**
- 2. Inform CMS that the RUC will ask specialty societies for the families of codes as well as comment**
- 3. The Workgroup will plan a schedule for review at their February 2009 meeting.**

Practice Expense RVUs

CMS, also through the NPRM, made a presumption that increases in the practice expense (PE) RVUs were due to changes in the direct PE inputs. RUC staff performed a detailed analysis and found an 82% concurrence between codes where PE RVUs increased and specialties that submitted supplemental surveys to CMS on indirect practice expense.

Therefore, the increase in PE RVUs is most likely due to CMS acceptance of indirect practice expense supplemental surveys. However, the Workgroup agree that increase in PE RVU is not an adequate screening criterion for potential misvaluation. The Practice Expense Subcommittee should continue to work with CMS to identify a process of ongoing review of PE inputs.

Other Objective Criteria for Potential Misvaluation

MPC Additions – to Qualify as A Codes

The Workgroup discussed the proposal that a criterion for reviewing a code in the rolling Five-Year Review include desire to add a code to the MPC.

Workgroup members expressed concern that doing so would create the potential for abuse by allowing an avenue for specialties to request that codes be reviewed outside of the regular CMS comment process. The desire to add a code to the MPC is not a criterion for potential misvaluation and should not be treated as such. Further, the Workgroup noted that the issue may be moot pending the outcome of its plans to review the Harvard-valued codes over time.

Joint CPT/RUC Workgroup on Bundled Services

Doctor Brin, Chair of the Joint CPT/RUC Workgroup on Bundled Services, participated by conference call to discuss the progress of the recommendations by the RUC and CPT for Type A codes to be bundled. Doctor Brin reported that a coding change proposal was submitted by SNM,

ACR, ACC, and ASNC and will be considered during the October Panel meeting. The Panel also received letters from American College of Cardiology (ACC) and American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) and American Speech-Language-Hearing Association (ASHA) regarding their respective bundling issues. Based on a recommendation of the Joint Workgroup, Doctors Rich and Thorwarth forwarded letters to those specialties reaffirming and clarifying the request to bundle the services.

ASHA and AAO-HNS indicated that their initial response in opposition to the change was based on a misunderstanding and that with clarification from the Workgroup, they are now developing a coding change proposal that makes clinical sense in their situation. They are working towards the November 8, 2008 deadline for the February 2009 CPT Meeting.

ACC is also attempting to accelerate their process and hopes to have their coding change proposal prepared in time for submission to the June 2009 CPT Meeting, with an update to the RUC in February 2009.

Other Issues

MedPAC Comment Letter on 2009 NPRM

Doctor Levy noted that a copy of MedPAC's comment letter to CMS regarding the NPRM was included in the meeting materials and encouraged Workgroup members to read it as it contains several passages of note regarding the identification of potentially misvalued services.

Items of Discussion for February 2009

Doctor Levy thanked the Workgroup for the tremendous amount of work they accomplished. Before adjourning, Doctor Levy provided a preliminary agenda for the Workgroup's next meeting in February 2009. She noted that the group will be discussing the prioritization of the review of services identified for survey during this meeting and the development of a specific work plan and timeline for review of the Harvard-valued services.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008 – Site of Service Anomaly

Skin Tissue Rearrangement

CPT codes 14001, 14021, 14041, 14061 and 14300 were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. These services were identified in the latter group. The specialty society added the following codes within the family to the review, 14000, 14020, 14040, and 14060. The RUC recommended a two-step action. First, the hospital visits were removed from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that the global period change from 090 to 000 day and that the services then be re-surveyed. CMS did not agree with the recommendation to change the global period.

14000, *Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less*

Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to account for their removal. The RUC agreed with the specialty societies' recommendation to remove one-half 99238 discharge day management service from the global period and the 0.64 work RVUs associated with it, as this is a service typically performed in the office. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 6.19.

Existing work RVU	6.83
<u>minus ½ 99238</u>	<u>0.64</u>
Recommendation	6.19

The RUC recommends removal of one-half 99238 discharge day management service, resulting in a work RVU of 6.19 for 14000.

14001, *Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm*

Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to account for their removal. The RUC agreed with the specialty societies' recommendation to remove one-half 99238 discharge day management service from the global period and the 0.64 work RVUs associated with it as well as the one-half 99231 hospital visit and the 0.38 work RVUs associated with it, as this is a service typically performed in the outpatient hospital. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 8.58.

Existing work RVU	9.60
minus ½ 99231	0.38
<u>minus ½ 99238</u>	<u>0.64</u>
Recommendation	8.58

The RUC recommends removal of one-half 99238 discharge day management service and one-half 99231 post-operative hospital visit resulting in a work RVU of 8.58 for 14001.

14020, *Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less*

Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to account for their removal. The RUC agreed with the specialty societies' recommendation to remove one-half 99238 discharge day management service from the global period and the 0.64 work RVUs associated with it, as this is a service typically performed in the office. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 7.02.

Existing work RVU	7.66
<u>minus ½ 99238</u>	<u>0.64</u>
Recommendation	7.02

The RUC recommends removal of one-half 99238 discharge day management service resulting in a work RVU of 7.02 for 14020.

14021, *Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm*

Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to account for their removal. The RUC agreed with the specialty societies' recommendation to remove one-half 99238 discharge day management service from the global period and the 0.64 work RVUs associated with it as well as the one-half 99231 hospital visit and the 0.38 work RVUs associated with it, as this is a service typically performed in the office. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 9.52.

Existing work RVU	11.18
minus ½ 99231	0.38
<u>minus 1 99238</u>	<u>1.28</u>
Recommendation	9.52

The RUC recommends removal of one-half 99238 discharge day management service and one-half 99231 post-operative hospital visit resulting in a work RVU of 10.16 for 14021.

14040, *Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less*

The RUC commented that 14040 is typically performed in the office and was valued appropriately in the Third Five-Year review without any hospital visits. **The RUC recommends removal of 14040 from the site of service anomaly screen and no change in work RVU.**

14041, *Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm*

Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to

account for their removal. The RUC agreed with the specialty societies' recommendation to remove one 99238 discharge day management service from the global period and the 1.28 work RVUs associated with it as well as the one 99231 hospital visit and the 0.76 work RVUs associated with it, as this is a service typically performed in the office. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 10.63.

Existing work RVU	12.67
minus 1 99231	0.76
<u>minus 1 99238</u>	<u>1.28</u>
Recommendation	10.63

The RUC recommends removal of one 99238 discharge day management service and one 99231 post-operative hospital visit resulting in a work RVU of 10.63 for 14041.

14060, Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

The RUC commented that 14060 is typically performed in the office and was valued appropriately in the Third Five-Year review without any hospital visits. **The RUC recommends removal of 14060 from the site of service anomaly screen and no change in the existing work RVU of 8.44.**

14061, Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm

Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to account for their removal. The RUC agreed with the specialty societies' recommendation to remove one 99238 discharge day management service from the global period and the 1.28 work RVUs associated with it as well as the one and one-half 99231 hospital visits and the 1.14 work RVUs associated with it, as this is a service typically performed in the office. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 11.25.

Existing work RVU	13.67
minus 1.5 99231	1.14
<u>minus 1 99238</u>	<u>1.28</u>

Recommendation 11.25

The RUC recommends removal of one 99238 discharge day management service and one and one-half 99231 post-operative hospital visit resulting in a work RVU of 11.25 for 14061.

14300, *Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area*

The specialty society commented that the descriptor does not accurately describe the work that may be involved in this service. Specifically, the work that is involved in performing the procedure in one area of the body may vary greatly from the work that is involved in performing the procedure in other areas of the body. The specialty society recommended and the RUC agreed that the code be referred to the CPT Editorial Panel for revision. **The RUC recommended that 14300 be referred to the CPT Editorial Panel for revision of the code descriptor.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	090	6.19
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm	090	8.58
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less	090	7.02
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	090	9.52
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	090	8.44 (No Change)
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm	090	10.63
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	090	9.01 6 (No Change)

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm	090	11.25
14300	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area	090	Referral to the CPT Editorial Panel



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September 5, 2008

Barbara Levy, MD, Chair
AMA RUC 5YR ID Workgroup
American Medical Association
515 N. State Street
Chicago, IL 60610

RE: AAD Recommendations on the Adjacent Tissue Transfer Codes - 14XXX

BACKGROUND

The adjacent tissue transfer family of codes were identified by the RUC 5YR ID Workgroup as site of service anomalies, because Medicare utilization data identifies these procedures as performed predominantly in the office rather than in facility. In September 2007, the RUC approved removing the facility data from these codes as interim, and recommended that the codes have a 000-day global to account for the different sites of service. Subsequent to that recommendation, CMS declined to change the global period and suggested that any survey be done with the existing 90-day global period.

At the April 2008 RUC meeting, a facilitation committee listened to specialty society arguments as well as observations of CMDs who were present. We believe that everyone (RUC members, CMS representative, CMDs, and specialties) at that meeting were in agreement that the global period should be changed to 000-day. After the RUC approved the recommendation, a request was sent to CMS, which again declined to change the global period for these codes.

AT ISSUE

The typical site of service for most of these codes is the office. The AAD believes that those patients being done in facility overwhelmingly represent differing practice patterns, and not different patient populations. We know from experience that similar patients referred to different doctors will have their surgeries performed in-office or in-facility based overwhelmingly on the choice and practice pattern of the physician.

The Academy was approached by ASPS and ACS with a proposal to resolve the site of service anomalies by "backing out" inpatient and discharge day visits which seems an appropriate way to recognize the typical patient environment for these procedures.

We respect the term "typical" as used by the RUC as a way to get at the median patient - some cases recognized as easier and some cases as harder. We believe that if the work was valued as the typical or median, then payment should be fair.

RECOMMENDATION

Given the history of discussion for these codes and the fact that a survey among the discussant societies may produce the same site of service variation that cannot be resolved by a change in global period, AAD has reviewed the proposed adjustments shown on the table below for codes 14000, 14001, 14020, 14021, 14041, and 14061 and concurs with these recommendations.

Codes 14040 and 14060 were reviewed during the 3rd 5YR and do not include facility data.

With respect to code 14300 *Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area*, we defer to having this discussed at CPT for a possible solution to the all inclusive nature of this code concerning anatomical site and the open ended size description. We believe that the physician work for procedures greater than 30 sq cm may be very different for different anatomical sites (eg, face versus trunk).

If you have questions regarding this submission, please contact Norma L. Border at 847 240 1814 or nborder@aad.org.

Sincerely,

A handwritten signature in black ink that reads "Brett Coldiron MD". The signature is written in a cursive, flowing style.

Brett Coldiron, M.D., FAAD, FACP
AAD Advisor to the
AMA/Specialty Society RVS Update Committee

Cc: Daniel M. Siegel, MD – AAD Representative to the AMA RUC
Bruce Deitchman, MD – AAD RUC Alternate

September 5, 2008

To: Barbara Levy, MD
Chair, RUC 5YR ID Workgroup

From: Scott Oates, MD, RUC Advisor, ASPS
Jane Dillon, MD, FACS, RUC Advisor, AAO-HNS
Christopher Senkowski, MD, FACS, RUC Advisor, ACS

Subject: Adjacent Tissue Transfer Codes

As background, the adjacent tissue transfer family of codes were identified by the RUC 5YR ID Workgroup as having a site of service anomaly. In September 2007, the RUC approved removing the facility data from these codes as interim, and recommended that the codes have a 000-day global to account for the wide variation in work by different providers and different sites of service. The RUC recommended these codes be surveyed with a 000-day global period. Subsequent to that recommendation, CMS was contacted and declined to change the global period. CMS suggested conducting a survey with the 90-day global period to prove that there was wide variation. Attempts between surgery and dermatology to develop and conduct such a survey failed.

We note that Medicare data clearly show that surgeons typically perform these services in a facility setting (including inpatient work) and dermatologists typically perform these procedures in an office. ASPS asked to bring all involved specialties and CMS into a discussion at the April 2008 RUC meeting. A facilitation committee listened to all sides, including observations of CMDs who were present. We believe that everyone (RUC members, CMS representative, CMDs, and Advisors) at that meeting were in agreement that the global period should be changed to 000-day. After the RUC approved the recommendation, a request was sent to CMS, but again the Agency declined to change the global period for these codes.

The American Society of Plastic Surgeons, the Academy of Otolaryngology-Head and Neck Surgeons, and the American College of Surgeons believe that a survey of these codes would produce the same variation in site of service that is seen in the Medicare database. Although the typical site of service for most of these codes is about 60% office, we believe that is the lowest level of service. The 40% of patients that require more than local sedation and/or patients that require hospitalization will always be more total work. By changing the database and the work RVU to reflect office-based work only, 40% of these procedures will never be reimbursed for the total work required in a facility where patients are under moderate sedation or general anesthesia. The term "typical" for the RUC originated as a way to get at the median patient - some cases were easier and some cases were harder. If the work was valued as the typical or median, then payment would be fair. The 5YR ID Workgroup use of the term typical for site of service is not the same as the RUC's historical use of "typical patient."

Given the history of discussion for these codes and the fact that a survey will produce the same site of service variation that cannot be resolved by a change in global period, we reluctantly offer the adjustments shown on the table below for codes 14000, 14001, 14020, 14021, 14041, and 14061. Codes 14040 and 14060 were reviewed during the 3rd 5YR and do not include facility data. With respect to code 14300 *Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area*, we defer to having this discussed at CPT for a possible solution to the all inclusive nature of this code concerning anatomical site and the open ended size description. We believe that the physician work for procedures greater than 30 sq cm may be very different for different anatomical sites (eg, face versus trunk).

CPT	DESCRIPTOR	2008 RVW	PROPOSED ADJUSTMENTS	NEW RVW
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	6.83	Remove 0.5 x 99238. Subtract 0.64 RVUs.	6.19
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm	9.60	Typically facility, but not inpatient. Remove 0.5 x 99231 and 0.5 x 99238. Subtract 1.12 RVUs.	8.58
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less	7.66	Remove 0.5 x 99238. Subtract 0.64 RVUs.	7.02
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	11.18	Remove 0.5 x 99231 and 0.5 x 99238. Subtract 1.12 RVUs.	9.52
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect	12.67	Remove 1 x 99231 and 1 x 99238. Subtract 2.04 RVUs.	10.63
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm	13.67	Remove 1.5 x 99231 and 1 x 99238. Subtract 2.42 RVUs.	11.25

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008 – Site of Service Anomaly

Skin Pedicle Flaps

CPT code 15574, *Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet*, and CPT code 15576, *Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral*, were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include in-patient hospital visits within their global periods, but are performed less than 50% of the time in the in-patient setting, according to recent Medicare utilization data. The Workgroup divided its analysis into two groups, services that contained only in-patient discharge day management service (a full 99238) and services that include additional in-patient visits. 15576 was identified in the former and was not recommended to be surveyed because of that anomaly. Rather, the RUC recommended and CMS agreed to reduce the full 99238 discharge day management service to one-half, with no impact on the work RVU. 15574 was recommended to be surveyed because the inclusion of the additional in-patient hospital visits within its global period. At that time, the RUC also recommended that the global period of 15574 and the other services within its family be changed from 090 to 000 days. CMS did not agree with the RUC regarding the change in global period, but did agree with the RUC's recommendation that 15570, *Formation of direct or tubed pedicle, with or without transfer; trunk*, 15572, *Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs*, 15574, and 15576 be re-surveyed.

At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies, which the RUC continues to use. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

15570

The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 15570. However, the specialty presented data from a survey of 25 plastic and general surgeons and consensus recommendations from an expert panel of plastic and general surgeons and otolaryngologists to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The rise of 23-hour observation stays in the out-patient hospital and ambulatory surgical

setting as well as the fact that roughly one-third of the procedures are performed in the in-patient setting account for this overnight stay. The specialty society survey and panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Additionally, the specialty recommended 10 minutes of positioning time to account for positioning the patient in the supine and slightly lateral position. The resulting pre-service time is 73 minutes. Further, the survey and panel recommended an intra-service time of 100 minutes and immediate post-service time of 30 minutes. The intra-service reflects a five minute reduction in time as compared to the current time and the immediate post-service is unchanged. Lastly, the specialty presented data that one 99231 hospital visit, one 99238 discharge day management service, and one 99212, two 99213 and one 99214 office visits are included. This differs from the current data which indicate that two 99231 visits and no 99214 visits are provided. The RUC agreed with the specialty society. The RUC also noted that the survey respondents indicated a median work RVU of 13.00 work RVUs.

The RUC recommends the new physician times as well as hospital and office visits, but recommends maintaining the current work RVU of 10.00 for 15570.

15572

The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 15572. However, the specialty presented data from a survey of 25 plastic and general surgeons and consensus recommendations from an expert panel of plastic and general surgeons and otolaryngologists to validate physician time and post-operative visits. The specialty society survey and panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Additionally, the specialty recommended 10 minutes of positioning time to account for positioning the patient in the supine and slightly lateral position. The resulting pre-service time is 73 minutes. Further, the survey and panel recommended an intra-service time of 90 minutes and immediate post-service time of 30 minutes, which is the same as the current intra-service and immediate post-service times. Lastly, the specialty presented data that one-half 99238 discharge day management service, and one 99212 and three 99213 office visits are performed. This differs from the current data which indicate that a full 99238, one 99231 visits and two 99213 visits are provided. The RUC agreed with the specialty society. The RUC also noted that the survey respondents indicated a median work RVU of 12.00 work RVUs.

The RUC recommends the new physician times and office visits, but recommends maintaining the current work RVU of 9.94 for 15572.

15574

The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 15574. However, the specialty presented data from a survey of 25 plastic and general

surgeons and consensus recommendations from an expert panel of plastic and general surgeons and otolaryngologists to validate physician time and post-operative visits. The specialty society survey and panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Additionally, the specialty recommended 7 minutes of positioning time to account for positioning the patient in the various positions pending the area of the body the procedure is performed on. The resulting pre-service time is 70 minutes. Further, the survey and panel recommended an intra-service time of 110 minutes and immediate post-service time of 30 minutes, which reflect a 10 minute reduction in intra-service time. Lastly, the specialty recommended adjusting post-operative office visits to include one 99212 and three 99213 visits as well as one-half 99238 discharge day management service. The RUC agreed with the specialty society. The RUC also noted that the survey respondents indicated a median work RVU of 14.00 work RVUs.

The RUC recommends the new physician times and office visits, but recommends maintaining the current work RVU of 10.52 for 15574.

15576

The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 15576. However, the specialty presented data from a survey of 25 plastic and general surgeons and consensus recommendations from an expert panel of plastic and general surgeons and otolaryngologists to validate physician time and post-operative visits. The specialty society survey and panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Additionally, the specialty recommended 7 minutes of positioning time to account for positioning the patient in the various positions pending the area of the body the procedure is performed on. The resulting pre-service time is 70 minutes. Further, the survey and panel recommended an intra-service time of 90 minutes and immediate post-service time of 30 minutes, which is the same as the current intra-service and immediate post-service times. Lastly, the specialty recommended adjusting post-operative office visits to include one 99212 and two 99213 visits as well as one-half 99238 discharge day management service, which is identical to what is currently included. The RUC agreed with the specialty society. The RUC also noted that the survey respondents indicated a median work RVU of 13.50 work RVUs.

The RUC recommends the new physician times and office visits, but recommends maintaining the current work RVU of 9.24 for 15576.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
15570	Formation of direct or tubed pedicle, with or without transfer; trunk	090	10.00 (No Change)
15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs	090	9.94 (No Change)
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet	090	10.52 (No Change)
15576	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral	090	9.24 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 15570 Tracking Number n/a

Specialty Society Recommended RVU: **10.00**

Global Period: 090

RUC Recommended RVU: **10.00**

CPT Descriptor: Formation of direct or tubed pedicle, with or without transfer; trunk

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old male requires reconstruction of a large thoraco-abdominal defect after tumor resection. A thoraco-epigastric tubed pedicle flap is raised and transferred to reconstruct the defect and primary closure of the donor site is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of pre-operative meds. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Assist with patient positioning in a supine and slightly lateral position, with the shoulder bumped up and stabilized, and extremities positioned and padded and application of thermal regulation drapes. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: After anesthesia is achieved, the flap design is evaluated, and transferred to the abdominal skin. The skin is incised and the subcutaneous tissue is divided using electrocautery. The dissection is carried down to the superficial fascia on both sides of the proposed tube. The tube pedicle is formed by undermining the subcutaneous tissues off the fascia using blunt dissection and electrocautery. The flap is then transferred to the defect and checked for undue tension along the peripheral edges. Additional release and undermining is performed if the flap is too tight on initial transfer. Once the flap reaches the defect without tension, it is inset with a combination of subcutaneous, deep dermal and skin sutures. The flap is checked often during inset for vascular compromise. The donor defect created is closed primarily by undermining the adjacent abdominal wall tissue at the subcutaneous level using blunt dissection and electrocautery. Once adequate advancement and hemostasis is achieved, layered closure of the donor defect is performed with separate subcutaneous and skin sutures. One or two closed suction drains are placed beneath the flap and/or the donor site depending on the size of the defect.

Description of Post-Service Work: Apply dressings. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later Same Day on Surgical Floor: review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an exam including dressing change and

assessment of flap viability. Consider relevant data, options, and risks and revise treatment plan as necessary. Next day: Review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess flap, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write prescriptions. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. At office visits, examine and talk with patient. Remove dressings, assess wounds, and remove sutures and drains when appropriate. Assess flap viability and wound healing. Redress wounds. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2008				
Presenter(s):		Scott Oates, MD; Christopher Senkowski, MD FACS				
Specialty(s):		plastic surgery; general surgery				
CPT Code:		15570				
Sample Size: 80		Resp N: 25		Response: 31.2 %		
Sample Type: Random						
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		1.00	1.00	2.00	2.00	8.00
Survey RVW:		9.80	11.00	13.00	16.00	30.00
Pre-Service Evaluation Time:				45.00		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				15.00		
Intra-Service Time:		60.00	90.00	100.00	120.00	300.00
Immediate Post Service-Time:		30.00				
Post Operative Visits		Total Min**		CPT Code and Number of Visits		
Critical Care time/visit(s):		0.00		99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):		20.00		99231x 1.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:		38.00		99238x 1.00 99239x 0.00		
Office time/visit(s):		102.00		99211x 0.00 12x 1.00 13x 2.00 14x 1.00 15x 0.00		
Prolonged Services:		0.00		99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	15570	Recommended Physician Work RVU: 10.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		13.00	3.00	10.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		100.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>20.00</u>	99231x 1.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>102.00</u>	99211x 0.00 12x 1.00 13x 2.00 14x 1.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49560	090	11.84	RUC Time

CPT Descriptor Repair initial incisional or ventral hernia; reducible**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 6 % of respondents: 24.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 15570	<u>Key Reference CPT Code:</u> 49560	<u>Source of Time</u> RUC Time
Median Pre-Service Time	73.00	45.00	
Median Intra-Service Time	100.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	102.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	363.00	223.00	
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	2.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	2.40
Urgency of medical decision making	2.67	2.20

Technical Skill/Physical Effort (Mean)

Technical skill required	2.83	2.83
Physical effort required	2.67	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.17
Outcome depends on the skill and judgment of physician	2.83	3.00
Estimated risk of malpractice suit with poor outcome	3.00	2.83

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.50	2.50
Intra-Service intensity/complexity	2.50	2.33
Post-Service intensity/complexity	2.33	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.*

Background for 15570, 15572, 15574, and 15576

Code 15574 was identified by the RUC 5YR ID Workgroup site of service anomaly screen. ASPS commented that Medicare claims are not representative of this procedure for which the typical patient has experienced trauma, industrial injuries, or burns. All of these cases are very likely to require an inpatient stay, and if serial debridement is required, the patient is already hospitalized. Additionally, ASPS noted that 15574 descriptor includes multiple regions of the

body, thus the individual circumstances can vary with respect to site of service. In September 2007, the 5YR ID Workgroup discussed the patients requiring 15574 and recommended that 15574 have a 000-day global period, so that post-op work could be appropriately reported. ASPS noted that if the global period changed for 15574, then the other three codes in the family should also have a global period change. ASPS agreed to survey all four codes if the global period was changed to 000-day, even though only code 15574 was identified by the 5YR ID Workgroup screen. Subsequent to the RUC recommendation, CMS was contacted and declined to change the global period. However, the RUC and CMS required all four codes in the family be surveyed.

