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Physicians Dedicated to Excellence in Dermatology™

MEMORANDUM

Date: October 10, 2006

To: Centers for Medicare and Medicaid Services

From: American Academy of Dermatology Association

Subject: CMS-1321-P

Enclosed is our comment letters (original and two copies) regarding the 2007 Medicare Physician Fee Schedule and other items. We submitted the comments electronically (temporary comment number 93171) earlier today. However, we submitted comments electronically for the Five Year Review and learned after the fact that there were glitches in the online submission system.

Please let Jayna Bonfini at 202.842.3555 if you have any questions.

Thank you.

American Academy of Dermatology Association

Physicians Dedicated to Excellence in Dermatology

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Ronald A. Henrichs, CAE
Executive Director & CEO

October 10, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: **CMS-1321-P**

Dear Administrator McClellan:

On behalf of the 15,000 members of the American Academy of Dermatology Association (AADA), I appreciate the opportunity to submit written comments regarding the 2007 Medicare Physician Fee Schedule. As advocates for dermatologists and their patients, the AADA believes that an adequate physician fee schedule ensures fairness and continued beneficiary access to quality, specialty health care services.

Unfortunately, flaws in the Sustainable Growth Rate (SGR) formula will lead to sharp cuts in Medicare physician payments beginning January 1, 2007 unless Congress takes action this year to avert a -5.1 percent reduction. If not addressed this year, physicians will have experienced five years of inadequate payments that have not begun to keep up with inflation as measured by the medical economic index (MEI). Further, according to the 2006 Medicare Trustees Report, if the SGR formula is not fixed, physicians will receive negative updates of approximately five percent each year from 2007 until 2015. These reductions may prompt a number of physicians to reconsider their participation in the Medicare program, to limit services to Medicare beneficiaries, or to restrict the number of new Medicare patients they are able to accommodate in their practice.

Changes in the Medicare Economic Index (MEI)

The Academy is concerned with the additional 0.5 percent reduction of the 2007 physician fee schedule update from -4.6 percent to -5.1 percent, announced earlier this year. The increase in the cut was caused by a downward revision of the MEI. This reduction was not proposed or even discussed in the proposed rule for implementing the 2007 fee schedule. Based on the impact table in the proposed rule that shows $75 billion of allowed charges under the physician fee schedule, a -0.5 percent reduction in the update will result in a $375 million cut in physician payments in 2007. We believe that CMS is in violation of the spirit if not the letter of the Administrative Procedures Act (APA) which requires publication in the Federal Register of most rules and a period for public comment.

Further, the reduced MEI was based on the use of a new measure of productivity by the Bureau of Labor Statistics (BLS) and lower projections of inflation. Few details were provided and comments on the changes were not requested. If able to comment, we would have questioned the use of data that shows increased productivity in a year when the productivity of most physician practices has been reduced significantly by the need to counsel Medicare beneficiaries about the new prescription drug benefit and the availability of preventive services. We therefore urge CMS to

delay any changes in the MEI pending publication in the Federal Register of the proposed changes and the solicitation of public comments.

Dermatology Specific Issue - Reassignment and Physician Self-Referral

We recognize the need to discourage business arrangements that carry significant risk of fraud, waste, and abuse—through kickbacks, fee-splitting and mark-ups, generation of unnecessary pathology lab tests, inappropriate referrals, and other dubious practices. We are concerned that the proposed rule changes contemplated by CMS regarding reassignment and physician self-referral relating to pathology laboratory services may not only prevent dermatologists from practicing their specialty, but may well cause unnecessary confusion. Indeed, this may adversely impact the role of dermatopathology in providing dermatologists with correct, accurate and timely diagnoses and thus threatens to compromise patient safety and quality of care.

The Academy strongly encourages CMS to consider the negative implications such revisions would have by preventing patients from access to care and restricting dermatologists—the physician specialists treating the majority of melanoma patients—to have timely and accurate interpretation of patients' skin biopsies, from exercising their choice of dermatopathologists.