Recommendation for 15570

A survey of plastic surgeons and general surgeons was conducted for 15570. It is acknowledged that the number of respondents is less than 30, but the RUC should be aware that this family of codes is rarely used and finding ASPS and ACS members who performed this procedure was difficult. However, please note, that all of the respondents have recent experience with this low volume code.

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from the standard 40 minutes
- Positioning: Add 10 minutes (total 13 min) to account for positioning of the patient in a supine and slightly lateral position, with the shoulder bumped up and stabilized, and extremities positioned and padded.
- Scrub/Dress/Wait: No change from standard 20 minutes.

A consensus committee of plastic surgeons, general surgeons and otolaryngologists reviewed the survey data and agree with the median response that this patient would be kept overnight in the hospital, with a visit later on the day of the procedure to check the drain and assess the wound and vitality of the flap. We do not have compelling evidence to recommend an increase for this code. We recommend the current RVW of 10.00. The resulting IWPUR is 0.022.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 15570

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 plastic surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. national frequency unknown

Specialty	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? 439

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare data

Specialty plastic surgery	Frequency 228	Percentage 51.93 %
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Specialty general surgery	Frequency 79	Percentage 17.99 %
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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. 15570 - use current 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: 15572 Tracking Number n/a

Specialty Society Recommended RVU: **9.94**

Global Period: 090

RUC Recommended RVU: **9.94**

CPT Descriptor: Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 23-year-old female requires reconstruction of a full thickness defect that exposes the Achilles tendon. A tubed pedicle flap is raised and transferred to reconstruct the defect and primary closure of the donor site is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 92 %

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0 %

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0 %

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of pre-operative meds. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Assist with patient positioning in a prone or frog-leg position and application of thermal regulation drapes. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on the proximal thigh. Prep and drape leg. Elevate and exsanguinate leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: After anesthesia is achieved, the defect is measured and the measurements transferred to the adjacent leg skin where a tubed pedicle flap is designed. The skin and subcutaneous tissue are incised down to the muscle fascia on both sides of the proposed tube using electrocautery. The skin and subcutaneous tissue is elevated using blunt dissection and electrocautery throughout the length of the flap. The tubed pedicle is formed and transferred to the defect. The flap is checked for tension along the peripheral edges. Additional release and undermining is performed if the flap is too tight on initial transfer. Once the flap reaches the defect without tension, it is inset with a combination of subcutaneous, deep dermal and skin sutures. The flap is checked often during inset for vascular compromise. The donor defect created is closed primarily by undermining the adjacent leg skin at the subcutaneous level using blunt dissection and electrocautery. The tourniquet is let down and hemostasis is achieved. A layered closure of the donor defect is performed with separate subcutaneous and skin sutures. A closed suction drain is placed beneath the flap and donor site closure.

Description of Post-Service Work: A bulky dressing and a plaster or fiberglass splint is placed around the ankle to prevent traction on the flap and donor site with motion. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient Dictate operative report. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and appropriate use of crutches or walker Reconcile medications with attention to pre-admission therapy and

outpatient formulary and write prescriptions. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be seen the next day to assess viability of the flap. Examine and talk with patient. Remove dressings, assess wounds, and remove sutures and drains when appropriate. Assess flap viability and wound healing. Redress wounds. Order medications as necessary. Order physical therapy as needed and assess progress. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2008			
Presenter(s):	Scott Oates, MD; Christopher Senkowski, MD FACS				
Specialty(s):	plastic surgery; general surgery				
CPT Code:	15572				
Sample Size:	80	Resp N:	25	Response: 31.2 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	1.00	1.00	2.00	5.00
Survey RVW:	10.00	11.00	12.00	15.00	25.00
Pre-Service Evaluation Time:			45.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	30.00	90.00	90.00	120.00	240.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.50 99239x 0.00			
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	15572	Recommended Physician Work RVU: 9.94		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		13.00	3.00	10.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		90.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.5 99239x 0.0		
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15738	090	18.92	RUC Time

CPT Descriptor Muscle, myocutaneous, or fasciocutaneous flap; lower 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 7 % of respondents: 28.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 15572	<u>Key Reference CPT Code:</u> 15738	<u>Source of Time</u> RUC Time
Median Pre-Service Time	73.00	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	0.00	
Median Other Hospital Visit Time	0.0	120.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	85.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	297.00	460.00	
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	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.67
Urgency of medical decision making	4.17	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	4.00
Physical effort required	3.67	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.33	4.00
Outcome depends on the skill and judgment of physician	4.17	4.17
Estimated risk of malpractice suit with poor outcome	3.67	3.67

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.50	3.50
Intra-Service intensity/complexity	3.83	3.67
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.*

Background for 15570, 15572, 15574, and 15576

Code 15574 was identified by the RUC 5YR ID Workgroup site of service anomaly screen. ASPS commented that Medicare claims are not representative of this procedure for which the typical patient has experienced trauma, industrial injuries, or burns. All of these cases are very likely to require an inpatient stay, and if serial debridement is required, the patient is already hospitalized. Additionally, ASPS noted that 15574 descriptor includes multiple regions of the

body, thus the individual circumstances can vary with respect to site of service. In September 2007, the 5YR ID Workgroup discussed the patients requiring 15574 and recommended that 15574 have a 000-day global period, so that post-op work could be appropriately reported. ASPS noted that if the global period changed for 15574, then the other three codes in the family should also have a global period change. ASPS agreed to survey all four codes if the global period was changed to 000-day, even though only code 15574 was identified by the 5YR ID Workgroup screen. Subsequent to the RUC recommendation, CMS was contacted and declined to change the global period. However, the RUC and CMS required all four codes in the family be surveyed.

Recommendation for 15572

It is acknowledged that the number of respondents is less than 30, but the RUC should be aware that this family of codes is rarely used and finding ASPS and ACS members who performed this procedure was difficult. However, please note, that all of the respondents have recent experience with this low volume code.

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from the standard 40 minutes
- Positioning: Many different positions are possible for 15572. For legs, the patient may be placed prone, lateral or supine/frog-leg. For arms, the patient may be supine with a hand table, or prone or lateral, depending on the location of the flap. For the scalp, the patient may be prone or lateral and the OR table would need to be turned. For the arms and legs, a tourniquet would be used. For all cases, padding and local anesthesia would be utilized. Given the variability in positioning, we are recommending an additional 10 minutes for a total of 13 minutes, recognizing that this does not capture the time for prone, which may be frequently required.
- Scrub/Dress/Wait: No change from standard 20 minutes.

A consensus committee of plastic surgeons, general surgeons and otolaryngologists reviewed the survey data and agree with the median response that this patient would be discharged on the same day as the procedure. We do not have compelling evidence to recommend an increase for this code. We recommend the current RVW of 9.94. The resulting IWPUP is 0.045.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period; work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 15572

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 plastic surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. national frequency unknown

Specialty	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? 586

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare data

Specialty plastic surgery	Frequency 340	Percentage 58.02 %
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Specialty general surgery	Frequency 82	Percentage 13.99 %
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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. 15572 - use current 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: 15574 Tracking Number n/a

Specialty Society Recommended RVU: **10.52**

Global Period: 090

RUC Recommended RVU: **10.52**

CPT Descriptor: Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old male requires reconstruction of a lateral brow defect after resection of a squamous cell carcinoma of the lower forehead. A tubed pedicle flap of hair bearing skin is raised and transferred to reconstruct the defect and primary closure of the donor site is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of pre-operative meds. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Assist with supine positioning, stabilizing the head. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. After induction of anesthesia, the OR table may need to be turned to free up the head / upper body area for the procedure, with anesthesia to the side or foot. This requires rearrangement of anesthesia lines.

Description of Intra-Service Work: After anesthesia is achieved, the dimensions of the defect are measured and transferred to the hair bearing skin of the adjacent scalp. The tube is designed to include hair bearing skin only at the end of the tubed pedicle to match the brow defect. The skin and subcutaneous tissue is incised down to the muscle fascia on both sides of the proposed tube using electrocautery. The skin and subcutaneous tissue is elevated using blunt dissection and electrocautery throughout the length of the flap. Care must be taken to avoid thermal injury to the hair follicles in the hair bearing skin. The tubed pedicle is formed and transferred to the defect. The flap is checked for tension along the peripheral edges. Additional release and undermining is performed if the flap is too tight on initial transfer. Once the flap reaches the defect without tension, it is inset with a combination of subcutaneous, deep dermal and skin sutures, taking special care to orient the hair follicles in the proper direction. The flap is checked often during inset for vascular compromise. The donor defect created is closed primarily by undermining the adjacent forehead and scalp skin at the level of the galea using blunt dissection and electrocautery. Once adequate advancement and hemostasis is achieved, layered closure of the donor defect is performed with separate subcutaneous and skin sutures. Antibiotic ointment is applied to the suture lines.

Description of Post-Service Work: Apply dressing held in place with a head wrap bandage. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient

Dictate operative report. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy and outpatient formulary and write prescriptions. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be seen the next day to assess viability of the flap. Examine and talk with patient. Remove dressings, assess wounds, and remove sutures and drains when appropriate. Assess flap viability and wound healing. Redress wounds. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008				
Presenter(s):	Scott Oates, MD; Jane Dillon, MD FACS				
Specialty(s):	plastic surgery; otolaryngology				
CPT Code:	15574				
Sample Size:	80	Resp N:	30	Response: 37.5 %	
Sample Type:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	2.00	4.00	15.00
Survey RVW:	7.00	12.00	14.00	16.00	30.00
Pre-Service Evaluation Time:			45.00		
Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	40.00	90.00	110.00	120.00	180.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.50 99239x 0.00			
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	15574	Recommended Physician Work RVU: 10.52		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		10.00	3.00	7.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		110.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.5 99239x 0.0		
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15731	090	14.12	RUC Time

CPT Descriptor Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 16 % of respondents: 53.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 15574	<u>Key Reference CPT Code:</u> 15731	<u>Source of Time</u> RUC Time
Median Pre-Service Time	70.00	75.00	
Median Intra-Service Time	110.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	85.0	125.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	314.00	369.00	
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	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.53
Urgency of medical decision making	4.00	3.93

Technical Skill/Physical Effort (Mean)

Technical skill required	4.27	4.20
Physical effort required	3.20	3.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.93	3.87
Outcome depends on the skill and judgment of physician	4.40	4.40
Estimated risk of malpractice suit with poor outcome	3.93	3.87

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	3.94
Intra-Service intensity/complexity	4.07	3.94
Post-Service intensity/complexity	3.60	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.*

Background for 15570, 15572, 15574, and 15576

Code 15574 was identified by the RUC 5YR ID Workgroup site of service anomaly screen. ASPS commented that Medicare claims are not representative of this procedure for which the typical patient has experienced trauma, industrial injuries, or burns. All of these cases are very likely to require an inpatient stay, and if serial debridement is required, the patient is already hospitalized. Additionally, ASPS noted that 15574 descriptor includes multiple regions of the

body, thus the individual circumstances can vary with respect to site of service. In September 2007, the 5YR ID Workgroup discussed the patients requiring 15574 and recommended that 15574 have a 000-day global period, so that post-op work could be appropriately reported. ASPS noted that if the global period changed for 15574, then the other three codes in the family should also have a global period change. ASPS agreed to survey all four codes if the global period was changed to 000-day, even though only code 15574 was identified by the 5YR ID Workgroup screen. Subsequent to the RUC recommendation, CMS was contacted and declined to change the global period. However, the RUC and CMS required all four codes in the family be surveyed.

Recommendation for 15574

A survey of plastic surgeons and otolaryngologists was conducted for 15574.

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from the standard 40 minutes
- Positioning: Many different positions are possible for 15574. For the feet, the patient may be placed prone, lateral or supine/frog-leg. For the hands, the patient will be supine with a hand table. For the face, neck, etc, the patient may be supine or lateral and the OR table may need to be turned. For the hands and feet, a tourniquet would be used. For all cases, padding and local anesthesia would be utilized. Given the variability in positioning, we are recommending an additional 7 minutes for a total of 10 minutes.
- Scrub/Dress/Wait: No change from standard 20 minutes.

A consensus committee of plastic surgeons, general surgeons and otolaryngologists reviewed the survey data and agree with the median response that this patient would be discharged on the same day as the procedure. We do not have compelling evidence to recommend an increase for this code. We recommend the current RVW of 10.52. The resulting IWPUP is 0.043.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 15574

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 plastic surgery How often? Commonly

Specialty otolaryngology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. national frequency unknown

Specialty	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?
2,244 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. 2006 Medicare data

Specialty plastic surgery	Frequency 1009	Percentage 44.96 %
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Specialty otolaryngology	Frequency 426	Percentage 18.98 %
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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. 15574 - use current 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: 15576 Tracking Number n/a

Specialty Society Recommended RVU: **9.24**

Global Period: 090

RUC Recommended RVU: **9.24**

CPT Descriptor: Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male requires reconstruction of the helical rim of the left ear after a traumatic injury. A post-auricular tubed pedicle flap is raised and transferred to reconstruct the defect and primary closure of the donor site is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of pre-operative meds. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Assist with patient positioning in a supine and slightly lateral position, with the shoulder bumped up and stabilized, and extremities positioned and padded and application of thermal regulation drapes. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. After induction of anesthesia, the OR table may need to be turned to free up the head / upper body area for the procedure, with anesthesia to the side or foot. This requires rearrangement of anesthesia lines.

Description of Intra-Service Work: After anesthesia is achieved, the wound is again débrided and its suitability for coverage confirmed. The ear cartilage is trimmed back to match the skin edge, and the skin edges are undermined in preparation for inset of the tubed pedicle. The dimensions of the defect are measured and transferred to the post-auricular skin. The tube is designed and the skin and subcutaneous tissue is incised down to the mastoid fascia on both sides of the proposed tube using electrocautery and scissors. The skin and subcutaneous tissue is elevated using blunt dissection and electrocautery throughout the length of the flap. The tubed pedicle is formed and transferred to the defect. The flap is checked for tension along the peripheral edges and excessive traction on the auricle. Additional release and undermining is performed if the flap is too tight on initial transfer. Once the flap reaches the defect without tension, it is inset with skin sutures, taking special care to assure complete coverage of all exposed cartilage surfaces. The flap is checked often during inset for vascular compromise. The donor defect created is closed primarily by undermining the adjacent skin at the level of the mastoid fascia using blunt dissection and electrocautery. Once adequate advancement and hemostasis is achieved, layered closure of the donor defect is performed with separate subcutaneous and skin sutures. Antibiotic ointment is applied to the suture lines.

Description of Post-Service Work: Apply dressing held in place with a head wrap bandage. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication

orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy and outpatient formulary and write prescriptions. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be seen the next day to assess viability of the flap. Examine and talk with patient. Remove dressings, assess wounds, and remove sutures and drains when appropriate. Assess flap viability and wound healing. Redress wounds. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2008				
Presenter(s):	Scott Oates, MD; Jane Dillon, MD FACS					
Specialty(s):	plastic surgery; otolaryngology					
CPT Code:	15576					
Sample Size:	80	Resp N:	30	Response: 37.5 %		
Sample Type:	Random					
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	1.00	2.00	3.00	18.00
Survey RVW:		9.00	11.00	13.50	18.00	35.00
Pre-Service Evaluation Time:				45.00		
Pre-Service Positioning Time:				10.00		
Pre-Service Scrub, Dress, Wait Time:				15.00		
Intra-Service Time:		30.00	60.00	90.00	120.00	180.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00				
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00				
Discharge Day Mgmt:	19.00	99238x 0.50 99239x 0.00				
Office time/visit(s):	62.00	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00				
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	15576	Recommended Physician Work RVU: 9.24		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		10.00	3.00	7.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		90.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.5 99239x 0.0		
Office time/visit(s):	<u>62.00</u>	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15731	090	14.12	RUC Time

CPT Descriptor Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 60.0 %

TIME ESTIMATES (Median)

	CPT Code: 15576	Key Reference CPT Code: 15731	Source of Time RUC Time
Median Pre-Service Time	70.00	75.00	
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	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	62.0	125.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	271.00	369.00	
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	3.76	3.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.53
Urgency of medical decision making	3.71	3.71

Technical Skill/Physical Effort (Mean)

Technical skill required	4.12	4.06
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.88	3.76
Outcome depends on the skill and judgment of physician	4.35	4.24
Estimated risk of malpractice suit with poor outcome	3.76	3.82

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.83	3.89
Intra-Service intensity/complexity	4.00	3.94
Post-Service intensity/complexity	3.61	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.*

Background for 15570, 15572, 15574, and 15576

Code 15574 was identified by the RUC 5YR ID Workgroup site of service anomaly screen. ASPS commented that Medicare claims are not representative of this procedure for which the typical patient has experienced trauma, industrial injuries, or burns. All of these cases are very likely to require an inpatient stay, and if serial debridement is required, the patient is already hospitalized. Additionally, ASPS noted that 15574 descriptor includes multiple regions of the

body, thus the individual circumstances can vary with respect to site of service. In September 2007, the 5YR ID Workgroup discussed the patients requiring 15574 and recommended that 15574 have a 000-day global period, so that post-op work could be appropriately reported. ASPS noted that if the global period changed for 15574, then the other three codes in the family should also have a global period change. ASPS agreed to survey all four codes if the global period was changed to 000-day, even though only code 15574 was identified by the 5YR ID Workgroup screen. Subsequent to the RUC recommendation, CMS was contacted and declined to change the global period. However, the RUC and CMS required all four codes in the family be surveyed.

Recommendation for 15576

A survey of plastic surgeons and otolaryngologists was conducted for 15576.

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from the standard 40 minutes
- Positioning: Add 7 minutes (total 10 min) to account for positioning of the patient in a supine and slightly lateral position, with the shoulder bumped up and head stabilized. Additionally, the OR table will need to be turned to free up the head / upper body area for the procedure, with anesthesia to the side or foot. This requires rearrangement of anesthesia lines.
- Scrub/Dress/Wait: No change from standard 20 minutes.

A consensus committee of plastic surgeons, general surgeons and otolaryngologists reviewed the survey data and agree with the median response that this patient would be discharged on the same day as the procedure. We do not have compelling evidence to recommend an increase for this code. We recommend the current RVW of 9.24. The resulting IWPOT is 0.048.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 15576

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 plastic surgery How often? Commonly

Specialty otolaryngology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. national frequency unknown

Specialty	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?

3,823 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. 2006 Medicare data

Specialty plastic surgery	Frequency 1414	Percentage 36.98 %
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Specialty otolaryngology	Frequency 688	Percentage 17.99 %
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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. 15576 - use current code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008 – High IWPUT

Destruction of Skin Lesions

CPT codes 17106, *Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm*, 17107, *Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm*, and 17108, *Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm*, were requested to be reviewed by CMS following identification by the RUC as potentially misvalued. These services were identified by the RUC's Five-Year Review Identification Workgroup through the High intra-service work per unit of time (IWPUT) screen. During the Workgroup's review, the Workgroup agreed that the current work relative values result in an excessively high IWPUT and the amount of physician time was either too low or the work RVU was too high. In addition, the services may have changed since the first Five-Year Review, when the RUC reviewed them. Therefore, the Workgroup agreed that resurveying these services would be appropriate. The RUC confirmed the recommendation and CMS agreed, requesting that the services be surveyed for review at the October 2008 RUC meeting.

17106

The RUC reviewed the survey data from 28 dermatologists presented by the specialty society and received additional clarification from the specialty society regarding this service. The RUC did not agree that the survey or the specialty society presentation provided an accurate account of the intensity involved in performing the service on the typical patient. The RUC did not agree with the specialty that the pre-service time warranted additional time beyond that of the 7 minutes for the standard non-facility procedure and recommends a pre-service time of 7 minutes. The RUC also discussed the post-operative visits in the society's summary of recommendations and agreed that one 99212 and one 99213 were appropriate. Lastly, the RUC agreed with the survey median intra-service time of 30 minutes, rather than the specialty society-recommended 20 minutes. The RUC considered imputing physician work through an IWPUT calculation using the intensity of other services commonly performed by dermatologists. However, the specialty clarified that the procedure is typically not performed in the non-Medicare population and that derivation of a value through means of IWPUT calculation of other dermatology codes would be inappropriate. It was noted that this service requires the highest level of intensity for a dermatologist. The RUC then looked to other services to develop a work value recommendation through magnitude estimation with appropriate reference codes.

The RUC identified 21031, *Excision of torus mandibularis* (wRVU = 3.26, intra-time = 30 minutes) as a primary reference code. The RUC noted that 21031 had one 99211 and one 99212 office visits. To develop an appropriate reference, the RUC added the value of

the difference between the 99211 and 99213 office visits which is 0.75 work RVUs. ($0.92 - 0.17 = 0.75$) Lastly, the RUC noted that 21031 requires significantly more pre-service time, 25 minutes rather than 7 minutes. By reducing the value by that difference of 18 minutes, 0.4032 RVUs are reduced. $18 \text{ minutes} \times 0.0224 = 0.4032 \text{ RVUs}$. The resulting value is 3.61. $3.26 + 0.75 - 0.4032 = 3.61$ work RVUs.

The value reflects an IWPUT of 0.062, which the RUC agreed was appropriate. The RUC also discussed several other reference codes including 25001, *Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)* (wRVU = 3.68, intra-time = 30 minutes) and 11624, *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm*, (wRVU = 3.57, intra-time = 40 minutes). **The RUC recommends a work RVU of 3.61, pre-service time of 7 minutes, intra-service time of 30 minutes, one 99212 visit and one 99213 visit for code 17106.**

17107

The RUC applied a building block approach to recommend values for the remainder of the codes in this family. For 17107, the RUC discussed the post-service office visits and agreed with the survey respondents concluding that the service requires two 99212 and one 99213 office visits. Additionally, the RUC agreed with the survey median intra-service time of 40 minutes. The RUC did not agree with the specialty society recommendation that the pre-service time warranted additional time beyond that of the 7 minutes for the standard non-facility procedure and recommends a pre-service time of 7 minutes. By applying the same IWPUT derived above, the RUC arrived at a work RVU recommendation of 4.68. ($40 \text{ minutes of intra-service time} \times 0.062 = 2.48$. $7 \text{ minutes pre} + 10 \text{ minutes immediate post} \times 0.0224 = 0.38$. $99212 \times 2 = 0.90$. $99213 \times 1 = 0.92$. $2.48 + 0.38 + 0.90 + 0.92 = 4.68$) In support of this recommendation, the RUC also discussed several reference services, including 33282, *Implantation of patient-activated cardiac event recorder* (wRVU = 4.70, intra-time = 40 min) and 46255, *Hemorrhoidectomy, internal and external, simple*; (wRVU = 4.88, intra-time = 45 minutes). **The RUC recommends a work RVU of 4.68 and pre-service time of 7 minutes, intra-service time of 40 minutes, two 99212 visits, and one 99213 visit for code 17107.**

17108

The RUC reviewed code 17108 and discussed the post-service office visits and agreed with the survey respondents concluding that the service requires three 99212 and one 99213 office visits. Additionally, the RUC agreed with the survey median intra-service time of 60 minutes. The RUC did not agree with the specialty society recommendation that the pre-service time warranted additional time beyond that of the 7 minutes for the standard non-facility procedure and recommends a pre-service time of 7 minutes. The RUC applied the same IWPUT value of 0.062 to 17108, noting that the same IWPUT as the other codes in the family was appropriate because, while the lesions are typically not located near the mouth or eye, they are much larger, deeper, and more vascularized requiring work of similar intensity. The resulting computation was a work RVU of 6.37. ($60 \text{ minutes of intra-service time} \times 0.062 = 3.72$. $7 \text{ minutes pre} + 10 \text{ minutes immediate post} \times 0.0224 = 0.38$. $99212 \times 3 = 1.35$. $99213 \times 1 = 0.92$. $3.72 + 0.38 + 1.35 + 0.92 =$

6.37) The RUC then discussed a reference service in support of this recommendation, including 27347, *Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee* (wRVU = 6.58, intra-time = 60 min). **The RUC recommends a work RVU of 6.37, pre-service time of 7 minutes, intra-service time of 60 minutes, three 99212 visits, and one 99213 visit for code 17108.**

New Technology

Because the procedures reflect a new and novel approach to the use of existing technology, the RUC recommended that 17106, 17107, and 17108 be added to the New Technology List.

Practice Expense

The practice expense direct inputs related to intra-service time and visits will be adjusted to the new recommended times and visits.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	090	3.61
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	090	4.68
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	090	6.37

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 17106 Tracking Number

Specialty Society Recommended RVU: **4.55**

Global Period: 090

RUC Recommended RVU: **3.61**

CPT Descriptor: Destruction of cutaneous vascular proliferative lesions (e.g. laser technique); less than 10 sq cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 3-month-old baby presents with a rapidly growing, 2.0 x 3.0 cm, bright red plaque on the left lower eyelid and cheek. The mixed hemangioma is beginning to obstruct vision.

Percentage of Survey Respondents who found Vignette to be Typical: 65%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 68%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 73%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Pre-service includes: procedural preparation to include preparation of supplies and equipment; such as use of appropriate surgical tray and laser calibration as well as special considerations for the pediatric patient. Two or more laser systems are calibrated prior to the laser procedures in anticipation of initiating the treatment. All nurses, physicians and parents are given wavelength specific protective eyewear for the various laser systems that will be utilized during the procedure. The treatment room is secured for unauthorized entry during the procedure and all reflective windows and glass are protected from reflecting laser beams. All flammable material is removed from the patient and surrounding treatment field. Surrounding hair-bearing areas are protected with a viscous gel to limit burning of the hair. External sources of oxygen or nitrous oxide are also removed from the surgical field.

The procedure and diagnosis are written on the informed consent and this is explained in detail. Informed consent is obtained from the parents as well as a full discussion of the procedure that is to take place including the risks, benefits, and alternatives. Special attention is placed on the emotional issues related to the procedure. The family is advised as well of the postoperative appearance of the laser induced wound.

A papoose and/or surgical restraints are prepared to immobilize the pediatric patient. A nurse is assigned to immobilize the head. In some cases the papoose cannot be placed on the child and under those circumstances additional nursing personnel are required to immobilize the pediatric patient by holding his/her arms and legs.

Tetracaine ophthalmic solution is placed under the eyelids to anesthetize the cornea in preparation for placement of a metal non-reflective ocular shield. The shield is placed directly on the cornea. Topical anesthetic is applied to the area to be treated for one hour prior to the procedure. The child is kept under observation to make sure that the anesthetic is not removed or swallowed inadvertently by the child.

Description of Intra-Service Work: Intra-service includes: removal of topical anesthetic, inspect and palpate lesions for size, location, functional risks, depth. Measure the area to be treated. Administer appropriate supplemental anesthesia and sedation. The KTP laser is calibrated at 532 nm, 3 mm spot size, and 15 joules per centimeter squared. An initial

test pulse is administered to the vascular malformation and the clinical response is observed for several minutes to ensure appropriate settings are being utilized. The conjunctival and lid component of the malformation is then treated with this laser until blanching and reduction in tumor volume has been achieved. A second laser is then required to treat the cutaneous component. At this point the KTP laser is removed from the surgical suite and replaced with the pulsed dye laser. After a warm-up period the pulsed dye laser is then calibrated. The cutaneous component of the malformation is then treated with the pulsed dye laser at a wavelength of 595 nm, 7 mm spot size and an energy of 11 joules per centimeter squared. The pulse duration with this laser is adjusted after several pulses and a determination of the purpuric endpoint. This endpoint is achieved at approximately 4 minutes after the pulse is delivered, multiple pulses are required to treat the entire surface area. Once the area has been treated completely a clinical inspection takes place and if there is an inadequate degree of purpura, retreatment is required. This process is continued until an adequate response to the photothermolysis has been achieved.

Description of Post-Service Work: Post service includes: removal of protective eye shields, cleansing of the treated area, application of cool gel packs, ice packs, antibacterial ointment to any areas where wounding has occurred. Instructions for postoperative care are explained in detail to the parents. Post treatment observation is required to assess for the presence of vesiculation and/or tissue sloughing. Post treatment cooling for approximately one hour is required to minimize thermal injury of normal skin. Completion of medical record including charting, dictation of operative report, and if appropriate, further communication with the family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2008			
Presenter(s):		Jerome Garden, MD, Roy Geronemus, MD, Scott Collins, MD			
Specialty(s):		American Academy of Dermatology			
CPT Code:		17106			
Sample Size:	90	Resp N:	28	Response: 31.1 %	
Sample Type: Panel					
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		35.00	20.00	115.00	125.00
Survey RVW:		4.00	4.55	9.61	10.00
Pre-Service Evaluation Time:				10.00	
Pre-Service Positioning Time:				10.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		15.00	20.00	30.00	45.00
Immediate Post Service-Time:		<u>10.00</u>			
Post Operative Visits		Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):		<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):		<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:		<u>0.00</u>	99238x 0.00 99239x 0.00		
Office time/visit(s):		<u>55.00</u>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00		
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:		17106		Recommended Physician Work RVU: 4.55	
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		7.00	7.00	0.00	
Pre-Service Positioning Time:		0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00	
Intra-Service Time:		30.00			
Immediate Post Service-Time:		<u>10.00</u>			
Post Operative Visits		Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):		<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):		<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:		<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):		<u>39.00</u>	99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00		
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
17286	010	4.45	Harvard Time

CPT Descriptor Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
13121	010	4.36	RUC Time	61,990

CPT Descriptor 1 Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11646	010	6.21	RUC Time	11,014

CPT Descriptor 2 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 19 % of respondents: 67.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 17106	<u>Key Reference CPT Code:</u> 17286	<u>Source of Time</u> Harvard Time
Median Pre-Service Time	7.00	9.00	
Median Intra-Service Time	30.00	48.00	
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	39.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	86.00	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	3.81	3.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.81	2.68
Urgency of medical decision making	4.18	3.87

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	4.13
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Physical effort required	4.44	4.13
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.43	3.25
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgment of physician	4.56	4.06
--------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	4.44	4.06
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INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.12	4.06
Intra-Service intensity/complexity	4.44	4.25
Post-Service intensity/complexity	4.06	4.06

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

In addition to conducting a survey, the American Academy of Dermatology has also used an expert panel of physicians performing this procedure. The surveyees and the expert panel are in agreement that the typical patient is a child and shares with CMS concerns that this code is reported incorrectly for services provided to the Medicare population with limited exceptions and which do not meet the CPT descriptor limitation to "cutaneous proliferative vascular lesions."

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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? Rarely

Specialty Plastic Surgeons How often? Rarely

Specialty Otolaryngology How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 15000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. Extrapolated estimate from frequency performed at multiple hub centers to national population.

Specialty Dermatology Frequency 8700 Percentage 58.00 %

Specialty Plastic Surgeons Frequency 1650 Percentage 11.00 %

Specialty Otolaryngology Frequency 675 Percentage 4.50 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

3,245 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. Medicare utilization

Specialty Dermatology Frequency 1590 Percentage 48.99 %

Specialty Plastic Surgeons Frequency 357 Percentage 11.00 %

Specialty Otolaryngology

Frequency 146

Percentage 4.49 %

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. work RVU = 3.61 Similar code performed by dermatologists = 17284

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: 17107 Tracking Number

Specialty Society Recommended RVU: **9.18**

Global Period: 090

RUC Recommended RVU: **4.68**

CPT Descriptor: Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 3-year-old child presents with a 5.0 x 3.0 cm venous malformation extending from his chin across his lower lip and on to the buccal mucosa. Laser therapy is indicated to prevent further proliferative growth and to minimize spontaneous injury while eating.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 54%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Pre-service includes: procedural preparation to include preparation of supplies and equipment; such as use of appropriate surgical tray and laser calibration as well as special considerations for the pediatric patient. Two or more laser systems are calibrated prior to the laser procedures in anticipation of initiating the treatment. All nurses, physicians and parents are given wavelength specific protective eyewear for the various laser systems that will be utilized during the procedure. The treatment room is secured for unauthorized entry during the procedure and all reflective windows and glass are protected from reflecting laser beams. All flammable material is removed from the patient and surrounding treatment field. Surrounding hair-bearing areas are protected with a viscous gel to limit burning of the hair. External sources of oxygen or nitrous oxide are also removed from the surgical field.

The procedure and diagnosis are written on the informed consent and this is explained in detail. Informed consent is obtained from the parents as well as a full discussion of the procedure that is to take place including the risks, benefits, and alternatives. Special attention is placed on the emotional issues related to the procedure. The family is advised as well of the postoperative appearance of the laser induced wound.

A papoose and/or surgical restraints are prepared to immobilize the pediatric patient. A nurse is assigned to immobilize the head. In some cases the papoose cannot be placed on the child and under those circumstances additional nursing personnel are required to immobilize the pediatric patient by holding his/her arms and legs.

Tetracaine ophthalmic solution is placed under the eyelids to anesthetize the cornea in preparation for placement of a metal non-reflective ocular shield. The shield is placed directly on the cornea. Topical anesthetic is applied to the area to be treated for one hour prior to the procedure. The child is kept under observation to make sure that the anesthetic is not removed or swallowed inadvertently by the child.

Description of Intra-Service Work: Intra-service includes: removal of topical anesthetic, inspect and palpate lesions for size, location, functional risks, depth. Measure the area to be treated. Administer appropriate supplemental anesthesia and sedation. The KTP laser is calibrated at 532 nm, 3 mm spot size, and 15 joules per centimeter squared. An initial

test pulse is administered to the vascular malformation and the clinical response is observed for several minutes to ensure appropriate settings are being utilized. The mucosal component of the malformation is then treated with this laser until blanching and reduction in tumor volume has been achieved. A second laser is then required to treat the cutaneous component. At this point the KTP laser is removed from the surgical suite and replaced with the pulsed dye laser. After a warm-up period the pulsed dye laser is then calibrated. The cutaneous component of the malformation is then treated with the pulsed dye laser at a wavelength of 595 nm, 7 mm spot size and an energy of 11 joules per centimeter squared. The pulse duration with this laser is adjusted after several pulses and a determination of the purpuric endpoint. This endpoint is achieved at approximately 4 minutes after the pulse is delivered, multiple pulses are required to treat the entire surface area. Once the area has been treated completely a clinical inspection takes place and if there is an inadequate degree of purpura, retreatment is required. This process is continued until an adequate response to the photothermolysis has been achieved.

Description of Post-Service Work: Post service includes: removal of protective eye shields, cleansing of the treated area, application of cool gel packs, ice packs, antibacterial ointment to any areas where wounding has occurred. Instructions for postoperative care are explained in detail to the parents. Post treatment observation is required to assess for the presence of vesiculation and/or tissue sloughing. Post treatment cooling for approximately one hour is required to minimize thermal injury of normal skin. Completion of medical record including charting, dictation of operative report, and if appropriate, further communication with the family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008				
Presenter(s):	Jerome Garden, MD, Roy Geronemus, MD, Scott Collins, MD				
Specialty(s):	American Academy of Dermatology				
CPT Code:	17107				
Sample Size:	90	Resp N:	28	Response: 31.1 %	
Sample Type:	Panel				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	8.00	40.00	200.00	275.00	285.00
Survey RVW:	4.00	4.50	9.18	9.75	12.00
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	10.00	10.00	40.00	60.00	75.00
Immediate Post Service-Time:	<u>10.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>55.00</u>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	17107	Recommended Physician Work RVU: 9.18		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		7.00	7.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		40.00		
Immediate Post Service-Time:	<u>10.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>55.00</u>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15260	090	10.04	RUC Time

CPT Descriptor Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
14060	090	9.06	RUC Time	94,445

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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15100	090	9.74	RUC Time	19,526

CPT Descriptor 2 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1 % of body area of infants and children (except 15050)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 17 % of respondents: 60.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> <u>17107</u>	<u>Key Reference CPT Code:</u> <u>15260</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	7.00	47.00	
Median Intra-Service Time	40.00	92.00	
Median Immediate Post-service Time	10.00	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	55.0	115.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	112.00	284.00	
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	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.81	2.56
Urgency of medical decision making	3.63	3.44

Technical Skill/Physical Effort (Mean)

Technical skill required	4.44	4.63
Physical effort required	4.31	4.44

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.38
Outcome depends on the skill and judgment of physician	4.75	4.75
Estimated risk of malpractice suit with poor outcome	4.25	4.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.56	4.37
Intra-Service intensity/complexity	4.50	4.38
Post-Service intensity/complexity	4.19	4.13

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 firmly believe that the physician work time and intensity is justified for this discrete family of codes. There were difficulties in getting greater than 30 surveys based on the sparseness of use of this code in all age groups. In addition, many logical reference service codes were unavailable (as the 14xxx family is also under RUC review at this meeting)

The surveyees and the expert panel are in agreement that the typical patient is a child and shares with CMS concerns that this code is reported incorrectly for services provided to the Medicare population with limited exceptions and which do not meet the CPT descriptor limitation to "cutaneous proliferative vascular lesions." The post operative visits presented represent real life follow-up for these typically young patients. We believe the calculated IWPUT is an accurate reflection of the intensity of this procedure that typically takes place around sensitive orifices.

In addition to conducting a survey, the American Academy of Dermatology has also used an expert panel of physicians performing this procedure. The surveyees and the expert panel are in agreement that the typical patient is a child and shares with CMS concerns that this code is reported incorrectly for services provided to the Medicare population with limited exceptions and which do not meet the CPT descriptor limitation to "cutaneous proliferative vascular lesions."

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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? Rarely

Specialty General Surgery

How often? Rarely

Specialty Plastic Surgery

How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 11000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Extrapolated estimate from frequency performed at multiple hub centers to national population.

Specialty Dermatology	Frequency 5390	Percentage 49.00 %
Specialty General Surgery	Frequency 1540	Percentage 14.00 %
Specialty Plastic Surgery	Frequency 880	Percentage 8.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,200 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare utilization data.

Specialty Dermatology	Frequency 1078	Percentage 49.00 %
Specialty General Surgery	Frequency 304	Percentage 13.81 %
Specialty Plastic Surgery	Frequency 217	Percentage 9.86 %

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. work RVU = 4.68. Similar code performed by dermatologists = 17286

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: 17108

Tracking Number

Specialty Society Recommended RVU: **13.52**

Global Period: 090

RUC Recommended RVU: **6.37**

CPT Descriptor: Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 13-year-old white female with a capillary vascular malformation on her left thigh measuring 10.0 x 15.0 cm presents for evaluation of Klippel-Trenaunay-Weber syndrome and treatment of the malformation which occasionally swells and bleeds.

Percentage of Survey Respondents who found Vignette to be Typical: 69%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 69%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Pre-service includes: procedural preparation to include preparation of supplies and equipment; such as use of appropriate surgical tray and laser calibration as well as special considerations for the pediatric patient. Two or more laser systems are calibrated prior to the laser procedures in anticipation of initiating the treatment. All nurses, physicians and parents are given wavelength specific protective eyewear for the various laser systems that will be utilized during the procedure. The treatment room is secured for unauthorized entry during the procedure and all reflective windows and glass are protected from reflecting laser beams. All flammable material is removed from the patient and surrounding treatment field. Surrounding hair-bearing areas are protected with a viscous gel to limit burning of the hair. External sources of oxygen or nitrous oxide are also removed from the surgical field.

The procedure and diagnosis are written on the informed consent and this is explained in detail. Informed consent is obtained from the parents as well as a full discussion of the procedure that is to take place including the risks, benefits, and alternatives. Special attention is placed on the emotional issues related to the procedure. The family is advised as well of the postoperative appearance of the laser induced wound.

Tetracaine ophthalmic solution is placed under the eyelids to anesthetize the cornea in preparation for placement of a metal non-reflective ocular shield. The shield is placed directly on the cornea. Topical anesthetic is applied to the area to be treated for one hour prior to the procedure.

Description of Intra-Service Work: Intra-service includes: removal of topical anesthetic, inspect and palpate lesions for size, location, functional risks, depth. Measure the area (s) to be treated. Administer appropriate supplemental anesthesia and sedation. Appropriate protective eyewear is placed. The extensive malformation is treated with the Alexandrite laser using an energy density of 755 nm, 10 mm spot size, and 40 joules per centimeter squared with pulsed durations of 3 ms. Dynamic cooling device parameters were a 50 mm spurt with a delay of 30 ms. Following the initial application of 5 pulses there was a procedural delay of 3 minutes to assess the purpuric response. Adjustments in energy

parameters and the pulse width were made based upon this response. Hundreds of pulses are required to treat the entire surface area.

The Alexandrite laser was turned off and removed from the treatment room and replaced with the V-Beam pulsed dye laser. After a several minute warm-up period several pulses with the V-Beam pulsed dye laser at an energy of 12.5 jules per centimeter squared, pulse duration of 6, 3 ms, and a 7 mm spot in diameter were utilized. Dynamic cooling device parameters were a 40 ms spurt with a delay of 20 ms. Several pulses were evaluated after a 3 minute delay to assess the purpuric response.

The pulsed dye laser was then turned off and removed from the treatment room and replaced with the 577 nm pulsed dye laser using an energy of 7 jules per centimeter squared, pulse duration of .45 ms and a 7mm spot beam. The purpuric response was again assessed following the application of 5 pulses after a 3 minute delay. Treatment parameters were adjusted following the assessment of the purpuric response. Hundreds of pulses are required to treat the entire surface area.

Description of Post-Service Work: Post service includes: removal of protective eye shields, cleansing of the treated area, application of cool gel packs, ice packs, antibacterial ointment to any areas where wounding has occurred. Instructions for postoperative care are explained in detail to the parents. Post treatment observation is required to assess for the presence of vesiculation and/or tissue sloughing. Post treatment cooling for approximately one hour is required to minimize thermal injury of normal skin. Completion of medical record including charting, dictation of operative report, and if appropriate, further communication with the family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2008				
Presenter(s):		Jerome Garden, MD, Roy Geronemus, MD, Scott Collins, MD				
Specialty(s):		American Academy of Dermatology				
CPT Code:		17108				
Sample Size: 90		Resp N: 28		Response: 31.1 %		
Sample Type: Panel						
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		8.00	13.00	85.00	120.00	150.00
Survey RVW:		7.35	12.50	13.52	14.00	22.82
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				10.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		15.00	45.00	60.00	75.00	120.00
Immediate Post Service-Time:		10.00				
Post Operative Visits		Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):		0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):		0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:		0.00	99238x 0.00	99239x 0.00		
Office time/visit(s):		71.00	99211x 0.00	12x 3.00	13x 1.00	14x 0.00 15x 0.00
Prolonged Services:		0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	17108	Recommended Physician Work RVU: 13.52			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		7.00	7.00	0.00	
Pre-Service Positioning Time:		0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00	
Intra-Service Time:		60.00			
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0			
Office time/visit(s):	71.00	99211x 0.00 12x 3.00 13x 1.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15731	090	14.12	RUC Time

CPT Descriptor Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15240	090	10.15	RUC Time	11,856

CPT Descriptor 1 Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
21046	090	13.97	RUC Time	348

CPT Descriptor 2 Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 16 % of respondents: 57.1 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 17108	<u>Key Reference CPT Code:</u> 15731	<u>Source of Time</u> RUC Time
Median Pre-Service Time	7.00	75.00	
Median Intra-Service Time	60.00	120.00	
Median Immediate Post-service Time	10.00	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	19.00	
Median Office Visit Time	71.0	120.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	148.00	364.00	
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	3.69	3.37
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.50
Urgency of medical decision making	4.13	4.06

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	4.25
Physical effort required	4.63	4.56

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.33	3.33
Outcome depends on the skill and judgment of physician	4.75	4.63
Estimated risk of malpractice suit with poor outcome	4.38	4.13

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.56	4.31
Intra-Service intensity/complexity	4.56	4.43
Post-Service intensity/complexity	4.19	4.19

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 firmly believe that the physician work time and intensity is justified for this discrete family of codes. There were difficulties in getting greater than 30 surveys based on the sparseness of use of this code in all age groups. In addition, many logical reference service codes were unavailable (as the 14xxx family is also under RUC review at this meeting)

The surveyees and the expert panel are in agreement that the typical patient is a child and shares with CMS concerns that this code is reported incorrectly for services provided to the Medicare population with limited exceptions and which do not meet the CPT descriptor limitation to “cutaneous proliferative vascular lesions.” The post operative visits presented represent real life follow-up for these typically young patients. We believe the calculated IWPOT is an accurate reflection of the intensity of this procedure that typically takes place around sensitive orifices.

In addition to conducting a survey, the American Academy of Dermatology has also used an expert panel of physicians performing this procedure. The surveyees and the expert panel are in agreement that the typical patient is a child and shares with CMS concerns that this code is reported incorrectly for services provided to the Medicare population with limited exceptions and which do not meet the CPT descriptor limitation to “cutaneous proliferative vascular lesions.”

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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? Rarely

Specialty General Sugery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 9000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. Extrapolated estimate from frequency performed at mutiple hub centers to national population.

Specialty Dermatology	Frequency 4590	Percentage 51.00 %
Specialty General Sugery	Frequency 1080	Percentage 12.00 %
Specialty	Frequency	Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 5,200 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. Medicare Utilization

Specialty Dermatology	Frequency 2652	Percentage 51.00 %
Specialty General Surgery	Frequency 624	Percentage 12.00 %
Specialty Internal Medicine	Frequency 364	Percentage 7.00 %

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? No

If no, please select another crosswalk and provide a brief rationale. 17311 Mohs Surgery. Has a similar work RVU of 6.20

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008

Treat Thigh Fracture

In April 2008, CPT Code 27245 *Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage* was identified by the RUC's Five Year Review Identification Workgroup as a service having a high intra-service work per unit of time (2008 Work RVU = 21.09; IWPUR = 0.133). The Workgroup agreed that similar service, CPT code 27244 *Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage*, (2008 Work RVU = 17.63) should be surveyed as it was directly related to 27245. The Workgroup had also agreed in April 2008 that the two codes should be valued the same as they describe a similar procedure utilizing different devices.

In October 2008, the RUC reviewed the survey results provided by the specialty for codes 27244 and 27245 and agreed that these survey data demonstrate that the services require the same work. From the specialty's survey results, both services have identical pre-service and post-service physician work time and there is a five minute difference in intra-service physician work (75 minutes and 80 minutes respectively). The survey median work RVU for both codes was 18.50 RVUs, however the specialty society agreed that both codes should be valued at 18.00 RVUs, the 25th percentile survey results for code 27245, as this value best reflects the work of the service.