All dermatologists have training and experience in dermatopathology. Indeed, dermatopathology is an integral part of a dermatologist's professional training. Dermatologists receive intensive training in dermatology, which includes dermatopathology and dermatologic surgery. With this background and knowledge, dermatologists are singularly qualified to diagnose and treat the wide variety of dermatologic conditions as well as benign and malignant skin tumors. Dermatologists perform many specialized diagnostic procedures and often purchase the technical component (slide preparation) in order to be able to perform their own in-house diagnostic interpretation and pathology report.

The Academy is concerned that the proposed rule can be misinterpreted and misapplied so as to prevent a dermatologist from being able to read their own slides. As many dermatologist choose to interpret their own dermatopathology, the Academy supports the right of dermatologist to be able to continue to perform their own dermatopathology interpretation, including having the ability to purchase the technical component, in accordance with current Medicare regulations, from an outside lab vendor in order to provide their own in-house professional diagnosis and render cost-effective quality patient care.

We wish to remind CMS that the expertise of dermatopathologists is relatively cost effective because as the foremost experts in reading and interpreting skin biopsy specimens, dermatopathologists are able to detect and properly diagnose skin biopsies the first time around. Moreover, the consultative communication that goes on between dermatologists and their trusted dermatopathologists is essential; without communication or trained eyes, the skin's subtle signs may confuse and mislead. Misdiagnosis leads not only to deficient care by forcing patients to undergo unnecessary procedures, but also increases the cost of care and the risk of a liability lawsuit. Conversely, an early and correct diagnosis allows a problem to be treated before it becomes more severe—and thus more costly to treat.

We consider dermatopathologic interpretation of biopsies an integral part of a dermatologist's ability to serve their patients. Many dermatologists prefer to refer skin biopsy specimens to specialized dermatopathology labs directed and staffed by dermatologists and/or pathologists with expertise in dermatopathology and immunopathology. Pathologists employed with national reference labs often lack this high level of training and expertise to accurately interpret skin biopsies. Accurate interpretation of skin biopsies requires an ability to recognize and record the details of the specimen, and to synthesize these findings with the clinical data available. Failure to

interpret skin biopsies, can mislead the clinician and interfere with appropriate medical or surgical therapy, potentially harming the patient.

The Academy wishes to remind CMS that any final rule changes, designed to prevent markups of assigned pathology lab services, need to be simple, straightforward, and uncomplicated so as to lighten the regulatory burden, minimize the margin of error, and contain costs. To that end, we wish to emphasize the following points:

1. Dermatologists should have the opportunity and the right to interpret their own specimens and be reimbursed by a professional cornponent for their professional services. The CMS regulations regarding "purchased diagnostic test" state that if the tissue is prepared by an outside lab, either the lab should bill Medicare directly for the technical service, or the dermatologist can submit the bill to Medicare for the ***lesser of either*** the net lab charge, actual physician billing charge, or the Medicare fee schedule amount. These regulations have been in place since 1992. We believe that the preceding scenario offers straightforward guidance to allow a physician to follow the basic premise ***when performing a medical service and being reimbursed for that service, nothing more, nothing less.***
2. The same anti-markup provision should apply to contractual arrangements whereby "condo or pod labs" reassign their payment rights to physician group practices to "indirectly" bill for technical and/or professional laboratory services. Therefore, we believe that CMS's proposal to amend 42CFR 424.80 (prohibiting markups of the technical component of the diagnostic service when reassigned in a contract exception arrangement) would suffice.
3. We also agree with the second provision that requires the billing entity (physician or group practice) to perform the test interpretation themselves in order to bill the TC along with the professional component. The physician performing the interpretation should be the only entity billing for this professional service. The Academy supports the current trend of larger dermatology groups or perhaps busy one- to two-person dermatology practices hiring their own pathologist as a member in the practice to interpret specimens at that same practice when the billing is in accord with the "purchased diagnostic test" regulation and is not marked up in the sense that there would be a big discrepancy between what a practice bills and what they pay the pathologist plus his/her expenses.
4. As for redefining "centralized building" criteria by adding a 350 sq ft. minimum requirement, we don't believe that such technical revisions are necessary since they appear to provide little or no disincentive to discourage abusive pod lab practices arrangements and wouldn't necessarily curtail of markups. Such technical requirements may risk inviting more creative responses by those willing to circumvent such narrow criteria. We believe that the best patient care is given when the dermatopathologists are focused on managing the lab and being responsible for various regulations in their lab, rather than running around and dividing their attention among different "pod" lab practices for purposes of marking up assigned technical pathology services. In these situations, utilization increases, there is indirectly a violation of the regulation regarding a markup of a "purchased diagnostic test", and a huge number of resources are expended trying to interpret and/or police these regulations. Therefore, we believe that by removing the financial incentives for markups and elirminating the opportunity of profit for increased self-referrals, CMS can effectively addresses the reimbursement issue without the need to monitor space and technician requirements.
5. We recommend a back to basics approach where many years ago Medicare said that one could not markup a "purchased diagnostic test". Whether it is the technical component or the professional component, if there is ***no mark up allowed***, there would be no problem. Indeed, such a clear and uncomplicated guideline would allow dermatologists to read their own slides and be reimbursed appropriately for this service and dermatopathologists, who have full-service labs, to be reimbursed fairly and appropriately for their services and not be in jeopardy of participating in a fee splitting and markup arrangements.

The Academy supports the principles of freedom of choice of consultants, and access to physicians of all specialties, direct access to dermatopathologists and/or dermatologists of their choice for interpreting skin cancers and other serious skin conditions. Medicare patients can be assured improved quality of care if their physicians have access to expert opinion from specialists trained in the evaluation of skin biopsy specimen. By working together, we believe we can help ensure patient safety and quality of care.

Dermatology Specific Issue - Payment for Splint and Cast Supplies
We appreciate that CMS has indicated that it intends to reimburse separately via HCPCS Q codes for splint and casting supplies. We agree that costs for these should be extracted from the practice expense direct inputs for those code ranges listed within the proposed rule. However, as supplies for CPT 29580 - Unna boot applications have been specifically excluded in the past and now is included within the listed code ranges, we would appreciate it if Unna boot supplies are specifically included in the list of supplies that will now be separately billable using HCPCS Q code(s).

Budget Neutrality
The proposed notice requires budget neutrality adjustments to physician work relative value units only as a result of changes from the five-year review process and other payment policy revisions. Application of the budget neutrality adjustment to the conversion factor would impact all physician services, whereas the application of the budget neutrality adjustment to the work RVUs would impact only those services that have physician work RVUs. Thus, we strongly urge CMS to implement any budget neutrality adjustments to the conversion factor.

Practice Expense
The Academy appreciates the CMS proposal to incorporate our practice expense supplemental survey data into the 2007 fee schedule. The Academy dedicated considerable staff and physician volunteer time and significant financial resources to submitting supplemental survey data, as provided by the Balanced Budget Refinement Act of 1999 (BBRA) and requested by CMS. Incorporating this data into the CY2007 fee schedule will increase the accuracy in determining the PE RVUs for the services our members provide, as well as improving the overall accuracy of the practice expense component of the fee schedule. Again, we appreciate CMS at last including the supplemental survey data into the proposed rule and request that the data be implemented in the final rule.

As you know, the AMA is sponsoring a multi-specialty supplemental study of practice expense costs. The AADA has already agreed to participate in and contribute to this additional practice expense survey. However, we are deeply concerned that the design and structure of the new survey in fact focus on practice expense costs – as originally communicated to the physician community – and also be in compliance with all of the criteria established for the specialty specific practice expense supplemental surveys accepted by CMS. Additionally, for consistency's sake, the new multi-specialty practice expense survey results must be held to the same standard relating to the level of precision as the supplemental surveys already accepted by CMS.