The RUC reviewed the survey's key reference code 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (Work RVU = 17.43, 090 Day Global) in relation to these two codes which indicated that the technical skill, physical effort and psychological stress required to perform these services were higher for both 27244 and 27245. The RUC agreed that CPT code 27245 is currently overvalued and should be reduced to be equivalent to 27244. **The RUC recommends relative work values of 18.00 for CPT Codes 27244 and 27245.**

Practice Expense

The direct practice expense inputs are recommended to be modified for changes in post-operative offices visits.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	090	18.00
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	090	18.00

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 27244

Tracking Number

Specialty Society Recommended RVU: **18.00**

Global Period: 090

RUC Recommended RVU: **18.00**

CPT Descriptor: Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 78-year-old female tripped and fell, landing on her right side. She has immediate pain in the hip and proximal thigh and is unable to stand upright. Radiographs in the emergency department reveal a displaced 3 part peritrochanteric proximal femur fracture and she undergoes open treatment of the fracture and fixation with a plate and screw type implant (eg, sliding screw-side plate).

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Note: After evaluation of the patient of the patient in the emergency room, a consult or initial hospital care will be reported and the patient is admitted. Surgery on a subsequent day will be scheduled by surgeon's office staff.

Day of procedure: Review previous day(s) testing, including labs and imaging studies, as well as any additional tests and progress notes or consults placed in the patient's chart since admission. Review medical clearance status with primary care physician or medical consult. Review medical clearance status with anesthesia; review the length of procedure and type of anesthesia with anesthesiologist. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of antibiotic and anticoagulation meds. Plan and template the surgical procedure and implants. Verify that all required instruments, supplies, and implants are available. Perform surgical "time out" with operating surgical team. Assist transfer from hospital bed and patient positioning on a traction table in a supine position, with application of traction devices and positioning and padding of extremities. Perform preliminary closed reduction of the fracture with traction and closed manipulation. Position fluoroscopy equipment and verify visualization of proximal femur with AP and lateral images; assess adequacy of reduction. Application of thermal regulation drapes. Indicate areas of skin to be prepped. Scrub and gown. Mark surgical incision and drape sterile field.

Description of Intra-Service Work: Under anesthesia an incision is made on the lateral aspect of the hip. The gluteal fascia and muscle are divided and the tip of the greater trochanter is exposed with digital palpation. If a satisfactory closed reduction was not obtained, the incision is larger and the lateral aspect of the proximal femur exposed; direct reduction is achieved and maintained with reduction clamps. The starting portal for the nail is made with an awl or guide pin and cannulated drill. The position is determined with the aid of image intensification. A long guide wire is then inserted and advanced past the fracture site, down the medullary canal, and into the distal femur. The femoral canal is sequentially reamed. After appropriate measurements with respect to nail length and diameter, the nail is inserted to the correct depth and rotation. Using external alignment jigs, a guide pin(s) is inserted through a separate incision, into the

femur, across the nail, and into the head/neck segment. Position is confirmed with fluoroscopy. The locking screws are inserted after measurement and pre-drilling. One or two distal locking screws are inserted. Final fluoroscopic views are obtained. The wounds are closed.

Description of Post-Service Work: Application of dressing. Assist with positioning for portable radiographs; review radiographs before ending anesthesia. Assist with patient transfer off of traction table to the bed for transfer to recovery room. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and post-operative orders, including anticoagulation, antibiotic, and pain meds. Monitor patient condition in the recovery room, including vital signs and circulation, sensation and motor function of the operated extremity. Review surgical course and outcome with medical consult or primary care physician. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Subsequent facility work: Review data not available on the unit (eg, diagnostic and imaging studies). Communicate with other professionals as well as with patient and patient's family. Perform a physical exam daily, including the day of procedure. Monitor vital signs, wounds (changing dressings daily), and drains. Monitor for infection, cardiopulmonary status, bowel function, coherence while on pain medication. Assess circulation, sensation and motor function of the operated extremity. Address interval data obtained. Consider relevant data, options, and risks and revise treatment plan as necessary (medical decision making of moderate complexity), including adjustment to medications (anticoagulation, antibiotics, pain) and ordering and assessing physical therapy. Communicate results and further care plans to other health care professionals and to the patient and/or family. On discharge day, review medical records. Perform a physical exam - check vital signs, wounds, and drains. Assess circulation, sensation and motor function of the operated extremity. Consider relevant data, options, and risks and formulate/revise diagnosis and treatment plan(s) including making the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Order post-discharge follow-up physical therapy / home health care services. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write prescriptions. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this hospitalization. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. At post-discharge office visits, examine and talk with patient. Remove dressings, assess wounds, remove sutures when appropriate. Assess circulation, sensation and motor function of the operated extremity. Redress wounds. Assess progress of physical therapy, and revise order, as necessary. Order and review interval lab and/or imaging studies, as necessary. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2008			
Presenter(s):	William Creevy, MD				
Specialty(s):	orthopaedic surgery				
CPT Code:	27244				
Sample Size:	150	Resp N:	58	Response: 38.6 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	10.00	15.00	50.00
Survey RVW:	15.00	17.63	18.50	20.00	35.00
Pre-Service Evaluation Time:			60.00		
Pre-Service Positioning Time:			20.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	50.00	60.00	75.00	90.00	120.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>120.00</u>	99231x 2.00 99232x 2.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27244	Recommended Physician Work RVU: 18.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		30.00	3.00	27.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		75.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>120.00</u>	99231x 2.00 99232x 2.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
27236	090	17.43	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 28 % of respondents: 48.2 %

TIME ESTIMATES (Median)

	CPT Code: 27244	Key Reference CPT Code: 27236	Source of Time RUC Time
Median Pre-Service Time	90.00	90.00	
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	120.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	438.00	473.00	
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	2.96	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.48	3.45
Urgency of medical decision making	3.70	3.70

Technical Skill/Physical Effort (Mean)

Technical skill required	3.48	3.40
Physical effort required	3.56	3.45

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.85	3.70
Outcome depends on the skill and judgment of physician	3.85	3.75
Estimated risk of malpractice suit with poor outcome	3.15	3.25

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.50	3.45
Intra-Service intensity/complexity	3.31	3.30
Post-Service intensity/complexity	3.08	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.*

COMPELLING EVIDENCE

The AAOS presented 27244 to the Five-Year Review ID workgroup at the April 2008 RUC meeting as part of the workgroups review of "high IWPUT" codes. While 27244 was not identified as part of the high IWPUT screen, or any other RUC screen, the AAOS brought it forward for review in conjunction with CPT code

27245 which was identified for review by the Five-Year Review ID workgroup as a "high IWPUT" code. One of the options available to responding specialties in the action plan format was to identify other CPT codes that should be considered as part of the family. It was here that we listed 27244.

We stated the following in our action plan:

"These two codes should be valued essentially the same as they are essentially similar procedures. We believe the high IWPUT for 27245 is reflective of a work RVU that is slightly high, whereas 27244 should have a slightly higher IWPUT, in our opinion. However, the best way to determine is to survey both codes. Neither 27245 nor 27244 have been surveyed but rather have Harvard values."

The 5-Year Review ID workgroup stated the following in their minutes from the April 2008 workgroup meeting:

"The Workgroup agreed with the specialty society that both 27244 and 27245 should be valued the same as they are essentially similar procedures. In addition to these assumptions, the specialty society noted that neither 27245 nor 27244 have been surveyed by the RUC. The Workgroup agreed with the specialty society that a RUC survey is necessary. **The Workgroup accepts the action plan of the specialty society and recommends that 27244 and 27245 be surveyed and presented to the RUC at the October 2008 meeting.**"

It is on the basis of this workgroup recommendation that the AAOS has proceeded with our surveys and our consensus panel review. We interpret the 5-Year Review ID workgroup as supporting a preliminary recommendation for similar values between 27244 and 27245 regardless of whether one or both code's value increases and decreases.

Relative rank is one of the accepted compelling evidence standards, and we believe that in order to address an existing or resultant rank order anomaly between 27245 and 27244 and assign the two codes similar RVWs, 27244 requires a slight increase in its RVW, along with a decrease in the RVW for 27245. In fact, we have recommended an increase in RVW for 27244 from its current value of 17.08 to 17.63. At the same time, we are recommending a decrease in the RVW for 27245 from its current value of 21.09 to 18.00. Thus, 27245 will have a .37 higher RVW which we believe properly reflects the differential time it takes to perform 27245 (80 minutes intra-service time for 27245 versus 75 minutes intra-service time for 27244).

In budget neutrality terms, if the recommended values for 27245 and 27244 are accepted, it will result in a net decrease of 152,412 RVUs which, using a conversion factor of 38.086, equals \$5,804,753 in savings accrued to the Medicare program. The analysis is detailed below.

Current RVW for 27244	= 17.08	
Recommended RVW for 2744	= 17.63	
Net RVW increase for 27244	= 0.55	
2006 Utilization for 27244	= 43,214	
Resultant increase total RVW	= 0.55 x 43214	= 23,768 RVW
Current RVW for 27245	= 21.09	
Recommended RVW for 2745	= 18.00	
Net RVW decrease for 27245	= 3.09	
2006 Utilization for 27245	= 57016	
Resultant decrease total RVW	= (3.09) x 57016	= (176,179) RVW
Decrease in total RVW for both codes	= 23,768 – (176,179)	= (152,412) RVW
Medicare conversion factor	= \$38.086	
Medicare savings	= (152,412) x \$38.086	= \$5,804,753

RECOMMENDATION FOR NEW WORK RVU:

We conducted a standard RUC survey, collecting 58 survey responses. The median number of procedures performed in the past 12 months was 10. Of the 58 respondents, 28 (48%) choose 27236, *open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* as the key reference code. Survey respondents recommended a median RVW of 18.50 with median intra-service time of 75 minutes. Survey respondents choose 60 minutes of pre-evaluation time, 15 minutes positioning time, and 15 minutes scrub, dress and wait time. The survey respondents indicated there would be hospital visits associated with the procedure, recommending 2-99232's and 2-99231's, plus a full discharge day, 99238. This is consistent with the Medicare utilization figures which indicate over 96% of these procedures were performed in the facility setting. Survey respondents recommended 4 total post-operative office visits, 3-99213's and 1-99212.

In comparison to key reference code 27236, *open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement*, using magnitude work estimation the respondents determined the surveyed code, 27244, requires slightly more work even if it requires slightly less intra-service time and follow-up visits. In the opinion of the expert consensus panel, the respondents properly estimated the difference in total work between 27236 and 27244. 27236 is an open procedure that requires a larger exposure which takes more time to open and close compared to 27244 which involves exposing the lateral femur through a smaller incision. As a result of using a smaller incision, 27244 has 15 minutes less intra-service time but a higher IWPUT (.086 for 27244 and .060 for 27236)

27236, while recently RUC surveyed as part of the 2005 5-Year Review, has an artificially low IWPUT. The AAOS had recommended a work RVU of 19.17 for 27236 which was the survey median, but the RUC did not feel there was sufficient compelling evidence to support an increase in value; however, the RUC did accept the survey times with then current value of 15.58 which gave 27236 an IWPUT of .040, an extremely low IWPUT for a major open orthopaedic procedure. Note that 27236 was increased in value from 15.58 to its current 17.43 value as a result of the changes in E/M values subsequent to the 2005 5-year review; the current IWPUT is 0.060. There is one more hospital visit (99231) assigned to 27236, which reflects the additional recovery needed as a result of the larger incision and exposure for 27236. Post-operative office visits are the same for the surveyed code and 27236.

Our consensus expert panel chose the 25% RVW response from the survey and we recommend a value of **17.63**. Our panel believes the value of 17.63 properly rank orders 27244 to both 27236 and 27245. The times for 27244 are the exact same as for 27245 except for 5 additional intra-operative minutes allocated to 27245. Our panel believes the survey respondents are potentially correct to estimate a 5 minute intra-service difference between 27245 and 27244. Please note however, that 5 minutes intra-operative time and .37 RVW represent a minimal (2%) difference, validating our panel's opinion that the two procedures are quite similar. Otherwise, the pre-service and post-service times for 27244 and 27245 are exactly the same.

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from the standard 40 minutes
- Positioning: Add 27 minutes (total 30 min) to account for assisting positioning of the patient, application of traction, reduction and fluoroscopic positioning and review.
- Scrub/Dress/Wait: No change from standard 20 minutes.

The table below shows the IWPUT, time, visit, and RVW settings for 27236, 27244 and 27245.

CPT Code	IWPUT	RVW	EVAL	POSIT	SDW	Intra	P-SD	9923 2	9923 1	9923 8	9921 3	9921 2
27236	.060	17.43	60	15	15	90	30	2	3	1	3	1
27244 Current (Harvard)	.062	17.08	32	24	25	79	36	0	9	1	0	4
27244 Recommended	.086	17.63	40	30	20	75	30	2	2	1	3	1
27245 Current (Harvard)	.144	21.09	80			85	20	0	4	1	1	3
27245 Recommended	.085	18.00	40	30	20	80	30	2	2	1	3	1

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27244

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic trauma surgery

How often? Commonly

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. National frequency not available. Types of fractures from trauma can vary widely from year to year.

Specialty

Frequency

Percentage

%

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? 43,214 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare data

Specialty orthopaedic trauma surgery	Frequency 43214	Percentage 100.00 %
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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**

CPT Code: 27245 Tracking Number

Specialty Society Recommended RVU: **18.00**

Global Period: 090

RUC Recommended RVU: **18.00**

CPT Descriptor: Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 78-year-old female tripped and fell, landing on her right side. She has immediate pain in the hip and proximal thigh and is unable to stand upright. Radiographs in the emergency department reveal a displaced 3 part peritrochanteric proximal femur fracture and she undergoes open treatment of the fracture and fixation with a cephalo-intramedullary implant (eg, recon type IMN).

Percentage of Survey Respondents who found Vignette to be Typical: 72%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Note: After evaluation of the patient of the patient in the emergency room, a consult or initial hospital care will be reported and the patient is admitted. Surgery on a subsequent day will be scheduled by surgeon's office staff.

Day of procedure: Review previous day(s) testing, including labs and imaging studies, as well as any additional tests and progress notes or consults placed in the patient's chart since admission. Review medical clearance status with primary care physician or medical consult. Review medical clearance status with anesthesia; review the length of procedure and type of anesthesia with anesthesiologist. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of antibiotic and anticoagulation meds. Plan and template the surgical procedure and implants. Verify that all required instruments, supplies, and implants are available. Perform surgical "time out" with operating surgical team. Assist transfer from hospital bed and patient positioning on a traction table in a supine position, with application of traction devices and positioning and padding of extremities. Perform preliminary closed reduction of the fracture with traction and closed manipulation. Position fluoroscopy equipment and verify visualization of proximal femur with AP and lateral images; assess adequacy of reduction

Application of thermal regulation drapes. Indicate areas of skin to be prepped. Scrub and gown. Mark surgical incision and drape sterile field.

Description of Intra-Service Work: Under anesthesia an incision is made on the lateral aspect of the hip. The gluteal fascia and muscle are divided and the tip of the greater trochanter is exposed with digital palpation. If a satisfactory closed reduction was not obtained, the incision is larger and the lateral aspect of the proximal femur exposed; direct reduction is achieved and maintained with reduction clamps. The starting portal for the nail is made with an awl or guide pin and cannulated drill. The position is determined with the aid of image intensification. A long guide wire is then inserted and advanced past the fracture site, down the medullary canal, and into the distal femur. The femoral canal is sequentially reamed. After appropriate measurements with respect to nail length and diameter, the nail is inserted to the

correct depth and rotation. Using external alignment jigs, a guide pin(s) is inserted through a separate incision, into the femur, across the nail, and into the head/neck segment. Position is confirmed with fluoroscopy. The locking screws are inserted after measurement and pre-drilling. One or two distal locking screws are inserted. Final fluoroscopic views are obtained. The wounds are closed.

Description of Post-Service Work: Application of dressing. Assist with positioning for portable radiographs; review radiographs before ending anesthesia. Assist with patient transfer off of traction table to the bed for transfer to recovery room. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and post-operative orders, including anticoagulation, antibiotic, and pain meds. Monitor patient condition in the recovery room, including vital signs and circulation, sensation and motor function of the operated extremity. Review surgical course and outcome with medical consult or primary care physician. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Subsequent facility work: Review data not available on the unit (eg, diagnostic and imaging studies). Communicate with other professionals as well as with patient and patient's family. Perform a physical exam daily, including the day of procedure. Monitor vital signs, wounds (changing dressings daily), and drains. Monitor for infection, cardiopulmonary status, bowel function, coherence while on pain medication. Assess circulation, sensation and motor function of the operated extremity. Address interval data obtained. Consider relevant data, options, and risks and revise treatment plan as necessary (medical decision making of moderate complexity), including adjustment to medications (anticoagulation, antibiotics, pain) and ordering and assessing physical therapy. Communicate results and further care plans to other health care professionals and to the patient and/or family. On discharge day, review medical records. Perform a physical exam - check vital signs, wounds, and drains. Assess circulation, sensation and motor function of the operated extremity. Consider relevant data, options, and risks and formulate/revise diagnosis and treatment plan(s) including making the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Order post-discharge follow-up physical therapy / home health care services. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write prescriptions. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this hospitalization. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. At post-discharge office visits, examine and talk with patient. Remove dressings, assess wounds, remove sutures when appropriate. Assess circulation, sensation and motor function of the operated extremity. Redress wounds. Assess progress of physical therapy, and revise order, as necessary. Order and review interval lab and/or imaging studies, as necessary. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2008			
Presenter(s):	William Creevy, MD				
Specialty(s):	orthopaedic surgery				
CPT Code:	27245				
Sample Size:	150	Resp N:	58	Response: 38.6 %	
Sample Type: Random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	8.00	15.00	24.00	150.00
Survey RVW:	16.00	18.00	18.50	20.38	35.00
Pre-Service Evaluation Time:			60.00		
Pre-Service Positioning Time:			20.00		
Pre-Service Scrub, Dress, Wait Time:			20.00		
Intra-Service Time:	50.00	60.00	80.00	90.00	120.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>120.00</u>	99231x 2.00 99232x 2.00 99233x 0.00			
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00			
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27245	Recommended Physician Work RVU: 18.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		30.00	3.00	27.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		80.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>120.00</u>	99231x 2.00 99232x 2.00 99233x 0.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0		
Office time/visit(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
27236	090	17.43	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 29 % of respondents: 50.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 27245	<u>Key Reference CPT Code:</u> 27236	<u>Source of Time</u> RUC Time
Median Pre-Service Time	90.00	90.00	
Median Intra-Service Time	80.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	120.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	443.00	473.00	
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	3.03	3.04
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.52
Urgency of medical decision making	3.60	3.52

Technical Skill/Physical Effort (Mean)

Technical skill required	3.90	3.74
Physical effort required	3.63	3.61

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.97	3.83
Outcome depends on the skill and judgment of physician	3.87	3.74
Estimated risk of malpractice suit with poor outcome	3.27	3.18

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.59	3.50
Intra-Service intensity/complexity	3.52	3.32
Post-Service intensity/complexity	3.10	3.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AAOS presented 27245 to the Five-Year Review ID workgroup at the April 2008 RUC meeting as part of the workgroups review of "high IWP/UT" codes. 27245 had been identified as a "high IWP/UT" code. One of the options available to responding specialties in the action plan format was to identify other CPT codes that should be considered as part of the family. It was here that we listed 27244.

We stated the following in our action plan:

"These two codes should be valued essentially the same as they are essentially similar procedures. We believe the high IWPUT for 27245 is reflective of a work RVU that is slightly high, whereas 27244 should have a slightly higher IWPUT, in our opinion. However, the best way to determine is to survey both codes. Neither 27245 nor 27244 have been surveyed but rather have Harvard values."

The 5-Year Review ID workgroup stated the following in their minutes from the April 2008 workgroup meeting:

"The Workgroup agreed with the specialty society that both 27244 and 27245 should be valued the same as they are essentially similar procedures. In addition to these assumptions, the specialty society noted that neither 27245 nor 27244 have been surveyed by the RUC. The Workgroup agreed with the specialty society that a RUC survey is necessary. **The Workgroup accepts the action plan of the specialty society and recommends that 27244 and 27245 be surveyed and presented to the RUC at the October 2008 meeting.**"

It is on the basis of this workgroup recommendation that the AAOS has proceeded with our surveys and our consensus panel review. We interpret the 5-Year Review ID workgroup as supporting a recommendation for essentially similar values between 27244 and 27245 regardless of whether one or both code's value increases and decreases.

We are recommending a decrease in the RVW for 27245 from its current value of 21.09 to 18.00. Thus, 27245 will have a .37 higher RVW which we believe properly captures the minimal difference in the time it takes to perform 27245 (80 minutes intra-service time for 27245 versus 75 minutes intra-service time for 27244).

In budget neutrality terms, if the recommended values for 27245 and 27244 are accepted, it will result in a net decrease of 152,412 RVUs which, using a conversion factor of 38.086, equals \$5,804,753 in savings accrued to the Medicare program. The analysis is detailed below.

Current RVW for 27244	= 17.08	
Recommended RVW for 2744	= 17.63	
Net RVW increase for 27244	= 0.55	
2006 Utilization for 27244	= 43,214	
Resultant increase total RVW	= 0.55 x 43214	= 23, 768 RVW
Current RVW for 27245	= 21.09	
Recommended RVW for 2745	= 18.00	
Net RVW decrease for 27245	= 3.09	
2006 Utilization for 27245	= 57016	
Resultant decrease total RVW	= (3.09) x 57016	= (176,179) RVW
Decrease in total RVW for both codes	= 23,768 – (176,179)	= (152,412) RVW
Medicare conversion factor	= \$38.086	
Medicare savings	= (152,412) x \$38.086	= \$5,804,753

RECOMMENDATION FOR NEW WORK RVU:

We conducted a standard RUC survey, collecting 58 survey responses. The median number of procedures performed in the past 12 months was 15. Of the 58 respondents, 29 (50%) choose 27236, *open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* as the key reference code. Survey respondents recommended a median RVW of 18.50 with median intra-service time of 75 minutes. Survey respondents choose 60 minutes of pre-evaluation time, 15 minutes positioning time, and 15 minutes scrub, dress and wait time. The survey respondents indicated there would be hospital visits associated with the procedure, recommending 2-99232's and 2-99231's, plus a full discharge day, 99238. This is consistent with the Medicare utilization figures which indicate over 96% of these procedures were performed in the facility setting. Survey respondents recommended 4 total post-operative office visits, 3-99213's and 1-99212.

In comparison to key reference code 27236, *open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement*, the respondents using magnitude work estimation determined the surveyed code, 27245, requires slightly more work even if it requires slightly less intra-service time and follow-up visits. In the opinion of the expert consensus panel, the respondents properly estimated the difference in total work between 27236 and 27245. 27236 is always an open procedure thus requires a larger exposure which takes more time to open and close compared to 27245 which exposed the lateral femur through a smaller incision. As a result of using a smaller incision 27245 has 10 minutes less intra-service time but a higher IWPUT (.085 for 27245 and .060 for 27236)

27236, while recently RUC surveyed as part of the 2005 5-Year Review, has an artificially low IWPUT. The AAOS had recommended a work RVU of 19.17 for 27236 which was the survey median, but the RUC did not feel there was sufficient compelling evidence to support an increase in value; however, the RUC did accept the survey times with then current value of 15.58 which gave 27236 an IWPUT of .040, an extremely low IWPUT for a major open orthopaedic procedure. Note that 27236 was increased in value from 15.58 to its current 17.43 value as a result of the changes in E/M values subsequent to the 2005 5-year review; the current IWPUT is 0.060. There is one more hospital visit (99231) assigned to 27236, which reflects the additional recovery needed as a result of the larger incision and exposure for 27236. Post-operative office visits are the same for the surveyed code and 27236.

Our consensus expert panel chose the 25% RVW response from the survey and we recommend a value of **18.00**. Our panel believes the value of 18.00 properly rank orders 27244 to both 27236 and 27245. The times for 27244 are almost the same as for 27245, except for 5 additional intra-operative minutes allocated to 27245. Our panel believes the survey respondents are potentially correct to estimate a 5 minute intra-service difference between 27245 and 27244. Please note however, that 5 minutes intra-operative time and .37 RVW represent a minimal (2%) difference, validating our panel's opinion that the two procedures are quite similar. Otherwise, the pre-service and post-service times for 27244 and 27245 are exactly the same

With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change from the standard 40 minutes
- Positioning: Add 27 minutes (total 30 min) to account for assisting positioning of the patient, application of traction, reduction and fluoroscopic positioning and review.
- Scrub/Dress/Wait: No change from standard 20 minutes.

The table below shows the IWPUT, time, visit, and RVW settings for 27236, 27244 and 27245.

CPT Code	IWPUT	RVW	EVAL	POSIT	SDW	Intra	P-SD	9923 2	9923 1	9923 8	9921 3	9921 2
27236	.060	17.43	60	15	15	90	30	2	3	1	3	1
27244 Current (Harvard)	.062	17.08	32	24	25	79	36	0	9	1	0	4
27244 Recommended	.086	17.63	40	30	20	75	30	2	2	1	3	1
27245 Current (Harvard)	.144	21.09	80			85	20	0	4	1	1	3

27245 Recommended	.085	18.00	40	30	20	80	30	2	2	1	3	1
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SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27245

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic trauma surgery

How often? Commonly

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. National frequency not available. Types of fractures from trauma can vary widely from year to year.

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? 57,016 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare data

Specialty orthopaedic trauma surgery	Frequency 57016	Percentage 100.00 %
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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 Committee
Summary of Recommendations

October 2008 - CMS Request: Practice Expense Review

Interventional Radiology Procedures

In June 2008, CMS requested the RUC to make a direct practice expense recommendation for the non-facility setting for the following CPT Codes:

36481 *Percutaneous portal vein catheterization by any method*

37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated*

47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency*

50200 *Renal biopsy; percutaneous, by trocar or needle*

The RUC initiated a level of interest process in June 2008 and in September 2008 received practice expense recommendation from a specialty society for review at the October 2008 RUC meeting.

36481

The RUC reviewed the direct practice expense inputs recommendation for code 36481 from the specialty society and determined that the medical supplies and equipment time included in the recommendation overlapped other services, such as imaging services, that are typically billed at the same time. The RUC also determined the specialty society recommendation lacked RUC standards for practice expense and that other similar services recently reviewed by the RUC may require revised recommendations. Based on these issues the RUC could not make an informed recommendation at this time. **The RUC recommends that the specialty society develop a revised direct practice expense input recommendation for code 36481 and all codes typically billed with code 36481 (to be determined) for presentation at the next RUC meeting . The RUC also recommends this service be placed on CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

37183

The RUC reviewed the specialty society direct practice expense inputs recommendation for code 37183 and made several edits in clinical staff types and time to be more reflective of the service. The RUC also agreed that this service is typically performed with moderate sedation. **The RUC recommends the attached direct practice expense inputs for code 37183 and recommends that this service be placed on CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

47382

The RUC reviewed the specialty society direct practice expense inputs recommendation for code 37183 and made several edits in clinical staff types for the typical patient scenario. The RUC also agreed that this service is typically performed with moderate sedation. **The RUC recommends the attached direct practice expense inputs for code 47382 and recommends that this service be placed on the CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

50200

The RUC reviewed the specialty society direct practice expense inputs recommendation for code 50200 and made edits in clinical staff types and time to reflect the typical patient encounter. The RUC also agreed that this service is typically performed with moderate sedation. **The RUC recommends the attached direct practice expense inputs for code 50200 and recommends that this service be placed on the CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
36481	Percutaneous portal vein catheterization by any method	000	Review of PE Only
37183	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated	000	Review of PE Only
47382	Ablation, one or more liver tumor(s), percutaneous, radiofrequency	010	Review of PE Only
50200	Renal biopsy; percutaneous, by trocar or needle	000	Review of PE Only

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			37183	
2		CMS	Staff	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)	
3	LOCATION	Code	Type	Non Facility	Facility
4	GLOBAL PERIOD			000	000
5	TOTAL TIMES BY STAFF TYPE				
6		L037D	RN/LPN/MTA	26.0	13.0
7		L041A	Angio Tech	99.5	0.0
8		L051A	RN	144.5	0.0
9	TOTAL CLINICAL LABOR TIME			270.0	13.0
10	TOTAL CLINICAL LABOR TIME			268.0	13.0
11	TOTAL PRE-SERV CLINICAL LABOR TIME			14.0	10.0
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			251.0	0.0
13	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	3.0
14					
15	Start: Following visit when decision for surgery or procedure made				
16	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5
17	Coordinate pre-surgery services				
18	Schedule space and equipment in facility	L037D	RN/LPN/MTA	3	5
19	Provide pre-service education/obtain consent				
20	Follow-up phone calls & prescriptions				
21	Other Clinical Activity (please specify) - Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting M	L041A	Angio Tech	6	
22	End: When patient enters office/facility for surgery/procedure				
23					
24	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
25	Review charts	L037D	RN/LPN/MTA	2	
26	Greet patient and provide gowning	L037D	RN/LPN/MTA	3	
27	Obtain vital signs	L037D	RN/LPN/MTA	5	
28	Provide pre-service education/obtain consent				
29	Prepare room, equipment, supplies	L041A	Angio Tech	4	
30	Setup scope (non facility setting only)				
31	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2	
32	Sedate/apply anesthesia	L051A	RN	2	
33	Intra-service				
34	Assist physician in performing procedure - CS	L051A	RN	77.5	
35	Assist physician in performing procedure	L041A	Angio Tech	77.5	
36	Post-Service				
37	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60	
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3	
39	Clean Scope				
40	Clean Surgical Instrument Package				
41	Complete diagnostic forms, lab & X-ray requisitions	L041A	Angio Tech	5	
42	Review/read X-ray, lab, and pathology reports				
43	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L051A	RN	3	
44	Discharge day management				
45	Other Clinical Activity (please specify): post procedure imaging processing	L041A	Angio Tech	7	
46	End: Patient leaves office				
47					
48	Start: Patient leaves office/facility				
49	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3
50	Office visits:				
51	List Number and Level of Office Visits				
52	99211 16 minutes		16		
53	99212 27 minutes		27		
54	99213 36 minutes		36		
55	99214 53 minutes		53		
56	99215 63 minutes		63		
57	Other				
58	Total Office Visit Time			0	0
59	Other Activity (please specify)				
60	End: with last office visit before end of global period				

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			37183	
2		CMS	Staff	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)	
3	LOCATION	Code	Type	Non Facility	Facility
61					
62	pack, minimum multi-specialty visit	SA048	pack	1	
63	pack, conscious sedation	SA044	pack	1	
64	kit, IV starter	SA019	kit	1	
65	gown, surgical, sterile	SB028	item	2	
66	gloves, sterile	SB024	pair	3	
67	mask, surgical, with face shield	SB034	item	2	
68	cap, surgical	SB001	item	2	
69	shoe covers, surgical	SB039	pair	2	
70	tray, shave prep	SA067	tray	1	
71	underpad 2ftx3ft (Chux)	SB044	item	1	
72	drape, sterile, femoral	SB009	item	1	
73	drape-towel, sterile 18inx26in	SB019	item	4	
74	Betadine	SJ041	ml	60	
75	applicator, sponge-tipped	SG009	item	4	
76	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10	
77	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	2	
78	heparin 1,000 units-ml inj	SH039	ml	5	
79	sodium chloride 0.9% flush syringe	SH065	item	2	
80	closed flush system, angiography	SC010	item	1	
81	catheter, angiographic, pig-tail	SC008	item	1	
82	blade, surgical (Bard-Parker)	SF007	item	1	
83	kit, AccuStick II Introducer System with RO Marker	SA071	kit	1	
84	guidewire, hydrophilic (Glidewire)	SD089	item	1	
85	guidewire, (Bentson)	SD172	item	1	
86	guidewire (Transcend)	SD175	item	1	
87	microcatheter guidewire introducer	SA016	item	1	
88	vascular sheath	SD136	item	2	
89	catheter microcatheter selective	SD154	item	1	
90	catheter (SIM2F1)	SD148	item	1	
91	catheter, curved (Headhunter)	SD153	item	1	
92	catheter (Glide)	SD147	item	1	
93	steri-strip (6 strip uou)	SG074	item	1	
94	sterile bowl	SD171	item	2	
95	gauze, sterile 4in x 4in	SG055	item	2	
96	dressing 3 X 4 wound care telfa	SG035	item	2	
97	tape, surgical paper 1in (Micropore)	SG079	item	6	
98	drape, sterile, c-arm, fluoro	SB008	item	1	
99	Tegaderm dressing	SG037	item	0	
100	Conray Inj (iothalamate 43%)	SH026	ml	60	
101	biohazard bag	SM004	item	2	
102	film, x-ray 14inx17in	SK034	item	6	
103	x-ray envelope	SK091	item	4	
104	x-ray developer solution	SK089	oz	6	
105	x-ray fixer solution	SK092	oz	6	
106	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1	
107	computer media, dvd	SK013	item	1	
108	stent, VIATORR manufacturer GORE Contact Antoinette Sheen)	NEW	item	1	
109					
110	room, angiography	EL011		1	
111	film alternator (motorized film viewbox)	ER029		4	
112	stretcher	EF018		1	

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			47382	
2		CMS	Staff	Ablation, one or more liver tumor(s), percutaneous, radiofrequency	
3	LOCATION	Code	Type	Non Facility	Facility
4	GLOBAL PERIOD			010	010
5	TOTAL TIMES BY STAFF TYPE				
6		L037D	RN/LPN/MTA	52.0	23.0
7		L041B	RT	153.0	0.0
8		L051A	RN	197.0	27.0
9	TOTAL CLINICAL LABOR TIME			402.0	50.0
10	TOTAL CLINICAL LABOR TIME			409.0	50.0
11	TOTAL PRE-SERV CLINICAL LABOR TIME			14.0	23.0
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			368.0	0.0
13	TOTAL POST-SERV CLINICAL LABOR TIME			27.0	27.0
14	Start: Following visit when decision for surgery or procedure made				
15	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5
16	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	10
17	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5
18	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3	
19	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3
20	Other Clinical Activity (please specify)				
21	End: When patient enters office/facility for surgery/procedure				
22	Service Period				
23	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
24	Review charts	L037D	RN/LPN/MTA	3	
25	Greet patient and provide gowning	L037D	RN/LPN/MTA	3	
26	Obtain vital signs	L037D	RN/LPN/MTA	5	
27	Provide pre-service education/obtain consent	L041B	RT	2	
28	Prepare room, equipment, supplies	L041B	RT	2	
29	Setup scope (non facility setting only)	L041B	RT	0	
30	Prepare and position patient/ monitor patient/ set up IV	L051A	RN	2	
31	Sedate/apply anesthesia				
32	Intra-service				
33	Assist physician in performing procedure - CS	L051A	RN	180	
34	Assist physician in performing procedure	L041B	RT	144	
35	Post-Service				
36	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	15	
37	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	1	
38	Clean Scope	L041B	RT	5	
39	Clean Surgical Instrument Package				
40	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	3	
41	Review/read X-ray, lab, and pathology reports				
42	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3	
43	Discharge day management				
44	Other Clinical Activity (please specify)				
45	End: Patient leaves office				
46	Post-Service Period				
47	Start: Patient leaves office/facility				
48	Conduct phone calls/call in prescriptions				
49	List Number and Level of Office Visits				
50	99211 16 minutes		16		
51	99212 27 minutes	L037D	RN/LPN/MTA	1	1
52	99213 36 minutes		36		
53	99214 53 minutes		53		
54	99215 63 minutes		63		
55	Other				
56	Total Office Visit Time			27	27
57	Other Activity (please specify)				
58	End: with last office visit before end of global period				

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			47382	
2		CMS	Staff	Ablation, one or more liver tumor(s), percutaneous, radiofrequency	
3	LOCATION	Code	Type	Non Facility	Facility
60	MEDICAL SUPPLIES		Unit		
61	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1	
62	applicator, sponge-tipped	SG009	item	4	
63	tape, surgical paper 1in (Micropore)	SG079	inch	12	
64	gauze, sterile 4in x 4in	SG055	item	3	
65	povidone soln (Betadine)	SJ041	ml	60	
66	tray, shave prep	SA067	tray	1	
67	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10	
68	mask, surgical, with face shield	SB034	item	2	
69	drape, sterile, fenestrated 16in x 29in	SB011	item	1	
70	gloves, sterile	SB024	pair	2	
71	drape-towel, sterile 18in x 26in	SB019	item	1	
72	pack, minimum multi-specialty visit	SA048	pack	2	
73	pack, conscious sedation	SA044	pack	1	
74	syringe 10-12ml	SC051	item	1	
75	drape, sterile, three-quarter sheet	SB014	item	1	
76	cup-container, sterile, graduated 1000ml	SL038	item	1	
77	scalpel with blade, surgical (#10-20)	SF033	item	1	
78	needle, 18-27g	SC029	item	2	
79	probe, radiofrequency, 3 array (StarBurstSDE)	SD109	item	1	
80	NEW- probe, radiofrequency Xli-Enhanced RF Probe, \$2695.00, manufacturer AngioDynamics [The Xli-Enhanced RF Probe, typical for liver RFA, is larger than the SD109- probe, radiofrequency, 3 array (StarBurstSDE) used for renal, pulmonary and bone RFA procedures. Cost information provided by Jeff Maudlin, Angiodynamics, Oncology Products Group, (727) 631-4517, jmaudlin@angiodynamics.com]	NEW	item	1	
81	NEW - Kit, radiofrequency introducer for Xli-Enhanced RF Probe, \$99.00, manufacturer- AngioDynamics [The Xli-Enhanced RF Probe introducer is different than SA026 and is specific for use with the larger Xli-Enhanced RF Probe presented above.]	NEW	item	1	
82	silver nitrate applicator	SJ046	item	1	
83	tray, biopsy procedure	SA061	tray	1	
84	cup, biopsy-specimen sterile 4oz	SL036	item	1	
85	water, sterile for irrigation (250-1000ml uou)	SG074	item	1	
86	tincture of benzoin, swab	SJ060	item	1	
87	syringe 20ml	SC053	item	1	
88	gown, surgical, sterile	SB028	item	2	
89	shoe covers, surgical	SB039	pair	2	
90	underpad 2ft x 3ft (Chux)	SB044	item	1	
91	Equipment	CMS	Code		
92	room, CT	EL007		1	
93	New Equipment - Angiodynamics Radiofrequency Generator (\$37,500) Jeff Maudlin, Angiodynamics, Oncology Products Group, (727) 631-4517, jmaudlin@angiodynamics.com	NEW		1	
94	New Equipment - Radiofrequency Infusion Pump (\$5,995) Jeff Maudlin, Angiodynamics, Oncology Products Group, (727) 631-4517, jmaudlin@angiodynamics.com	NEW		1	
95	table, exam	EF023		1	

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			50200	
2		CMS	Staff	Renal biopsy;	
3	LOCATION	Code	Type	Non Facility	Facility
4	GLOBAL PERIOD			000	000
5	TOTAL TIMES BY STAFF TYPE				
6		L037D	RN/LPN/MTA	34.0	26.0
7		L041B	RT	49.4	
8		L051A	RN	70.0	
9	TOTAL CLINICAL LABOR TIME			153.4	26.0
10	TOTAL CLINICAL LABOR TIME			155.4	26.0
11	TOTAL PRE-SERV CLINICAL LABOR TIME			14.0	26.0
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			141.4	0.0
13	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0
14	PRE-SERVICE				
15	Start: Following visit when decision for surgery or procedure made				
16	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5
17	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	10
18	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5
19	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3	3
20	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3
21	Other Clinical Activity (please specify)				
22	End: When patient enters office/facility for surgery/procedure				
23	SERVICE PERIOD				
24	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
25	Review charts	L037D	RN/LPN/MTA	3	
26	Greet patient and provide gowning	L037D	RN/LPN/MTA	3	
27	Obtain vital signs	L037D	RN/LPN/MTA	5	
28	Provide pre-service education/obtain consent	L041B	RT	2	
29	Prepare room, equipment, supplies	L041B	RT	2	
30	Setup scope (non facility setting only)				
31	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2	
32	Sedate/apply anesthesia	L051A	RN	2	
33	Intra-service				
34	Assist physician in performing procedure - CS	L051A	RN	53	
35	Assist physician in performing procedure	L041B	RT	42	
36	Post-Service				
37	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	15	
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	1	
39	Clean Scope	L041B	RT	5	
40	Clean Surgical Instrument Package				
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	3	
42	Review/read X-ray, lab, and pathology reports				
43	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3	
44	Discharge day management				
45	Other Clinical Activity (please specify)				
46	End: Patient leaves office				
47	POST-SERVICE				
48	Start: Patient leaves office/facility				
49	Conduct phone calls/call in prescriptions				
50	Office visits:				
51	List Number and Level of Office Visits				
52	99211 16 minutes		16		
53	99212 27 minutes		27		
54	99213 36 minutes		36		
55	99214 53 minutes		53		
56	99215 63 minutes		63		
57	Other				
58	Total Office Visit Time			0	0
59	Other Activity (please specify)				
60	End: with last office visit before end of global period				

AMA Specialty Society Recommendation

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			50200	
2		CMS	Staff	Renal biopsy;	
3	LOCATION	Code	Type	Non Facility	Facility
61	MEDICAL SUPPLIES		Unit		
62	pack minimum multi-specialty visit	SA048	pack	1	
63	pack, conscious sedation	SA044	pack	1	
64	angiocatheter 14g-24g	SC001	item	1	
65	heparin lock	SC012	item	1	
66	needle, 18-27g	SC029	item	1	
67	needle, biopsy, spring-loaded	SC033	item	1	
68	syringe 5-6 ml	SC057	item	1	
69	tray, biopsy procedure	SA061	tray	1	
70	povidone solution (Betadine)	SJ041	ml	30	
71	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10	
72	sodium chloride 0.9% flush syringe	SH065	item	1	
73	bandage, strip 0.75 x 3 in (Bandaid)	SG021	item	1	
74	drape, sterile, for Mayo stand	SB012	item	1	
75	gloves, sterile	SB024	pair	2	
76	pillow case	SB037	item	0	
77	sterile gown	SB028	item	2	
78	surgical mask	SB033	item	2	
79	biohazard bag	SM004	item	1	
80	cup, biopsy-specimen sterile 4 oz	SL036	item	1	
81	cytology, preservative and vial	SL040	item	3	
82	EQUIPMENT				
83	room, CT	EL007		1	
84	mayo stand	EF015		1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008 – Identified through High IWPUT Screen

Change Biliary Drainage Catheter

In April 2008, the Five-Year Review Identification Workgroup identified CPT code 47525 *Change of percutaneous biliary drainage catheter* in its high IWPUT screening process. Additionally, the RUC recommended and CMS agreed that code 47525 be changed from a 010-day global period to a 000-day global period. The RUC requested that the specialty society survey code 47525.

The RUC reviewed code 47525 and determined when utilizing magnitude estimation that this procedure is a more difficult procedure compared to other tube change procedures. Patients are typically terminally ill and are in a fragile state. The RUC compared code 47525 to its key reference service code 49423 *Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)* (work RVU = 1.46) and 50387 *Removal and replacement of externally accessible transnephric ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation* (work RVU = 2.00).

The RUC reviewed the physician time required to provide this service and determined that the specialty society recommended pre-service package 1B – Straightforward patient procedure (with sedation/anesthesia) (19 minutes evaluation, 1 minute positioning and 5 minutes scrub, dress wait), 20 minutes intra-service time and 10 minutes immediate post-service time are appropriate. The RUC determined that a half discharge day was not required.

The RUC determined that the proper rank order for this service is between the two reference services 49423 and 50387. The RUC determined that code 47525 was approximately 20% more complex and intense than code 50387, excluding the fluoroscopy. Therefore, the RUC used reference code 50387 as a base, subtracted the work RVUs associated with the fluoroscopy and then increased the RVU by 20% to account for the higher complexity of this service ($2.00 - 0.72 = 1.28 \times 1.20 = 1.54$).

$$\begin{array}{r} 2.00 \text{ (50387)} \\ - 0.72 \text{ (fluoroscopy)} \\ \hline 1.28 \\ \times 1.20 \text{ (increased by 20\%)} \\ \hline \mathbf{1.54 \text{ work RVUs}} \end{array}$$

At a value of 1.54 work RVUs, code 47525 has an intra-service work per unit of time of 0.0413, which the RUC noted is appropriate for this short intra-service procedure. The RUC compared this intra-service intensity to similar services 45303 *Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)* (work RVU = 1.50, intra-service time =15 minutes and immediate post-service time = 10) and 45990 *Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic* (work RVU = 1.80, intra-service time = 20 minutes and immediate post-service time = 25) to support this 20% increase. The recommended work RVU of 1.54 is substantially lower than the current 2008 value of 5.55. **The RUC recommends a work RVU of 1.54 for code 47525 with a global period of 000.**

The RUC recommends that code 47525 be placed on the conscious sedation list, as it is inherent in this procedure. The conscious sedation standard package will be added to the direct practice expense inputs. The practice expense inputs should also be adjusted to remove the cost of the visits and to update the assist the physician time to be consistent with the new intra-service time.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
47525	Change of percutaneous biliary drainage catheter	010 000	1.54

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 47525 Tracking Number 47525

Specialty Society Recommended RVU: **1.90**

Global Period: 000

RUC Recommended RVU: **1.54**CPT Descriptor: Change of percutaneous biliary drainage catheter

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 68 year old male with colorectal cancer metastatic to liver and hilar obstruction of the biliary system previously treated with a right biliary drainage catheter. Patient is undergoing chemotherapy and now complains of drainage malfunction.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 86%

Is moderate sedation inherent to this procedure in the office setting? Yes Percent of survey respondents who stated it is typical in the office setting? 78%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work:

The physician:

- briefly examines the patient in the interventional suite
- 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 exchange of the biliary catheter
- Supervises staff establishing an intravenous site and places the patient in a supine position on the table
- Confirms proper room set up including sterile preps and drapes and selects appropriate devices such as catheters, snare device, sheaths, guidewires, and replacement biliary drainage device (catheter or bare metal stent)
- Proper positioning of the patient on the radiologic table is confirmed with sterile prep and drape performed

Description of Intra-Service Work:

The physician

- Orders medication for conscious sedation
- Under fluoroscopic guidance (imaging separately reportable) the low-profile device is removed and a 0.035-inch guidewire is inserted through the access catheter
- An 8-French angiography introducer is inserted over the guidewire to access the bile duct, and contrast material is injected through its sidearm for cholangiography (imaging separately reportable)
- Complete removal is confirmed with fluoroscopy, and permanent image(s) are obtained for the medical record (imaging separately reportable)
- A new biliary drainage catheter is advanced and placed over the guidewire relieving biliary reobstruction
- The guide/sheath/safety wire are removed

- Appropriate position is confirmed with fluoroscopy, and permanent image(s) are obtained for the medical record (imaging separately reportable)

Description of Post-Service Work:

The physician

- Makes a note in the patient record and orders are written
- Oversees the transfer of the patient to the recovery unit
- Notifies the referring physician of the outcome of the procedure, and of subsequent procedures to be done
- Discusses the outcome of the procedure with the patient and family and instructions are given
- Dictates a report for the permanent record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008				
Presenter(s):	Sean Tutton, MD, SIR Robert Vogelzang, MD, SIR Gerald Niedzwiecki, MD, SIR Geraldine McGinty, MD, ACR				
Specialty(s):	Society of Interventional Radiology and American College of Radiology				
CPT Code:	47525				
Sample Size:	750	Resp N:	45	Response: 6.0 %	
Sample Type:	Panel				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	4.00	10.00	20.00	50.00	500.00
Survey RVW:	1.48	1.90	3.00	3.95	6.00
Pre-Service Evaluation Time:			20.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			10.00		
Intra-Service Time:	10.00	15.00	20.00	30.00	70.00
Immediate Post Service-Time:	<u>10.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.50 99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	47525	Recommended Physician Work RVU: 1.90		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		19.00	19.00	0.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		20.00		
Immediate Post Service-Time:	<u>10.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
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Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49423	000	1.46	RUC Time

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>	<u>Time Source</u>	Most Recent <u>Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent <u>Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 22 % of respondents: 48.8 %

TIME ESTIMATES (Median)

	CPT Code: 47525	Key Reference CPT Code: 49423	Source of Time RUC Time
Median Pre-Service Time	25.00	15.00	
Median Intra-Service Time	20.00	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	

Prolonged Services Time	0.0	0.00
Median Total Time	55.00	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	2.45	1.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.55	2.05
Urgency of medical decision making	2.41	1.81

Technical Skill/Physical Effort (Mean)

Technical skill required	2.41	1.86
Physical effort required	2.00	1.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.73	1.72
Outcome depends on the skill and judgment of physician	2.82	1.90
Estimated risk of malpractice suit with poor outcome	1.95	1.48

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.32	2.00
Intra-Service intensity/complexity	3.59	1.90
Post-Service intensity/complexity	2.23	1.81

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 current physician work value for 47525 of 5.55 RVUs reflects a 10-day global period and results in an IWPUT of 0.14. The ACR and SIR are proposing a revised work value of 1.90 based on the 25% percentile survey recommendation; ensuring rank order when compared to related procedures.