Telehealth Services

The AADA appreciates CMS extending the opportunity to submit requests for added telehealth services to the Medicare program. Besides increasing access for patients, telemedicine can also reduce overall costs. Dermatology patients who participate in telemedicine would otherwise likely receive treatment for their skin conditions from a non-dermatologist physician, the accuracy of the diagnoses rendered via telemedicine can be higher and diseases can be treated effectively and at earlier stages than they would be if a patient waited until complications made a long trip to see a dermatologist imperative. Patients who are spared a long trip also benefit economically from such

an arrangement because they do not bear the cost of missing work or traveling. Telemedicine moves information – not the patient.

While making treatment more effective for patients, telemedicine also helps to make optimal use of the short supply of dermatologists. While it will never replace the face to face patient visit, the Academy considers telemedicine a viable method of treatment and one important component of an overall plan to improve patient access to dermatology.

Currently, Medicare reimburses telemedicine for rural patients (defined as patients who live in non-metropolitan statistical areas) if it takes place in a live interactive ("two way") mode. The patient and physician communicate in real time but from different locations using video conferencing technology. Medicare reimbursement currently does not exist for store and forward consultations, which take place when patient pictures and information are forwarded by a referring physician to a dermatologist, who evaluates them and responds with a diagnosis and treatment plan. The AADA and the American Telemedicine Association have reviewed the effectiveness of live interactive telemedicine visits compared with store and forward and found both to be clinically equivalent to traditional face to face patient encounters. Store and forward is more convenient for both the patient and the two physicians, allowing for asynchronous communication that simplifies the amount of coordination required. Therefore, the AADA believes that dermatologic office visits conducted via live interactive or store and forward telemedicine should be covered under the Medicare program.

Thank you for the opportunity to comment on this proposed notice. For further information, please contact Jayna Bonfini at jbonfini@aad.org or 202-842-3555 or Norma Border at nborder@aad.org or 847-330-0230.

Sincerely,

Brett M. Coldiron MD

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Chairman, Health Care Financing Committee

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Cyndi Del Boccio, Director, Executive Office
Jayna Bonfini, Assistant Director, Federal Affairs
Norma Border, Senior Manager, Coding and Reimbursement
Sandra Peters, Senior Manager, Workforce, Insurance & Practice Issues
William Brady, Manager, Practice Management
Vernell St. John, Senior Coding and Reimbursement Specialist
Peggy Eiden, Coding & Reimbursement Specialist

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The Academy strongly encourages CMS to consider the negative implications such revisions would have by preventing patients from access to care and restricting dermatologists—the physician specialists treating the majority of melanoma patients—to have timely and accurate interpretation of patients' skin biopsies, from exercising their choice of dermatopathologists.

All dermatologists have training and experience in dermatopathology. Indeed, dermatopathology is an integral part of a dermatologist's professional training. Dermatologists receive intensive training in dermatology, which includes dermatopathology and dermatologic surgery. With this background and knowledge, dermatologists are singularly qualified to diagnose and treat the wide variety of dermatologic conditions as well as benign and malignant skin tumors. Dermatologists perform many specialized diagnostic procedures and often purchase the technical component (slide preparation) in order to be able to perform their own in-house diagnostic interpretation and pathology report.

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Michael Bigby, MD, FAAD, AADA RUC Representative
Bruce Deitchman, MD, FAAD, AADA RUC Representative
John Zitelli, MD, FAAD, Chair, AADA CPT Committee
John D. Barnes, Deputy Executive Director, AADA
Judy Magel, PhD, Senior Director, Practice, Science & Research
Laura Saul Edwards, Director, Federal Affairs
Cyndi Del Boccio, Director, Executive Office
Jayna Bonfini, Assistant Director, Federal Affairs
Norma Border, Senior Manager, Coding and Reimbursement
Sandra Peters, Senior Manager, Workforce, Insurance & Practice Issues
William Brady, Manager, Practice Management
Vernell St. John, Senior Coding and Reimbursement Specialist
Peggy Eiden, Coding & Reimbursement Specialist

Docket Management Comment Form

Docket: CMS-1321-P - Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calenda Year 2007 and other Changes to Payment Under Part B

Temporary Comment Number: 93171

Submitter:
Dr. Brett Coldiron **Date:** 10/10/06

Organization: American Academy of Dermatology Assn

Category: Health Care Professional or Association

Issue Areas/Comments

General
See attachment

Attachments
CMS-1321-P-T93171-Attach-1.doc

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interpret skin biopsies, can mislead the clinician and interfere with appropriate medical or surgical therapy, potentially harming the patient.