Based on median survey times, the proposed physician work value for this service will result in an IWPUT of 0.02333

Physician work	RVU 1.90
Pre eval	20
Positioning	5
Scrub/Wait	10
Intra	20
Immediate Post	10
Post Op	99238- 0.5 Standard for 0-day global

IWPUT	RVW	1.90
Pre-service	$[(25 \times 0.0224) + (10 \times 0.0081)]$	0.64
Post-service	10×0.0224	0.22
99238	0.5×1.28	0.64
Intra	20	0.40
IWPUT	0.0200	

Based on survey pre-service times, the most appropriate pre-service package is 1b - Straightforward Patient/Straightforward Procedure (With sedation/anesthesia care), which if applied, results in an IWPUT of 0.02738

Physician work	RVU 1.90
Pre Eval/positioning	20
Scrub/Wait	5
Intra	20
Immediate Post	10
Post Op	99238- 0.5 Standard for 0-day global

IWPUT	RVW	1.90
Pre-service	$[(20 \times 0.0224) + (5 \times 0.0081)]$	0.47
Post-service	10×0.0224	0.22
99238	0.5×1.28	0.64
Intra	20	0.55
IWPUT	0.02738	

Code 47525 with a proposed work RVU of 1.90 is typically reported in conjunction with 75984 with a physician work RVU of 0.72; resulting in total proposed work RVUs of 2.62 for biliary catheter exchange performed using fluoroscopic guidance.

Rank Order Examination**Reference Service Code - believed to be less intensive**

Code 49423 RVU 1.46
 0-day global

Pre	15
Intra	30
Post	15

IWPUT		RVU	1.46
Pre-service	$[(15 \times 0.0224)]$		0.34
Post-service	15×0.0224		0.34
Intra	30		0.78
IWPUT	0.026		

Related Service External Ureteral Stent – believed to be more intensive than reference service but still less intensive than 47525

Code 50387 RVU 2.00
 0-day global

Pre Eval	19
Scrub/wait	10
Other pre	9
Intra	18
Post	10

IWPUT		RVU	2.00
Pre-service	$[(28 \times 0.0224) + (10 \times 0.0081)]$		0.71
Post-service	105×0.0224		0.22
Intra	18		1.07
IWPUT	0.0594 (Note: missing- 0.5-99238)		

Code 47525 with a proposed work RVU of 1.90 is typically reported in conjunction with 75984 with a physician work RVU of 0.72; resulting in total proposed work RVUs of 2.62 for biliary catheter exchange performed using fluoroscopic guidance.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☒ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 47525 reported with 75984; global periods 000 and XXX respectively; a proposed work RVUs of 1.90 and existing work RVU of 0.72, respectively. For TOTAL WORK RVUs 2.62

	pre-time	intra-time	post-time
47525	25 (1b-pre-service pkg)	20	10
75984*	1.5	11.25	2.25
TOTAL	26.5	31.25	12.25

*Only total time of 15 minutes is available in RUC database for 75984; assumption made that pre-service = 10%, intra-service = 75% and post service = 15%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 47525

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Interventional Radiology How often? Commonly

Specialty Other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 15100

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database Medicare claims data for 2006 is 10,620. It is believed that Medicare claims represent 70% of the total claims for this service.

Specialty Diagnostic Radiology Frequency 11050 Percentage 73.14 %

Specialty Interventional Radiology Frequency 3600 Percentage 23.84 %

Specialty Other Frequency 450 Percentage 2.98 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,620 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database Medicare claims data for 2006

Specialty Diagnostic Radiology Frequency 7770 Percentage 73.16 %

Specialty Interventional Radiology Frequency 2525 Percentage 23.77 %

Specialty Other Frequency 325 Percentage 3.06 %

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 Committee
Summary of Recommendations

October 2008 – Identified through High Volume Growth Screen

Cystourethroscopy

In April 2008, the RUC's Five Year Identification Workgroup identified codes 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands* and 52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy* through the high volume growth screen. The RUC recommended the elimination of the duplication between the electrocautery and the laser techniques as supplies and equipment for both modalities are currently included in the direct practice expense inputs. In October 2008, the RUC and the specialty society agreed with the elimination of the electrocautery supplies and equipment. **The RUC recommends the following revised direct practice expense inputs for codes 52214 and 52224.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	000	Review of PE Only
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	000	Review of PE Only

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands

Sample Size: _____ Response Rate: (%): _____ Global Period: _____

Geographic Practice Setting %: Rural _____ Suburban _____ Urban _____

Type of Practice %: _100_ 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 Panel consists of four urologists who represent urological practice from across the United States. They represent the states of Washington, Illinois, Virginia and New York. The panel reviews current information, makes recommendations and submits them to the AMA.

Reason for request:

The AUA is submitting these recommendations at the request of the RUC Five-Year Review Committee to research appropriate supplies and equipment to perform CPT code 52214. We have done so and are recommending the deletion of supplies and equipment for electrocautery for fulguration and retain the use of laser to perform this procedure.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy

Sample Size: _____ Response Rate: (%): _____ Global Period: _____

Geographic Practice Setting %: Rural _____ Suburban _____ Urban _____

Type of Practice %: 100 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 Panel consists of four urologists who represent urological practice from across the United States. They represent the states of Washington, Illinois, Virginia and New York. The panel reviews current information, makes recommendations and submits them to the AMA.

Reason for request:

The AUA is submitting these recommendations at the request of the RUC Five-Year Review Committee to research appropriate supplies and equipment to perform CPT code 52224. We have done so and are recommending the deletion of supplies and equipment for electrocautery for fulguration and retain the use of laser to perform this procedure.

	A	B	D	E
1	AMA Specialty Society RVS Update Committee Recommendation		52214	52224
2		CMS Code	Cysto, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	Cysto, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy
3	LOCATION		In Office	In Office
4	GLOBAL PERIOD		000	000
5	TOTAL CLINICAL LABOR TIME	L037D	80.0	78.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	18.0	18.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	62.0	60.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	0.0	0.0
9	PRE-SERVICE			
10	to have			
11	Complete pre-service diagnostic & referral forms	L037D	5	5
12	Coordinate pre-surgery services	L037D	3	3
13	Schedule space and equipment in facility			
14	Office visit before surgery/procedure: Review test and exam results			
15	Provide pre-service education/obtain consent	L037D	7	7
16	Follow-up phone calls & prescriptions	L037D	3	3
17	Other Clinical Activity (please specify)			
18	End:When patient enters office/facility for surgery/procedure			
19	SERVICE PERIOD			
20	Start: When patient enters office/facility for surgery/procedure			
21	Pre-service services			
22	Review charts	L037D	3	3
23	Greet patient and provide gowning	L037D	3	3
24	Obtain vital signs	L037D	3	3
25	Provide pre-service education/obtain consent			
26	Prepare room, equipment, supplies	L037D	2	2
27	Set up Scope	L037D	5	5
28	Prepare and position patient/ monitor patient/ set up IV	L037D	2	2
29	Sedate/apply anesthesia(RN)			
30	Intra-service			
31	Assist physician in performing procedure 2/3 MD time	L037D	23	21
32	Monitor IV sedation (RN)			
33	Post-Service			
34	Monitor pt. following service/check tubes, monitors, drains	L037D	2	2
35	Clean room/equipment by physician staff	L037D	3	3
36	Clean Scope	L037D	10	10
37	Complete diagnostic forms, lab & X-ray requisitions	L037D	3	3
38	Review/read X-ray, lab, and pathology reports			
39	Check dressings & wound/ home care instructions /coordinate o	L037D	3	3
40	Coordination of Care			
41	Discharge day management 99238 --12 minutes			
42	Other Clinical Activity (please specify)			
43	POST-SERVICE Period			
44	Start: Patient leaves office/facility			
45	Conduct phone calls/call in prescriptions			
46	Other Activity (please specify)			
47	End: with last office visit before end of global period			

	A	B	D	E
1	AMA Specialty Society RVS Update Committee Recommendation		52214	52224
2		CMS Code	Cysto, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	Cysto, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy
3	LOCATION		In Office	In Office
48	MEDICAL SUPPLIES			
49	pack, minimum multi-specialty visit	SA048	1	1
50	pack, cleaning and disinfecting	SA042	1	1
51	pack, urology cystoscopy visit	SA058	1	1
52	scissors	SA027		1
53	bugbee electrode	SD164	4	4
54	dressings, 3inx4in (Telfa, Release)	SG035		1
55	catheter, ureteral, open ended	SD033	1	
56	cautery pad	SF021	4	4
57	drainage bag	SJ031	1	1
58	foley catheter	SD024	1	1
59	underpad - chux (2ft x 3ft)	SB044	1	1
60	laser fiber, disposable	SF028	1	1
61	drape-towel, sterile (18in x 26in)	SB011	3	3
62	Equipment			
63	Light source	EQ167	1	1
64	Power table	EF031	1	1
65	Forceps, grasping	ES007	1	1
66	Mobile back table with wheels	EF027	1	1
67	Electrocautery	E30005	4	4
68	Albarran bridge	ES001	1	1
69	Cystoscopy, rigid	ES008	1	1
70	Laser generator	EQ153	1	1
71	Biopsy forceps	ES006	1	1
72				

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008 - CMS Request: Practice Expense Review

Cryoablation of Prostate

In June 2008, CMS requested the RUC to review direct practice expense recommendations for the non-facility setting for CPT Code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)*. The RUC initiated a level of interest process in June 2008 and in September 2008 received practice expense recommendation from Urology for review at the October 2008 RUC meeting.

The American Urological Association Quality Improvement and Patient Safety Committee maintained that procedure CPT Code 55873 may be performed in the office setting assuming that a Class C surgical facility designation for anesthesia has been achieved. The RUC reviewed the direct practice expense recommendation in the non-facility setting as presented by the specialty and realized the service was initially reviewed as a new code by the RUC in February 2001. RUC members believed that the intra-service physician time had most likely declined (from 200 minutes) as the service is now more often performed. The RUC agreed with the specialty that the service should be surveyed for physician work for presentation with revised direct practice expense input information at the next RUC meeting. **The RUC recommends that code 55873 be surveyed for physician work for presentation with revised direct practice expense inputs for the RUC's January 29 – February 1, 2009 meeting.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)	090	Review of Physician Work and Practice Expense at February 2009 RUC Meeting

AMA/Specialty Society RVS Update Committee
Health Care Professionals Advisory Committee (HCPAC)
Summary of Recommendations

October 2008

Speech Device Evaluation

The American Speech-Language Hearing Association (ASHA) requests that the HCPAC postpone review of speech device evaluation code 92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech*, until a future meeting in 2009. ASHA fully realizes the HCPAC needs to review the practice expense for CPT code 92597. However, due to the new legislation which allows speech language pathologists (SLP) to bill Medicare directly for their services starting in 2009 and the need to reassess the SLP services for the professional work component, ASHA is requesting postponement. ASHA has informed the HCPAC that they have submitted a request to CMS to establish work for all of their services.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	XXX	Postponement until Review of Entire Service

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008 - CMS Request of Audiology Services

Audiology Services

The American Speech-Language-Hearing Association (ASHA) met with CMS on September 8, 2006, and requested that CMS agree to consider establishing physician work relative values for services provided by audiologists. ASHA specifically requested that the professional work effort for audiologists providing these services be reflected in the work relative values rather than in the practice expense relative values. CMS responded to ASHA on November 14, 2006, and indicated that they agree to consider this possibility further. CMS advised the RUC and HCPAC that if the committee recommends the use of work values for the audiology services, CMS will consider their recommendation. CMS also indicated that the practice expense relative values would need to be adjusted as appropriate to avoid double counting of the audiologists' work effort.

In April 2007, the RUC reviewed and made work RVU recommendations for nine audiology services, which were implemented in January 2008. ASHA and the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) surveyed over 100 physicians and audiologists. At this meeting, October 2008, the RUC reviewed the remaining six audiology services.

92620 Evaluation of central auditory function, with report; initial 60 minutes

The RUC reviewed the specialty societies' survey results for CPT code 92620. The median survey data reflected an intra-service time in excess of 60 minute time definition of this code. The specialty societies indicated and the RUC agreed that median survey time of 85 minutes may have been the time estimate for the total service and, therefore, the median RVW may have been overstated. The specialty societies recommended and the RUC agreed that 60 minutes of intra-service time as indicated in the descriptor and close to the survey 25th percentile (56 minutes) is appropriate. The RUC also determined that the recommended pre-service time of 7 minutes for reviewing the patient history and audiometric results and immediate post-service time of 10 minutes to generate a report was appropriate. The specialty society recommended and the RUC agreed that the 25th percentile work RVU of 1.50 is an appropriate estimate of the work required to perform this service.

The RUC also compared 92620 to two additional codes to support this recommendation: 95972 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour* (work RVU = 1.50, 3 minutes pre-service, 60 minutes intra-service and 5 minutes post-service); and 95928 *Central motor evoked potential study (transcranial motor stimulation); upper limbs* (work RVU = 1.50, 15 minutes pre-service, 60 minutes intra-service and 15 minutes post service).

The RUC recommends the survey 25th percentile work RVU of 1.50 for code 92620.

92621 Evaluation of central auditory function, with report; each additional 15 minutes

The RUC reviewed add-on service 92621 with the understanding that the work required to perform 92621 is approximately one-fourth that of its 60 minute base code, 92620, for which the RUC recommends a work RVU of 1.50. Although the intra-service time is one-fourth of CPT 92620, because there are no pre- and post-time, the specialty societies recommended a slightly lower work RVU of 0.35. The RUC also reviewed the following reference codes to support a work RVU of 0.35 for this service: 92568 *Acoustic reflex testing; threshold* (work RVU = 0.29, 1 minute pre-service, 8 minutes intra-service and 1 minute post-service time); 97036 *Application of a modality to one or more areas; Hubbard tank, each 15 minutes* (work RVU = 0.28, 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service time); and 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU = 0.38, 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service time). **The RUC recommends a work RVU of 0.35 for code 92621.**

92625 Assessment of tinnitus (includes pitch, loudness matching, and masking)

The RUC reviewed the specialty societies' survey results for code 92625 and compared code it to 92604 *Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming* (work RVU = 1.25, 5 minutes pre-service, 50 minutes intra-service and 10 minutes post-service time) and determined that the intensity and complexity required for 92625 is slightly lower than that required for 92604. The RUC also compared 92625 to codes: 92557 *Comprehensive audiometry threshold evaluation and speech recognition* (work RVU = 0.60, 3 minutes pre-service, 20 minutes intra-service and 5 minutes post-service times); and 88361 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology* (work RVU = 1.18, 0 minutes pre-service time, 40 minutes intra-service time and 0 minutes post-service time).

The RUC determined that the survey median work RVU of 1.15 appropriately reflects the work required to perform this service. **The RUC recommends 7 minutes pre-service, 40 minutes intra-service, and 10 minutes post-service time and the survey median work RVU of 1.15 for code 92625.**

92626 Evaluation of auditory rehabilitation status; first hour

The RUC reviewed code 92626 and determined that this service requires slightly less intensity and complexity than code 92620 (recommended work RVU of 1.50). The specialty societies recommended and the RUC agreed that a work RVU of 1.40 for 92626 was appropriate. The intensity for 92626 with an RVU of 1.40 and 7 minutes pre-service, 60 minutes intra-service, and 10 minutes post-service times was calculated at 0.01699 which is slightly less than the IWPOT for 92620 (0.01865). The RUC also compared 92626 to codes 92602 *Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming* (work RVU = 1.30, 5 minutes pre-service, 50 minutes intra-service and 10 minutes post-service time); and 38211 *Transplant preparation of hematopoietic progenitor cells; tumor cell depletion* (work RVU = 1.42, 5 minutes pre-service, 60 minutes intra-service and 10 minutes post-service time) in relation to the physician work time and intensity. **The RUC recommends a work RVU of 1.40 for code 92626.**

92627 Evaluation of auditory rehabilitation status; each additional 15 minutes

The RUC reviewed the specialty societies' survey results for this add-on service 92627. The specialty societies recommended that the work required to perform 92627 is approximately one-fourth that of its 60 minute base code, 92626, therefore the RUC recommends a work RVU of 1.40. The intensity for this service is higher than the intensity for 92626 due to testing beyond the first hour and the need to maintain the patient's attention to obtain accurate test measurements of residual hearing function. Additionally, although the intra-service time is one-fourth of CPT 92620, because there are no pre- and post-time, the specialty societies recommended a slightly lower work RVU of 0.33.

The RUC also reviewed the following reference codes to support a work RVU of 0.33 for this service: 92568 *Acoustic reflex testing; threshold* (work RVU = 0.29, 1 minute pre-service, 8 minutes intra-service and 1 minute post-service time); 97036 *Application of a modality to one or more areas; Hubbard tank, each 15 minutes* (work RVU = 0.28, 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service time); and 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU = 0.38, 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service time). **The RUC recommends a work RVU of 0.33 for code 92627.**

92640 Diagnostic analysis with programming of auditory brainstem implant, per hour

The RUC reviewed the specialty societies' survey results for CPT code 92640. The median survey data reflected an intra-service time in excess of 60 minute time definition of this code. The specialty societies indicated and the RUC agreed that median survey time of 95 minutes may have been the time estimate for the total service and, therefore, the median work RVU may have been overstated. The specialty societies recommended and the RUC agreed that 60 minutes of intra-service time as indicated in the descriptor is appropriate. The RUC also determined that the recommended pre-service time of 4 minutes for describing the various components of programming the brainstem implant and immediate post-service time of 5 minutes was appropriate. The specialty society recommended the survey 25th percentile work RVU of 1.76, which is appropriate because the 60 minutes of intra-service time falls between the survey 25th percentile and median times (43.75 minutes and 95 minutes). The RUC agreed that the 25th percentile work RVU of 1.76 is an appropriate estimate of the work required to perform this service.

The RUC also compared 92620 to two additional codes to support this recommendation: 96125 *Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report* (work RVU = 1.70, 0 minutes pre-service, 60 minutes intra-service and 0 minutes post-service time); and 96116 *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 interpreting test results and preparing the report* (work RVU = 1.86, 7 minutes pre-service, 60 minutes intra-service and 0 minutes post-service time).

The RUC recommends the survey 25th percentile work RVU of 1.76 for code 92640.

Practice Expense

The RUC recommends removing the associated audiologists' time from the direct practice expense inputs, as all physician and audiologist work is captured in the work RVU.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
92620	Evaluation of central auditory function, with report; initial 60 minutes	XXX	1.50
+92621	Evaluation of central auditory function, with report; each additional 15 minutes	ZZZ	0.35
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	XXX	1.15
92626	Evaluation of auditory rehabilitation status; first hour	XXX	1.40
+92627	Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure)	ZZZ	0.33
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour	XXX	1.76

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 92620 Tracking Number

Specialty Society Recommended RVU: **1.50**

Global Period: XXX

RUC Recommended RVU: **1.50**

CPT Descriptor: Evaluation of central auditory function, with report; initial 60 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A seven-year old male was referred for a comprehensive evaluation of auditory processing abilities due to academic difficulties and a discrepancy between IQ potential and classroom performance. A prior hearing evaluation indicated that hearing sensitivity was normal for all test frequencies.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The health care professional reviewed the referral information, pertinent written case history and audiometric results.

Description of Intra-Service Work: After greeting the family and bringing them to the audiometric booth, a history was taken to obtain information on developmental, familial, and medical factors that may have impacted the child's auditory processing abilities. The child was then seated in the sound treated room and earphones were positioned. The child was initially instructed to listen carefully to words that may be hard to understand. His task was to repeat the word or sentence to the best of his abilities and guess at individual responses when he is not sure. The audiologist leaves the child in the patient side of the audiometric booth and takes a seat behind the diagnostic audiometer, while maintaining eye contact with the child. Each test is played via CD or cassette tape and routed through the diagnostic audiometer. The audiologist records the child's responses on respective scoring forms for each test. After administration of each test, the audiologist determines the raw and standard scores and plots the standard scores for a visual representation of the child's performance. Before the administration of each new test, the child receives instructions through the earphones with regard to the nature of the task and the child's required responses. The audiologist must not only record the child's responses, but must also monitor the child's performance to ensure that the child can continue to tend to the task at hand and is not beginning to fatigue. After administering all necessary tests, the audiologist compiles the respective scores to derive an interpretation of the age-equivalent performance level and types of stimuli and environments that will cause difficulties for the child. The results, interpretation, and recommendations are then conveyed to the accompanying family members.

Description of Post-Service Work: Representatives of the other professional disciplines (e.g., educator, psychologist) are notified of the test results and interpretation in the event that these findings influence the conclusions and recommendations generated by their respective test results.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008				
Presenter(s):	Robert Fifer, PhD, Jane Dillon, MD, Paul Pessis, AuD, Peter Weber, MD				
Specialty(s):	audiology, otolaryngology				
CPT Code:	92620				
Sample Size:	200	Resp N:	60	Response: 30.0 %	
Sample Type:	Convenience				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	15.00	40.00	300.00
Survey RVW:	0.00	1.50	1.87	2.21	10.00
Pre-Service Evaluation Time:			20.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	56.25	85.00	120.00	240.00
Immediate Post Service-Time:	<u>52.50</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	92620	Recommended Physician Work RVU: 1.50		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		7.00	13.00	-6.00
Pre-Service Positioning Time:		0.00	1.00	-1.00
Pre-Service Scrub, Dress, Wait Time:		0.00	6.00	-6.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	<u>10.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0		
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96101	XXX	1.86	RUC Time

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 administering tests to the patient and time interpreting these test results and preparing the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90801	XXX	2.80	RUC Time	1,349,524

CPT Descriptor 1 Psychiatric diagnostic interview examination

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99385	XXX	1.53	RUC Time	0

CPT Descriptor 2 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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 30.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> <u>92620</u>	<u>Key Reference CPT Code:</u> <u>96101</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	7.00	7.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	77.00	77.00
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	4.05	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.23	3.80
Urgency of medical decision making	2.98	3.27

Technical Skill/Physical Effort (Mean)

Technical skill required	4.30	4.08
Physical effort required	2.87	2.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	2.40
Outcome depends on the skill and judgment of physician	4.18	4.08
Estimated risk of malpractice suit with poor outcome	2.38	2.83

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.13	2.77
Intra-Service intensity/complexity	4.20	3.85
Post-Service intensity/complexity	4.10	3.67

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an WPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

With guidance received on October 3, 2008, from the RUC Pre-facilitation Committee, the American Speech-Language-Hearing Association, the American Academy of Audiology, and the American Academy of Otolaryngology – Head and

Neck Surgery are recommending an RVW of 1.50 based on the 25th percentile of the survey. The median survey data reflected an intra-service time in excess of 60 minute time definition of this code. We concluded that median time of 85 minutes may have been the time estimate for the total service and, therefore, the median RVW may have been overstated for that reason. The RVW recommended at the 25th percentile data of 1.50 is a realistic and reasonable estimate of the work involved in performing this service

We also note that the resulting IWPUT for this code (0.019) is consistent with those for other audiology procedures, including the highest volume code 92557 and with other XXX codes, including a midlevel office visit (99213 – IWPUT of 0.049), a physical therapy evaluation (97001 – IWPUT of 0.031), and ECG interpretation and report (93010 – IWPUT of 0.037). The IWPUT is substantially less than for these procedures

This value was also supported by comparing it to two additional codes.

95972 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour. RVW = 1.50. 3 minutes pre-service, 60 minutes intra-service, 5 minutes post-service.

95928 Central motor evoked potential study (transcranial motor stimulation); upper limbs. RVW = 1.50. 15 minutes pre-service, 60 minutes intra-service, 15 minutes post service.

The American Speech-Language-Hearing Association, the American Academy of Otolaryngology – Head and Neck Surgery and the American Academy of Audiology had convened a consensus panel to discuss the survey data and reach a final recommendation. We started with the combined survey data and then discussed the procedure and the times and value that was appropriate. The new (10/4/08) IWPUT (0.019) ensures that it is reasonable when compared to other XXX codes including a midlevel office visit (99213 – IWPUT of 0.049), a physical therapy evaluation (97001 – IWPUT of 0.031), and ECG interpretation and report (93010 – IWPUT of 0.037). The IWPUT is substantially less than for these procedures.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code is typically reported with the add-on code, 92621 (each additional 15 minutes)

CPT	Global Period	Work Value
92621	ZZZ	0.00

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 audiology How often? Sometimes

Specialty otolaryngology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15600

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. Consensus panel discussion - this is a procedure provided primarily to a pediatric population.

Specialty audiology Frequency 5000 Percentage 50.00 %

Specialty otolaryngology Frequency 5000 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?

1,200 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC data base

Specialty audiology Frequency 408 Percentage 34.00 %

Specialty otolaryngology Frequency 492 Percentage 41.00 %

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? No

If no, please select another crosswalk and provide a brief rationale. 97001, PLI RVU= 0.05, performed by similar non-MD profession and 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: 92621 Tracking Number

Specialty Society Recommended RVU: **0.35**

Global Period: ZZZ

RUC Recommended RVU: **0.35**

CPT Descriptor: Evaluation of central auditory function, with report; each additional 15 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A seven-year-old male was referred for a comprehensive evaluation of auditory processing abilities due to academic difficulties and a discrepancy between IQ potential and classroom performance. A prior hearing evaluation indicated the hearing sensitivity was normal for all test frequencies.

Percentage of Survey Respondents who found Vignette to be Typical: 91 %

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: None

Description of Intra-Service Work: Tests are continued to be played via CD or cassette tape and routed through the diagnostic audiometer. The audiologist continues to record the child's responses on respective scoring forms for each test. After administration of each test, the audiologist determines the raw and standard scores and plots the standard scores for a visual representation of the child's performance. Before the administration of each new test, the child receives instructions through the earphones with regard to the nature of the task and the child's required responses. The audiologist must not only record the child's responses, but must also monitor the child's performance to ensure that the child can continue to tend to the task at hand and is not beginning to fatigue.

Description of Post-Service Work: Communication with specialists in other disciplines.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008				
Presenter(s):	Robert Fifer, PhD, Jane Dillon, MD, Paul Pessis, AuD, Peter Weber, MD				
Specialty(s):	audiology and otolaryngology				
CPT Code:	92621				
Sample Size:	198	Resp N:	48	Response: 24.2 %	
Sample Type:	Convenience				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.50	13.00	41.00	500.00
Survey RVW:	0.00	0.49	0.77	1.59	5.00
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	15.00	15.00	60.00	240.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	92621	Recommended Physician Work RVU: 0.35		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	13.00	-13.00
Pre-Service Positioning Time:		0.00	1.00	-1.00
Pre-Service Scrub, Dress, Wait Time:		0.00	6.00	-6.00
Intra-Service Time:		15.00		
Immediate Post Service-Time:	0.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00 57x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92557	XXX	0.60	RUC Time

CPT Descriptor Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92083	XXX	0.50	RUC Time	2,519,141

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30°, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97110	XXX	0.45	RUC Time	29,272,311

CPT Descriptor 2 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 9 % of respondents: 18.7 %

TIME ESTIMATES (Median)

	CPT Code: 92621	Key Reference CPT Code: 92557	Source of Time RUC Time
Median Pre-Service Time	0.00	3.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	0.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	15.00	28.00
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	4.12	3.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.27	3.76
Urgency of medical decision making	2.85	3.22

Technical Skill/Physical Effort (Mean)

Technical skill required	4.34	4.00
Physical effort required	2.80	2.56

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.20	2.50
Outcome depends on the skill and judgment of physician	4.39	4.00
Estimated risk of malpractice suit with poor outcome	2.49	2.98

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.76	2.51
Intra-Service intensity/complexity	3.90	3.68
Post-Service intensity/complexity	3.73	3.10

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an WPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

With guidance received on October 3, 2008, from the RUC Pre-facilitation Committee, the American Speech-Language-Hearing Association, the American Academy of Audiology, and the American Academy of Otolaryngology – Head and Neck Surgery are recommending an RVW of 0.35. This is a 15 minute add-on code to the 60 minute base code, 92620, for which a 1.50 RVW is recommended. Although the intra- time is one-fourth of CPT 92620, because there are no pre- and post-time, we are recommending a slightly lower RVW or 0.35.

The IWPUT for this code (0.023) is generally consistent with the IWPUT for other audiology codes and is substantially lower than the IWPUT assigned to other XXX codes such as a midlevel office visit (99213 – IWPUT of 0.049), a physical therapy evaluation (97001 – IWPUT of 0.031), and ECG interpretation and report (93010 – IWPUT of 0.037).

The recommended value of 92621 was also supported by comparing it to two additional codes.

97036 Application of a modality to one or more areas; Hubbard tank, each 15 minutes.
RVW = 0.28. 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service time.

93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete. RVW = 0.38. 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service times.

The American Speech-Language-Hearing Association, the American Academy of Otolaryngology – Head and Neck Surgery and the American Academy of Audiology had convened a consensus panel to discuss the survey data and reach a final recommendation. We started with the combined survey data and then discussed the procedure and the times and value that was appropriate. The new (10/04/08) IWPUT (0.023) ensures it was reasonable when compared to XXX codes including a midlevel office visit (99213 – IWPUT of 0.049), a physical therapy evaluation (97001 – IWPUT of 0.031), and ECG interpretation and report (93010 – IWPUT of 0.037). The IWPUT is substantially less than for these procedures.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This is an add-on code that is billed with the base code 92620

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 Audiology How often? Sometimes

Specialty Otolaryngology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. Consensus panel discussion - this is a procedure provided primarily to a pediatric population

Specialty Audiology Frequency 2600 Percentage 50.00 %

Specialty Otolaryngology Frequency 2600 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? 19

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Data Base

Specialty Audiology Frequency 12 Percentage 63.15 %

Specialty Otolaryngology Frequency 7 Percentage 36.84 %

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? No

If no, please select another crosswalk and provide a brief rationale. 97012, PLI RVU= 0.01, performed by similar non-MD profession and 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: 92625 Tracking Number

Specialty Society Recommended RVU: **1.15**

Global Period: XXX

RUC Recommended RVU: **1.15**

CPT Descriptor: Assessment of tinnitus (includes pitch, loudness matching, and masking)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 69-year-old female is reporting the onset of a constant, irritating, high pitched sound in both ears. She now finds that she has considerable difficulty in going to sleep because the perceived loudness appears to increase and is most bothersome during the quiet times of the day.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The audiologist reviews pertinent case history and audiometric results.

Description of Intra-Service Work: The audiologist greets the patient and accompanies her to the testing suite. The audiologist prepares the patient by inserting earphones into each ear canal after otoscopic inspection. The audiologist then sits at the diagnostic audiometer in the control booth facing the patient in the test booth. Pitch (frequency) matching is accomplished by individually presenting nine frequencies (500, 750, 1000, 1500, 2000, 3000, 4000, 6000 and 8000 Hz) using a two-alternative forced-choice procedure (2AFC) whereby the patient must choose which tone is closest in pitch to her self-perceived tone. The audiometric tones are presented at intensity levels slightly above the patient's auditory threshold at each frequency. The patient describes the pitch of the stimulus as higher, lower, or similar to her perceived sound. This pitch bracketing process continues until the patient states that the stimulus is the same as or very similar to her perceived sound or is fully bracketed between adjacent half-octave frequencies. This procedure is then performed on the patient's other ear. Loudness matching testing is then performed by presenting a series of pure tones and the patient is asked to report if each presented tone is louder, softer or equal in loudness to the self-perceived sound.

Typically, octave and mid-octave frequencies from 500 Hz to 8000 Hz are presented at intensity levels slightly above the patient's auditory threshold at each frequency. The intensity level of the stimulus is increased or decreased in 1 dB steps by the audiologist. When the patient reports the external stimulus as being equal in loudness to her self-perceived sound, this level is recorded as the loudness match (in dB) for that frequency. Equal loudness estimates are calculated in dB SL (loudness match in dB HL minus the auditory threshold in dB HL at that frequency). This loudness matching procedure is performed for each ear separately, resulting in eighteen (nine matches per ear) loudness matches between the stimulus and the patient's self-perceived sound. Instructions regarding the masking procedure are then given to the patient and masking stimuli are presented to the same earphone as the perceived tone. Ten individual masking stimuli nine frequencies of narrow band noise at octave and mid-octave frequencies from 500 - 8000 Hz as well as wide band noise) are individually increased in intensity from threshold in 1-2 dB steps until masking of the tinnitus is accomplished.

The Minimum Masking Level (MML) is recorded in dB SL (SL=Sensation Level, e.g., the effective tinnitus masking level in dB HL minus the auditory threshold for the masking stimulus) for each masking stimulus. Comparative measurements between the various forms of maskers are needed to select the masker with the greatest efficiency in

providing the most effective masking stimulus. This procedure is performed for each ear independently and for binaural stimulation for those patients with bilateral tinnitus. The audiologist then presents the most effective masking stimulus at +10 to +15 dB SL (above the MML) continuously for 60 seconds. The patient is asked to report if her perceived tinnitus increased, decreased or was unchanged after cessation of the masking stimulus. The length of time the patient is without perception of the tinnitus is determined and the duration of tinnitus suppression ("residual inhibition") is calculated.

The patient is informed of the outcome of the evaluation and the potential for remediation.

Description of Post-Service Work: The referring physician is notified verbally of the outcomes and recommendations. A report is also written regarding the evaluation results and recommendations regarding tinnitus masking strategies and/or other nonmedical intervention regimens.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2008			
Presenter(s):	Robert Fifer, PhD, Jane Dillon, MD, Paul Pessis, AuD, Peter Weber, MD				
Specialty(s):	audiology, otolaryngology				
CPT Code:	92625				
Sample Size:	170	Resp N:	46	Response: 27.0 %	
Sample Type: Convenience					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.50	20.00	48.00	150.00
Survey RVW:	0.00	0.70	1.15	1.69	9.99
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	20.00	40.00	60.00	120.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	92625	Recommended Physician Work RVU: 1.15		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		7.00	13.00	-6.00
Pre-Service Positioning Time:		0.00	1.00	-1.00
Pre-Service Scrub, Dress, Wait Time:		0.00	6.00	-6.00
Intra-Service Time:		40.00		
Immediate Post Service-Time:	10.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0		
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92557	XXX	0.60	RUC Time

CPT Descriptor Comprehensive audiometry threshold evaluation and speech recognition (92543 and 92556 combined)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99214	XXX	1.42	RUC Time	62,901,327

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A 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>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95819	XXX	1.08	RUC Time	345,912

CPT Descriptor 2 Electroencephalogram (EEG); including recording awake and asleep

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 13 % of respondents: 28.2 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> <u>92625</u>	<u>Key Reference CPT Code:</u> <u>92557</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	7.00	3.00	
Median Intra-Service Time	40.00	20.00	
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	
Prolonged Services Time	0.0	0.00	

Median Total Time	57.00	28.00
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	3.54
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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	3.48
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Urgency of medical decision making	2.98	3.09
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.07	3.76
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Physical effort required	2.57	2.50
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.50	2.70
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Outcome depends on the skill and judgment of physician	4.02	3.85
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Estimated risk of malpractice suit with poor outcome	2.52	3.00
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INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.50	2.48
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Intra-Service intensity/complexity	3.87	3.67
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Post-Service intensity/complexity	3.46	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 WPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

With guidance received on October 3, 2008, from the RUC Pre-facilitation Committee, the American Speech-Language-Hearing Association, the American Academy of Audiology, and the American Academy of Otolaryngology – Head and

Neck Surgery are recommending an RVW of 1.15 based on the median value of the survey. The associated IWPUT was 0.019 with 7 minutes pre-service, 40 minutes intra-service, and 10 minutes post-service times. This value is further supported through comparison with two other codes.

38361 Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology. RVW = 1.18. 0 minutes pre-service time, 40 minutes intra-service time, and 0 minutes post-service time.

92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined). RVW = 0.60. 3 minutes pre-service, 20 minutes intra-service, 5 minutes post-service times.

The American Speech-Language-Hearing Association, the American Academy of Otolaryngology – Head and Neck Surgery and the American Academy of Audiology had convened a consensus panel to discuss the survey data and reach a final recommendation. We started with the combined survey data and then discussed the procedure and the times and value that was appropriate. The new IWPUT (0.019) ensure that it was reasonable when compared to other XXX codes including a midlevel office visit (99213 – IWPUT of 0.049), a physical therapy evaluation (97001 – IWPUT of 0.031), and ECG interpretation and report (93010 – IWPUT of 0.037). The IWPUT is substantially less than for these procedures.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 Audiology How often? Sometimes

Specialty Otolaryngology How often? Sometimes

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. Please explain the rationale for this estimate. The procedure was billed to Medicare 2,318 times during 2006 so a reasonable estimate would add approximately 2,500 more adults to this number.

Specialty Audiology	Frequency 2500	Percentage 50.00 %
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Specialty Otolaryngology	Frequency 2500	Percentage 50.00 %
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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? 2,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare billing has 62% for otolaryngology and 32% for independently billing audiologists.

Specialty Otolaryngology	Frequency 1500	Percentage 60.00 %
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Specialty Audiology	Frequency 800	Percentage 32.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? 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. 97001, PLI RVU= 0.05, performed by similar non-MD profession and 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: 92626 Tracking Number Specialty Society Recommended RVU: **1.40**

Global Period: XXX RUC Recommended RVU: **1.40**

CPT Descriptor: Evaluation of auditory rehabilitation status; first hour

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A three-year-old male with a history of profound sensorineural hearing loss received a cochlear implant. After activation and programming of the implant device for minimum and maximum stimulation across the electrodes, the child is referred for an evaluation of aural rehabilitation status to determine current auditory perceptual abilities and to develop an individualized plan of aural rehabilitation.

Percentage of Survey Respondents who found Vignette to be Typical: 61%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The 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.

Description of Intra-Service Work: 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.

Description of Post-Service Work: The audiologist writes a report and communicates verbally with the referring physician, the audiologist or speech-language pathologist who will be providing the auditory rehabilitation, and the child's classroom teacher.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008				
Presenter(s):	Robert Fifer, PhD, Jane Dillon, MD, Paul Pessis, AuD, Peter Weber, MD				
Specialty(s):	Audiology and Otolaryngology				
CPT Code:	92626				
Sample Size:	161	Resp N:	34	Response: 21.1 %	
Sample Type:	Convenience				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	11.00	50.00	200.00
Survey RVW:	0.00	0.99	1.46	1.88	3.20
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	32.50	50.00	60.00	90.00
Immediate Post Service-Time:	17.50				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55), 99211 (7); 99212 (16); 99213 (23); 99214 (40), 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	92626	Recommended Physician Work RVU: 1.40		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		7.00	13.00	-6.00
Pre-Service Positioning Time:		0.00	1.00	-1.00
Pre-Service Scrub, Dress, Wait Time:		0.00	6.00	-6.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	10.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00 57x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99243	XXX	1.88	RUC Time

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. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92004	XXX	1.82	RUC Time	2,107,931

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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99214	XXX	1.42	RUC Time	62,901,327

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A 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>	<u>Time Source</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: 8 % of respondents: 23.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 92626	<u>Key Reference CPT Code:</u> 99243	<u>Source of Time</u> RUC Time
Median Pre-Service Time	7.00	5.00	
Median Intra-Service Time	60.00	25.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	77.00	40.00
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	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.85	3.62
Urgency of medical decision making	3.00	3.06

Technical Skill/Physical Effort (Mean)

Technical skill required	4.06	3.82
Physical effort required	2.94	2.71

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.90	2.30
Outcome depends on the skill and judgment of physician	3.94	3.85
Estimated risk of malpractice suit with poor outcome	2.21	2.59

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.97	2.74
Intra-Service intensity/complexity	4.03	3.77
Post-Service intensity/complexity	3.38	3.12

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.*

With guidance received on October 3, 2008, from the RUC Pre-facilitation Committee, the American Speech-Language-Hearing Association, the American Academy of Audiology, and the American Academy of Otolaryngology – Head and Neck Surgery are recommending an RVW of 1.40. This value was derived in part on magnitude estimation compared to the value of CPT code 92620 which was considered to be of greater intensity than 92626. The IWPUT for 92626 with times of 7 minutes pre-service, 60 minutes intra-service, and 10 minutes post-service times was calculated at 0.017 which is slightly less than the IWPUT for 92620. Further support of this value comes from comparison with the following code:

38211 Transplant preparation of hematopoietic progenitor cells; tumor cell depletion. RVW = 1.42. 5 minutes pre-service, 60 minutes intra-service, and 10 minutes post-service times.

The American Speech-Language-Hearing Association, the American Academy of Otolaryngology – Head and Neck Surgery and the American Academy of Audiology had convened a consensus panel to discuss the survey data and reach a final recommendation. We started with the combined survey data and then discussed the procedure and the times and value that was appropriate. The new IWPUT (0.017) ensure that it was reasonable when compared to other XXX codes including a midlevel office visit (99213 – IWPUT of 0.049), a physical therapy evaluation (97001 – IWPUT of 0.031), and ECG interpretation and report (93010 – IWPUT of 0.037). The IWPUT is substantially less than for these procedures.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code is typically reported with the add on code 92627 (each additional 15 minutes)

3.	CPT	Global Period	Work RVU
4.	92627	ZZZ	0.00

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 Audiology How often? Commonly

Specialty Otolaryngology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate.

Specialty Audiology Frequency 7500 Percentage 75.00 %

Specialty Otolaryngology Frequency 2500 Percentage 25.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

3,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. RUC data base

Specialty Audiology Frequency 1750 Percentage 50.00 %

Specialty Otolaryngology Frequency 1604 Percentage 45.82 %

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. 97001, PLI RVU= 0.05, performed by similar non-MD profession and 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: 92627

Tracking Number

Specialty Society Recommended RVU: **0.33**

Global Period: ZZZ

RUC Recommended RVU: **0.33**CPT Descriptor: Evaluation of auditory rehabilitation status; each additional 15 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A three-year-old male with a history of profound sensorineural hearing loss received a cochlear implant. After activation and programming of the implant device for minimum and maximum stimulation across the electrodes, the child is referred for an evaluation of aural rehabilitation status to determine current auditory perceptual abilities and to develop an individualized plan of aural rehabilitation.

Percentage of Survey Respondents who found Vignette to be Typical: 59%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: None

Description of Intra-Service Work:

The 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.

Description of Post-Service Work: The audiologist writes a report and communicates verbally with the referring physician, the audiologist or speech-language pathologist who will be providing the auditory rehabilitation, and the child's classroom teacher.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008				
Presenter(s):	Robert Fifer, PhD, Jane Dillon, MD, Paul Pessis, AuD, Peter Weber, MD				
Specialty(s):	Audiology and Otolaryngology				
CPT Code:	92627				
Sample Size:	150	Resp N:	27	Response: 18.0 %	
Sample Type:	Convenience				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	10.00	15.50	150.00
Survey RVW:	0.00	0.55	0.75	1.09	1.98
Pre-Service Evaluation Time:			2.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	14.50	15.00	22.50	90.00
Immediate Post Service-Time:	7.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	92627	Recommended Physician Work RVU: 0.33		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	13.00	-13.00
Pre-Service Positioning Time:		0.00	1.00	-1.00
Pre-Service Scrub, Dress, Wait Time:		0.00	6.00	-6.00
Intra-Service Time:		15.00		
Immediate Post Service-Time:	0.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0		
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99213	XXX	0.92	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97110	XXX	0.45	RUC Time	29,272,311

CPT Descriptor 1 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99211	XXX	0.17	RUC Time	9,869,521

CPT Descriptor 2 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>	<u>Time Source</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: 5 % of respondents: 18.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 92627	<u>Key Reference CPT Code:</u> 99213	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	5.00	
Median Immediate Post-service Time	0.00	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
Prolonged Services Time	0.0	0.00
Median Total Time	15.00	7.00
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.41	3.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.48	3.30
Urgency of medical decision making	2.78	2.85

Technical Skill/Physical Effort (Mean)

Technical skill required	4.22	3.81
Physical effort required	2.89	2.70

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.10	2.30
Outcome depends on the skill and judgment of physician	4.11	3.70
Estimated risk of malpractice suit with poor outcome	2.07	2.41

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.74	2.89
Intra-Service intensity/complexity	4.04	3.82
Post-Service intensity/complexity	3.04	2.85

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.*

With guidance received on October 3, 2008, from the RUC Pre-facilitation Committee, the American Speech-Language-Hearing Association, the American Academy of Audiology, and the American Academy of Otolaryngology – Head and Neck Surgery are recommending an RVW of 0.33. The rationale for this value is based on a proration of the base code (92626) value of 1.40. The IWPUT this code increased to 0.022 compared to an IWPUT for 92626 (0.017) due to increased intensity of testing beyond the first hour and the need to maintain the patient's attention in order to obtain accurate test measurements of residual hearing function. This value of 92627 was also supported by comparing it to two additional codes.

97036 Application of a modality to one or more areas; Hubbard tank, each 15 minutes.

RVW = 0.28. 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service time.

93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete. RVW – 0.38. 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service times.