The Academy wishes to remind CMS that any final rule changes, designed to prevent markups of assigned pathology lab services, need to be simple, straightforward, and uncomplicated so as to lighten the regulatory burden, minimize the margin of error, and contain costs. To that end, we wish to emphasize the following points:

1. Dermatologists should have the opportunity and the right to interpret their own specimens and be reimbursed by a professional component for their professional services. The CMS regulations regarding "purchased diagnostic test" state that if the tissue is prepared by an outside lab, either the lab should bill Medicare directly for the technical service, or the dermatologist can submit the bill to Medicare for the ***lesser of either*** the net lab charge, actual physician billing charge, or the Medicare fee schedule amount. These regulations have been in place since 1992. We believe that the preceding scenario offers straightforward guidance to allow a physician to follow the basic premise ***when performing a medical service and being reimbursed for that service, nothing more, nothing less.***
2. The same anti-markup provision should apply to contractual arrangements whereby "condo or pod labs" reassign their payment rights to physician group practices to "indirectly" bill for technical and/or professional laboratory services. Therefore, we believe that CMS's proposal to amend 42CFR 424.80 (prohibiting markups of the technical component of the diagnostic service when reassigned in a contract exception arrangement) would suffice.
3. We also agree with the second provision that requires the billing entity (physician or group practice) to perform the test interpretation themselves in order to bill the TC along with the professional component. The physician performing the interpretation should be the only entity billing for this professional service. The Academy supports the current trend of larger dermatology groups or perhaps busy one- to two-person dermatology practices hiring their own pathologist as a member in the practice to interpret specimens at that same practice when the billing is in accord with the "purchased diagnostic test" regulation and is not marked up in the sense that there would be a big discrepancy between what a practice bills and what they pay the pathologist plus his/her expenses.
4. As for redefining "centralized building" criteria by adding a 350 sq ft. minimum requirement, we don't believe that such technical revisions are necessary since they appear to provide little or no disincentive to discourage abusive pod lab practices arrangements and wouldn't necessarily curtail of markups. Such technical requirements may risk inviting more creative responses by those willing to circumvent such narrow criteria. We believe that the best patient care is given when the dermatopathologists are focused on managing the lab and being responsible for various regulations in their lab, rather than running around and dividing their attention among different "pod" lab practices for purposes of marking up assigned technical pathology services. In these situations, utilization increases, there is indirectly a violation of the regulation regarding a markup of a "purchased diagnostic test", and a huge number of resources are expended trying to interpret and/or police these regulations. Therefore, we believe that by removing the financial incentives for markups and eliminating the opportunity of profit for increased self-referrals, CMS can effectively addresses the reimbursement issue without the need to monitor space and technician requirements.
5. We recommend a back to basics approach where many years ago Medicare said that one could not markup a "purchased diagnostic test". Whether it is the technical component or the professional component, if there is ***no mark up allowed***, there would be no problem. Indeed, such a clear and uncomplicated guideline would allow dermatologists to read their own slides and be reimbursed appropriately for this service and dermatopathologists, who have full-service labs, to be reimbursed fairly and appropriately for their services and not be in jeopardy of participating in a fee splitting and markup arrangements.

The Academy supports the principles of freedom of choice of consultants, and access to physicians of all specialties, direct access to dermatopathologists and/or dermatologists of their choice for interpreting skin cancers and other serious skin conditions. Medicare patients can be assured improved quality of care if their physicians have access to expert opinion from specialists trained in the evaluation of skin biopsy specimen. By working together, we believe we can help ensure patient safety and quality of care.

Dermatology Specific Issue - Payment for Splint and Cast Supplies
We appreciate that CMS has indicated that it intends to reimburse separately via HCPCS Q codes for splint and casting supplies. We agree that costs for these should be extracted from the practice expense direct inputs for those code ranges listed within the proposed rule. However, as supplies for CPT 29580 - Unna boot applications have been specifically excluded in the past and now is included within the listed code ranges, we would appreciate it if Unna boot supplies are specifically included in the list of supplies that will now be separately billable using HCPCS Q code(s).

Budget Neutrality
The proposed notice requires budget neutrality adjustments to physician work relative value units only as a result of changes from the five-year review process and other payment policy revisions. Application of the budget neutrality adjustment to the conversion factor would impact all physician services, whereas the application of the budget neutrality adjustment to the work RVUs would impact only those services that have physician work RVUs. Thus, we strongly urge CMS to implement any budget neutrality adjustments to the conversion factor.

Practice Expense
The Academy appreciates the CMS proposal to incorporate our practice expense supplemental survey data into the 2007 fee schedule. The Academy dedicated considerable staff and physician volunteer time and significant financial resources to submitting supplemental survey data, as provided by the Balanced Budget Refinement Act of 1999 (BBRA) and requested by CMS. Incorporating this data into the CY2007 fee schedule will increase the accuracy in determining the PE RVUs for the services our members provide, as well as improving the overall accuracy of the practice expense component of the fee schedule. Again, we appreciate CMS at last including the supplemental survey data into the proposed rule and request that the data be implemented in the final rule.

As you know, the AMA is sponsoring a multi-specialty supplemental study of practice expense costs. The AADA has already agreed to participate in and contribute to this additional practice expense survey. However, we are deeply concerned that the design and structure of the new survey in fact focus on practice expense costs – as originally communicated to the physician community – and also be in compliance with all of the criteria established for the specialty specific practice expense supplemental surveys accepted by CMS. Additionally, for consistency's sake, the new multi-specialty practice expense survey results must be held to the same standard relating to the level of precision as the supplemental surveys already accepted by CMS.

Telehealth Services

The AADA appreciates CMS extending the opportunity to submit requests for added telehealth services to the Medicare program. Besides increasing access for patients, telemedicine can also reduce overall costs. Dermatology patients who participate in telemedicine would otherwise likely receive treatment for their skin conditions from a non-dermatologist physician, the accuracy of the diagnoses rendered via telemedicine can be higher and diseases can be treated effectively and at earlier stages than they would be if a patient waited until complications made a long trip to see a dermatologist imperative. Patients who are spared a long trip also benefit economically from such

an arrangement because they do not bear the cost of missing work or traveling. Telemedicine moves information – not the patient.

While making treatment more effective for patients, telemedicine also helps to make optimal use of the short supply of dermatologists. While it will never replace the face to face patient visit, the Academy considers telemedicine a viable method of treatment and one important component of an overall plan to improve patient access to dermatology.

Currently, Medicare reimburses telemedicine for rural patients (defined as patients who live in non-metropolitan statistical areas) if it takes place in a live interactive ("two way") mode. The patient and physician communicate in real time but from different locations using video conferencing technology. Medicare reimbursement currently does not exist for store and forward consultations, which take place when patient pictures and information are forwarded by a referring physician to a dermatologist, who evaluates them and responds with a diagnosis and treatment plan. The AADA and the American Telemedicine Association have reviewed the effectiveness of live interactive telemedicine visits compared with store and forward and found both to be clinically equivalent to traditional face to face patient encounters. Store and forward is more convenient for both the patient and the two physicians, allowing for asynchronous communication that simplifies the amount of coordination required. Therefore, the AADA believes that dermatologic office visits conducted via live interactive or store and forward telemedicine should be covered under the Medicare program.

Thank you for the opportunity to comment on this proposed notice. For further information, please contact Jayna Bonfini at jbonfini@aad.org or 202-842-3555 or Norma Border at nborder@aad.org or 847-330-0230.

Sincerely,

Brett M. Coldiron MD

Brett Coldiron, MD, FAAD
Chairman, Health Care Financing Committee

Cc: Stephen P. Stone, MD, FAAD, President
Diane R. Baker, MD, FAAD, President-Elect
David M. Pariser, MD, FAAD, Secretary-Treasurer
Ronald A. Henrichs, CAE, Executive Director and CEO
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Bruce Deitchman, MD, FAAD, AADA RUC Representative
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American Academy of Dermatology Association

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Executive Director & CEO

October 10, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: **CMS-1321-P**

Dear Administrator McClellan:

On behalf of the 15,000 members of the American Academy of Dermatology Association (AADA), I appreciate the opportunity to submit written comments regarding the 2007 Medicare Physician Fee Schedule. As advocates for dermatologists and their patients, the AADA believes that an adequate physician fee schedule ensures fairness and continued beneficiary access to quality, specialty health care services.

Unfortunately, flaws in the Sustainable Growth Rate (SGR) formula will lead to sharp cuts in Medicare physician payments beginning January 1, 2007 unless Congress takes action this year to avert a -5.1 percent reduction. If not addressed this year, physicians will have experienced five years of inadequate payments that have not begun to keep up with inflation as measured by the medical economic index (MEI). Further, according to the 2006 Medicare Trustees Report, if the SGR formula is not fixed, physicians will receive negative updates of approximately five percent each year from 2007 until 2015. These reductions may prompt a number of physicians to reconsider their participation in the Medicare program, to limit services to Medicare beneficiaries, or to restrict the number of new Medicare patients they are able to accommodate in their practice.

Changes in the Medicare Economic Index (MEI)

The Academy is concerned with the additional 0.5 percent reduction of the 2007 physician fee schedule update from -4.6 percent to -5.1 percent, announced earlier this year. The increase in the cut was caused by a downward revision of the MEI. This reduction was not proposed or even discussed in the proposed rule for implementing the 2007 fee schedule. Based on the impact table in the proposed rule that shows $75 billion of allowed charges under the physician fee schedule, a -0.5 percent reduction in the update will result in a $375 million cut in physician payments in 2007. We believe that CMS is in violation of the spirit if not the letter of the Administrative Procedures Act (APA) which requires publication in the Federal Register of most rules and a period for public comment.

Further, the reduced MEI was based on the use of a new measure of productivity by the Bureau of Labor Statistics (BLS) and lower projections of inflation. Few details were provided and comments on the changes were not requested. If able to comment, we would have questioned the use of data that shows increased productivity in a year when the productivity of most physician practices has been reduced significantly by the need to counsel Medicare beneficiaries about the new prescription drug benefit and the availability of preventive services. We therefore urge CMS to

Y-ME National Breast Cancer Organization™

October 5, 2006

Administrator Mark McClellan
Center for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Rule: Physician Fee Schedule (CMS-1321-P); and

Rule: Hospital Outpatient Prospective Payment System (OPPS) (CMS-1506-P)

Dear Administrator McClellan:

Y-ME National Breast Cancer Organization is writing to express our concern that the two proposed rules referenced above would make disproportionate cuts in Medicare reimbursement for critical breast cancer treatment methods. The effect of the proposed reductions could create barriers to treatment options for Medicare women with breast cancer and may place physicians in the impossible situation of having to select treatment based upon reimbursement considerations rather than what is best for the patient.

Y-ME is a national nonprofit organization whose mission is to ensure, through information, empowerment and peer-support, that no one faces breast cancer alone. The Y-ME hotline is the only 24/7call center operated by trained and certified peer counselors who are breast cancer survivors. Each year more than 40,000 calls are answered giving support and answering questions about the disease and treatment options. Interpreters in over 150 languages are available. The Y-ME affiliates, located throughout the nation, provide support groups, early detection workshops and have advocacy networks.

One of our concerns is the proposed cuts for breast brachytherapy. Standard of care is to follow lumpectomy, breast conserving surgery with radiation. This procedure has allowed women to preserve their breast. Brachytherapy for women with early stage breast cancer who have had a lumpectomy delivers radiation only to the tissue at highest risk for cancer recurrence. The treatment is completed in five days rather than the six to seven weeks of daily treatment with whole breast radiation. This is one of the most compelling reasons that patients and physicians prefer this procedure. Y-ME strongly believes that CMS should be encouraging the use of more patient-friendly treatment options such as brachytherapy, rather than giving women little or no choice of choosing a mastectomy and/or whole breast radiation.

We understand that the intent of CMS was not to impede access or deny patients the choice of brachytherapy. Therefore we propose the following:

Hospital Outpatient Prospective Payment System (OPPS) (CMS-1506-P)

- CMS proposes to reassign CPT codes 19296 and 19297 from New Technology APCs to clinical APCs in 2007. The CMS proposed APC assignment for CPT Codes 19296 and 19297 would result in significant decreases in 2007 payment ranging from –22.8% to –37.0%. These reductions result in a payment rate that will not cover the cost of the actual device required to deliver the breast brachytherapy. In fact, the proposed rates fall $400-1000 (15-36%) below the cost of the device.

- CMS proposed a new payment methodology for the radiation source used for breast brachytherapy resulting in payment for these sources below the actual cost. We understand that the Coalition for Advancing Brachytherapy has met with CMS to discuss this concern.

Physician Fee Schedule (CMS-1321-P)
- CMS proposed RVU reductions for the multiple codes associated with planning, treating and delivering high dose breast brachytherapy. These reductions will result in the RVUs for the radiation oncologist in the freestanding center (a site of service where many women receive their radiation) to decrease by over 50%.
- CMS proposed a reduction in the RVUs for the code associated with placing the catheter in the woman to deliver the radiation. This reduction will result in the RVUs for the surgeon by over 30% when they place the catheter in their office. This is a site of service that is preferred by most women to avoid going back to the operating room at the hospital.

In order to ensure breast cancer patients' access to brachytherapy under Medicare, Y-ME respectfully requests that CMS consider the following recommendations:

1. CMS should reconsider the proposed assignment of the breast brachytherapy codes (CPT 19296 and 19297) to a new APC under the **Outpatient Prospective Payment System** proposed rule. We request that both codes remain in the current New Technology codes. Alternatively, CMS should assign breast brachytherapy to a more appropriate breast procedure APC that accurately reflects the costs of the procedure.

2. CMS should not make any reductions to the RVUs for breast conservation surgery and breast conservation therapy (breast brachytherapy) under the Physician Fee Schedule. Should changes be required, Y-ME recommends that CMS not decrease the RVUs by more than 5%.

Y-ME believes that these recommendations would enable health providers and hospitals to continue to offer breast brachytherapy to eligible Medicare women. We appreciate the opportunity to comment on these proposed regulations and strongly urge CMS to reconsider and revise these rules.

Sincerely,

Kay Wissmann

Kay Wissmann
Director of Government Relations

cc: Helen Pass, MD, President, American Society of Breast Surgeons
Robert Lee, MD, President, American Brachytherapy Society
Carol M. Bazell, MD, MPH, - CMS, Director, Division of Outpatient Care
Carolyn Mullen, Deputy Director, Division of Practitioner Services

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Alta Bates Summit Medical Center

A Sutter Health Affiliate

2001 Dwight Way
Berkeley, CA 94704
510.204.4444

October 9, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Mail Stop: C4-26-05
7500 Security Blvd.
Baltimore, Md. 21244-1850

To Whom It May Concern:

Re: PPS-CMS-1506-P; CY 2007 Proposed Daily Rate for APC Code 0033 - Partial Hospitalization Programs and 0322, 0323, 0324, 0325 – Outpatient psychiatric services

Our hospital, Alta Bates Summit Medical Center is an acute care Hospital facility in Berkeley, California. We are part of the Sutter Healthcare system in Northern California. We serve approximately 450 patients on an annual basis. We provide intensive psychiatric programs, including partial hospitalization services that are greatly needed by the severe and persistently mentally ill and the elderly in our community.

We are requesting that CMS cease from going forward with the proposed CY 2007 15% rate cut for