The American Speech-Language-Hearing Association, the American Academy of Otolaryngology – Head and Neck Surgery and the American Academy of Audiology had convened a consensus panel to discuss the survey data and reach a final recommendation. We started with the combined survey data and then discussed the procedure and the times and value that was appropriate. The new IWPUT (0.022) ensures that it was reasonable when compared to XXX codes including a midlevel office visit (99213 – IWPUT of 0.049), a physical therapy evaluation (97001 – IWPUT of 0.031), and ECG interpretation and report (93010 – IWPUT of 0.037). The new IWPUT is substantially less than for these procedures.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code is an add on code typically billed with the base code of 92626

CPT	Global Period	Work RVUs
92626	XXX	0.00

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 Audiology How often? Sometimes

Specialty Otolaryngology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. We expect that at least half the patients who have an auditory rehabilitation evaluation will need additional time for the procedure because children will need a slower pace while adults may need additional testing.

Specialty Audiology Frequency 3500 Percentage 70.00 %

Specialty Otolaryngology Frequency 1500 Percentage 30.00 %

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? 576

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC data base

Specialty Audiology Frequency 70 Percentage 12.15 %

Specialty Otolaryngology Frequency 478 Percentage 82.98 %

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? No

If no, please select another crosswalk and provide a brief rationale. 97012, PLI RVU= 0.01, performed by similar non-MD profession and 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: 92640 Tracking Number

Specialty Society Recommended RVU: **1.76**

Global Period: XXX

RUC Recommended RVU: **1.76**

CPT Descriptor: Diagnostic analysis with programming of auditory brainstem implant, per hour

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30 year old male was seen with a diagnosis of neurofibromatosis type 2 (NF2) for whom bilateral mass lesions of the VIIIth cranial nerve were diagnosed and resected. After six weeks of post-operative healing, the patient was referred for auditory brainstem implant programming.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The audiologist meets with the patient and the patient's family and describes the nature of the procedure. The audiologist explains the usual length of the procedure (two visits of four hours each) and what occurs with the various components of the programming of the implant

Description of Intra-Service Work: Description of Procedure
Location of the Implanted Receiver/Stimulator

The audiologist's first step is the locating of the ABI receiver/stimulator. The patient's receiver/stimulator magnet was removed at the time of implantation because he must have MRIs in the future to follow other NF2-related central nervous system tumors. Without the magnet in place, the externally worn transmitter coil will not "self-center" over the receiver/stimulator antenna. Locating this precise spot requires a combination of steps including palpation of the area above and behind the patient's ear and software tests linking to the implant for telemetric purposes. If the audiologist fails to establish a 100% effective link, a misidentification of the patient as a "non-stimulating" patient will occur with the possible result of a wasting of the implant device.

"Threshold" Testing and Magnitude Scaling of Non-Auditory Sensations

After locating the receiver/stimulator the audiologist instructs the patient to indicate when a stimulus is perceived, electrical stimuli are then introduced at increasing intensities using programming software designed for ABI testing. The first step elicits responses regarding the onset (threshold) of either auditory or non-auditory sensations. The thresholds are recorded for each electrode. The patient experiences some non-auditory sensations (tingling sensations, dizziness, or some slight "jittering" of the visual field). The audiologists is not able to include 30% of ABI electrodes in the final program because of annoying non-auditory side effects. The audiologist notes that approximately 50% of electrodes elicited some non-auditory sensations that require adjustment of the stimulation parameters in order to eliminate or reduce these non-auditory sensations. The patient judged the magnitude of non-auditory sensations on a 4-point scale (1=barely noticeable and 4=intolerable). These judgments were recorded so that the electrodes can be retained for use

if they elicit only mild non-auditory sensations and because it is generally beneficial to retain as many electrodes as possible for best performance.

“Comfortable Loudness Level” Testing

After threshold testing, the electrical stimulus levels are raised in amplitude to establish comfortable loudness levels for auditory sensations and to determine if new non-auditory sensations appear or change in character or magnitude. These values are recorded, and the magnitude of non-auditory sensations is again scaled and recorded.

The audiologist monitors the charge density being presented to ABI electrodes (determined by the stimulus pulse duration and the actual current level used) and prevent charge levels from exceeding the established safety limits. This may rule out the use of some electrodes by the patients, or require special counseling and monitoring of threshold and comfort levels in patients who are extremely restricted in the number of electrodes that they have available for use.

Management of Non-Auditory Sensations

The audiologist eliminates non-auditory sensations in magnitude by changing stimulus parameters such as pulse duration (usually by increasing this value) or by changing stimulus geometry by altering the selection of reference ground electrode or electrode stimulus pairs. Special software features and knowledge are used for this process to proceed in an efficient and organized fashion. An understanding of the changes that can occur in brainstem electrical fields guides the process of eliminating or reducing non-auditory effects. Non-auditory sensations that cannot be eliminated require the de-activation and non-use of the electrode.

Loudness Balancing

After establishing which electrodes may be potentially useful for providing auditory sensations, and their respective threshold and comfortable loudness levels, the audiologist balances the loudness on these electrodes in preparation for the next step in the fitting process: pitch scaling and ranking. This step is done to help control any variable effects of loudness differences on pitch. The reason these percepts are important is that ABI sound processors code frequency-specific information on different electrodes in a fashion similar to cochlear implants (e.g., lower frequencies to electrodes that tend to sound lower in pitch).

Pitch Magnitude Scaling

Prior to the psychophysical scaling of ABI pitch magnitude, the audiologist compares each electrode to the other electrodes at the previously obtained comfort level, and the individual current levels are balanced until all electrodes have the same loudness level. The patient is then asked to assign a number for the pitch of the sound on each electrode using a 1-100 (1=low pitch, 100=high pitch) magnitude scale. Due to the absence of prior experience, the magnitude estimates are expected to vary from test to retest. The audiologist obtains multiple estimates of pitch magnitude so that a mean and standard deviation of the judgments can be calculated. The mean pitch scale values from this testing yields important information about the distribution of electrode-specific pitch across the pitch range.

Pitch Scanning

For pitch scanning, the audiologist activates each available electrode in sequence and the ABI recipient is asked to select the electrode with the lowest (or the highest) pitch percept. This electrode is recorded and dropped from the next electrode “scan”. The next scan targets the opposite pitch extreme and the highest (or lowest) pitch electrode is recorded and dropped from the subsequent scan. This process continues until no electrodes remain to be scanned, and the result is an approximate relative ranking (from lowest to highest) of the electrodes on the pitch dimension. In the ABI programming software display, the electrodes’ positions are shifted to conform to the patient’s pitch-rank judgments to achieve the proper relative positions (from lowest pitch to highest pitch). This technique serves as a cross-check and validation of the previously described pitch magnitude scaling and is necessary both because of the extreme differences in ABI stimulation versus natural hearing and to maximize ultimate speech perception via the implant system.

Formal Pairwise Electrode Pitch Comparisons

The audiologist next performs pairwise comparisons between electrode channels as the next step in the process of accurately defining individual patients' electrode pitch rank order. In this testing, a scan across electrodes is repeated with the patient to verify the highest and lowest pitch electrodes. Then the lowest pitch electrode and the next lowest (from the previous pitch scanning results above) are compared by alternating stimulation several times between these two electrodes, and the recipient is asked to indicate which electrode sounds highest in pitch. The results of this comparison are recorded. Then, the highest pitch electrode from this comparison is alternately stimulated several times with the next highest pitched electrode from the previous pitch scanning test. The patient's report of the highest pitch electrode is again noted, and the next pairwise comparisons are done in sequence until no electrodes remain to be compared. The patient has two reversals of pitch rank order so the audiologist reassesses the pitch rank order of lower pitch sounding electrode channels. The audiologist deactivates the electrodes in favor of assigning input frequencies to another electrode to promote distinctive and independent pitch cues.

Sound Processor Programming (Mapping)

Based on the outcomes of the diagnostic testing described above, the audiologist now has the necessary information and provides auditory information safely and effectively to the patient including threshold and comfortable loudness levels, the levels of any non-auditory sensations, the proper pitch rank ordering of electrodes, and information about which electrodes should not be used because of non-auditory sensations, high charge density levels, or non-independence of the auditory cues (specifically pitch) provided. The audiologist uses this information to configure a sound processor map that appropriately transforms acoustic information from the sound environment into electrical impulses that are delivered to the auditory neurons in the region of the ventral cochlear nucleus.

Speech Perception Testing

The last step with the patient is speech perception testing. This test is used as a validation technique and is presented to the patient using the following three formats: auditory only, speech-reading only, and auditory plus speech-reading modalities. The audiologist performs two or three map configurations to assess the relative efficacy of such stimulation elements as double-entry of lower frequency electrode channels vs. higher frequency channels. The patient's responses indicate that there is a different performance and further adjustments are made to the processor in order to provide the optimum configuration for the final speech processor program.

Counseling

The audiologist then describes the results with the patient and what the patient can expect as auditory perception. The patient is asked to remember how auditory stimuli are perceived during the next 24 hours because there will be further analysis and adjustments made to the processor.

Description of Post-Service Work: The audiologist calls the referring surgeon and explains the programming outcome. The audiologist subsequently writes a detailed report explaining the outcomes of the threshold testing and magnitude scaling of non-auditory stimuli, the comfortable loudness level testing, the elimination of non-auditory sensations, pitch magnitude scaling, pitch scanning, formal pairwise electrode pitch comparisons, sound processor programming, speech perception testing and counseling.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008				
Presenter(s):	Robert Fifer, PhD, Jane Dillon, MD, Paul Pessis, AuD, Peter Weber, MD				
Specialty(s):	Audiology and Otolaryngology				
CPT Code:	92640				
Sample Size:	110	Resp N:	12	Response: 10.9 %	
Sample Type:					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	0.00	5.25	130.00
Survey RVW:	0.35	1.76	2.00	3.00	11.25
Pre-Service Evaluation Time:			12.50		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	43.75	95.00	120.00	270.00
Immediate Post Service-Time:	17.50				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	92640	Recommended Physician Work RVU: 1.76		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		4.00	13.00	-9.00
Pre-Service Positioning Time:		0.00	1.00	-1.00
Pre-Service Scrub, Dress, Wait Time:		0.00	6.00	-6.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	5.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0		
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92603	XXX	2.25	RUC Time

CPT Descriptor Diagnostic analysis of cochlear implant, age 7 years or older; with programming**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90801	XXX	2.80	RUC Time	1,349,524

CPT Descriptor 1 Psychiatric diagnostic interview examination

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99385	XXX	1.53	RUC Time	0

CPT Descriptor 2 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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 4 % of respondents: 33.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 92640	<u>Key Reference CPT Code:</u> 92603	<u>Source of Time</u> RUC Time
Median Pre-Service Time	4.00	20.00	
Median Intra-Service Time	60.00	82.00	
Median Immediate Post-service Time	5.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	69.00	122.00	
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	3.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	3.83
Urgency of medical decision making	3.75	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	4.42	3.75
Physical effort required	3.25	2.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.80	2.80
Outcome depends on the skill and judgment of physician	4.42	4.08
Estimated risk of malpractice suit with poor outcome	2.92	2.75

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.67	3.33
Intra-Service intensity/complexity	4.50	3.83
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.*

With guidance received on October 3, 2008, from the RUC Pre-facilitation Committee, the American Speech-Language-Hearing Association, the American Academy of Audiology, and the American Academy of Otolaryngology – Head and Neck Surgery are recommending an RVW of 1.76 with times of 3.5 minutes pre-service, 60 minutes intra-service, and 5 minutes post-service. The rationale for recommending this value is based on the 25th percentile of the survey. It is further supported by comparing these values to two other codes:

96125 Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report. RVW = 1.70. 0 minutes pre-service, 60 minutes intra-service, 0 minutes post-service times.

96116 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 interpreting test results and preparing the report. RVW = 1.86. 7 minutes pre-service, 60 minutes intra-service, and 0 minutes post-service times.

The American Speech-Language-Hearing Association, the American Academy of Otolaryngology – Head and Neck Surgery and the American Academy of Audiology had convened a consensus panel to discuss the survey data and reach a final recommendation. We started with the combined survey data and then discussed the procedure and the times and value that was appropriate. The new IWPUT (0.026) ensures that it is reasonable when compared to other XXX codes including a midlevel office visit (99213 – IWPUT of 0.049), a physical therapy evaluation (97001 – IWPUT of 0.031), and ECG interpretation and report (93010 – IWPUT of 0.037). The IWPUT is substantially less than for these procedures.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 Audiology How often? Rarely

Specialty Otolaryngology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 145

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A major clinic estimates 25 per year and there are approximately 24 approved clinics. Assuming there are 5 performed in each of the other clinics there would be 145.

Specialty Audiology	Frequency 40	Percentage 27.58 %
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Specialty Otolaryngology	Frequency 105	Percentage 72.41 %
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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? 40

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is a rarely performed procedure so the estimate reflects the proportion of the 145 above that would be anticipated to be in the Medicare population.

Specialty Audiology	Frequency 10	Percentage 25.00 %
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Specialty Otolaryngology	Frequency 30	Percentage 75.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? 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. 97001, PLI RVU= 0.05, performed by similar non-MD profession and 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 Committee
Summary of Recommendations

October 2008 - CMS Request: Practice Expense Review

Microvolt T-Wave Assessment

CMS requested that code CPT Code 93025 *Microvolt T-wave alternans for assessment of ventricular arrhythmias* be reviewed by the RUC for proposed changes to the direct practice expense inputs. In CMS' Notice of Proposed Rule Making dated Monday, July 7, 2008 page 38512, CMS proposes to change the clinical staff type from blend of clinical labor staff to a registered nurse, and to assign the entire service period time of 53 minutes. In addition, CMS proposed to replace the cardiac monitoring equipment with treadmill equipment with a Microvolt T-wave testing treadmill. The RUC and the specialty society agreed with CMS's proposed direct practice expense inputs changes. **The RUC recommends the attached direct practice expense inputs for CPT code 93025.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
93025	Microvolt T-wave alternans for assessment of ventricular arrhythmias	XXX	Review of PE Only

93025

AMA Specialty Society RVS Update Committee Recommendation – October 2008

			93025	
			Microvolt T-wave alternans for assessment of ventricular arrhythmias	
	CMS	Staff		
LOCATION	Code	Type	Non Facility	Facility
GLOBAL PERIOD			XXX	XXX
Current CLINICAL LABOR TIME	L037D	RN/LPN/MTA	53.0	0.0
CMS Proposed change		RN	53.0	0.0
	CMS Code	Unit		
<u>MEDICAL SUPPLIES</u>				
electrode, ECG (single)	SD053	1 item	7	0
sensor, microvolt (Micro-V)	SD115	1 item	7	0
gown, patient	SB026	1 item	1	0
paper, exam table	SB036	1 foot	7	0
pillow case	SB037	1 item	1	0
sanitizing cloth-wipe (patient)	SM021	1 item	1	0
paper, recording (per sheet)	SK059	1 item	10	0
razor	SK068	1 item	1	0
electrode skin prep tape (One-Step)	SJ023	1 inch	1	0
gauze, sterile 4in x 4in	SG055	1 item	2	0
	CMS Code			
<u>EQUIPMENT</u>				
table, exam	EF023	1338.17	23	0
cardiac monitor w treadmill (12-lead PC-based ECG)	EQ078	14271.03	15	0
cardiac monitor w treadmill (microvolt, CH2000)	EQ079	32600	15	0
table, exam	EF023	1338.17	53	0
Microvolt T-wave testing treadmill		40,000	53	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008 – Identified by RUC at April 2008 Meeting as Anomaly

Stress Echo with ECG Monitoring

CPT code 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision* (RUC recommended work RVU = 1.75) was recently surveyed and reviewed by the RUC in April 2008. The RUC recognized that the new survey data and recommended total physician time for 93351 (35 minutes) is lower than the current 2008 total physician time for 93350 (40 minutes), and therefore, noted the potential anomalies in the physician work and/or physician time data for 93350. The RUC recommended that 93350 be surveyed and reviewed at the October 2008 RUC meeting for physician work and physician time.

The RUC reviewed the specialty society recommendations for code 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report*. The specialty society recommended slightly reduced pre- and post-services from the expert panel responses. The RUC agreed with 3 minutes pre-service, 20 minutes intra-service and 5 minutes immediate post-service time as indicated by the specialty society. The RUC compared code 93350 to key reference service 78465 *Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification* (work RVU = 1.46) and agreed that these services are very similar. Although the results indicated that 93350 is more complex than the key reference service, the expert panel recommended identical intra-service time. The RUC determined that an intra-service time of 20 minutes is appropriate to review these images. The specialty society recommended and the RUC agreed that the survey 25th percentile work RVU of 1.46, which is slightly lower than the currently work RVU of 1.48, appropriately estimates the physician work required to perform this service. **The RUC recommends a work RVU of 1.46 for 93350.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
93350	Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	XXX	1.46

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93350 Tracking Number

Specialty Society Recommended RVU: **1.46**

Global Period: XXX

RUC Recommended RVU: **1.46**

CPT Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;

(The appropriate stress testing code(s) from the 93016 -93018 series should be reported in addition to 93350 to capture the exercise stress portion of the study)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old man with hypertension and a history of cigarette smoking describes occasional exertional chest discomfort that is thought to be possible, but not definite, angina pectoris. His resting electrocardiogram demonstrates LVH with QRS widening and secondary repolarization changes. A treadmill stress echocardiogram is requested to evaluate for inducible myocardial ischemia and to aid in risk-stratification.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 6%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the request for stress echocardiography and relevant clinical records to clarify the indications for the procedure and to determine the clinical questions that need to be answered.

Description of Intra-Service Work: The sonographer hooks up a three lead ECG for gating and places the patient in left lateral decubitus position and obtains a baseline echocardiogram at rest, including assessment of ventricular function, chamber sizes, wall thicknesses, wall motion, aortic root, and valves. Images are acquired from multiple cardiac windows including the parasternal long axis, parasternal short axis, apical four chamber, and apical two chamber views.

Resting echocardiographic images are reviewed to insure adequate visualization of all LV segments.

Cardiac sonographer is present throughout exercise protocol so that peak stress imaging can begin immediately upon cessation of exercise

The sonographer records echocardiographic images for assessment of left ventricular wall motion immediately after exercise ends. In the case of treadmill exercise, the patient must be moved onto the examination table and placed in the left decubitus position. The sonographer organizes acquired selected images in a side-by-side format for review and interpretation by the physician.

The physician reviews the sequence of tomographic images, recorded both at baseline and again immediately following completion of treadmill exercise. Global and regional ventricular performance is evaluated carefully. Other cardiac causes of chest pain are also assessed. Where appropriate, measurements of cardiac structure and function are made. When available, prior studies are retrieved and reviewed side-by-side with the current images. A diagnostic interpretation is developed.

Description of Post-Service Work: The physician may discuss the test result with the patient or referring physician. The physician dictates a report, which specifies results of the resting echocardiogram and the stress echocardiogram. Results are transmitted to the ordering physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2008				
Presenter(s):		James Maloney, MD and Benjamin Byrd, MD				
Specialty(s):		Cardiology				
CPT Code:		93350				
Sample Size: 250		Resp N: 45	Response: 18.0 %			
Sample Type: Panel						
		Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	150.00	300.00	500.00	4000.00
Survey RVW:		0.72	1.46	1.67	2.50	5.00
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		5.00	15.00	20.00	30.00	60.00
Immediate Post Service-Time:		10.00				
Post Operative Visits		Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):		0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):		0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:		0.00	99238x 0.00	99239x 0.00		
Office time/visit(s):		0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:		0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:		93350	Recommended Physician Work RVU: 1.46		
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:			3.00	7.00	-4.00
Pre-Service Positioning Time:			0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:			0.00	0.00	0.00
Intra-Service Time:			20.00		
Immediate Post Service-Time:		5.00			
Post Operative Visits		Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):		0.00	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):		0.00	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:		0.00	99238x 0.0	99239x 0.0	
Office time/visit(s):		0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:		0.00	99354x 0.00	55x 0.00	56x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
78465	XXX	1.46	CMS Time File

CPT Descriptor tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99203	XXX	1.34	CMS Time File	5,188,911

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

A detailed history;
A detailed examination; and
Medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
73721	XXX	1.35	CMS Time File	580,553

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</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: 24 % of respondents: 53.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 93350	<u>Key Reference CPT Code:</u> 78465	<u>Source of Time</u> CMS Time File
Median Pre-Service Time	3.00	5.00	

Median Intra-Service Time	20.00	20.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	28.00	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	4.08	3.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	3.54
Urgency of medical decision making	4.13	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.42	4.13
Physical effort required	2.75	2.46

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.79	3.71
Outcome depends on the skill and judgment of physician	4.79	4.58
Estimated risk of malpractice suit with poor outcome	4.25	4.17

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.08	2.92
Intra-Service intensity/complexity	3.96	3.46
Post-Service intensity/complexity	3.50	3.38

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Cardiology convened a panel of experts that included physicians that have performed this service on numerous occasions to review the survey data and make a recommendation to the RUC. The ACC notes that the current work value for this service is 1.48. The code is being presented to the RUC as a result of the recent creation of bundled codes that include both transthoracic echocardiography and a cardiac stress test. The RUC recommended values on those services at its April meeting.

The group believed that the survey had an appropriate response rate and reviewed the data. In reviewing the preservice time recommended by the surveyees, the group felt that the pre-service time was too long, and the group recommended that the preservice work be reduced to three minutes. This is four minutes less than the established package time for a non-facility service that does not include conscious sedation and would more closely resemble the five minutes of preservice time associated with the key reference service of 78465.

The group reviewed the intraservice time reported by the surveyees and felt that this time appropriately reflected the intraservice work associated with the described echocardiography service. Twenty minutes of intraservice time was the median value reported on the survey and is also identical to the intraservice time associated with the reference code 78465.

For the postservice time, the group believed that the surveyees may have overestimated the associated postservice time and instead recommended that the postservice time be five minutes which both reflects the time associated with the service and matches the postservice time associated with the key reference service.

In reviewing the work value recommendations from the survey, the group noted that the surveyed code 93350 was considered to be of higher intensity than the reference code service 78465. For most of the measures, 93350 was reported to be moderately more intense than the key reference service. Considering that the intraservice time was identical to the key reference service and it was reported to be only modestly more complex, the ACC recommends that 93350 be assigned a work value of 1.46, which is identical to that of the key reference service code 78465 and is the work value for the 25th percentile on the survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) Codes that bundled together echocardiography and cardiac stress tests were approved by the CPT editorial panel at the February 2008 meeting and those codes were valued at the April 2008 RUC meeting. Historically, 93350 was reported along with a code for a cardiac stress test. As noted in the frequency information below, this code will reduce significantly in utilization with the

establishment of these new bundled codes. This component code is maintained for circumstances in which the work described in 93350 is completed but the bundled service is not.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93350

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 30000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Please explain the rationale for this estimate. 93350 was coded more than 400,000 times for the Medicare population in 2007. Because of the introduction of the bundled codes for 2009, the ACC expects that the majority of the services will be reported using a bundled code and this code will only be used to reflect when components were provided by separate physicians.

Specialty Cardiology Frequency 27000 Percentage 90.00 %

Specialty Other specialties Frequency 3000 Percentage 10.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

20,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 93350 was coded more than 400,000 times for the Medicare population in 2007. Because of the introduction of the bundled codes for 2009, the ACC expects that the majority of the services will be reported using a bundled code and this code will only be used to reflect when components were provided by separate physicians.

Specialty Cardiology Frequency 18000 Percentage 90.00 %

Specialty Other specialties Frequency 2000 Percentage 10.00 %

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. Utilize existing PLI for 93350.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical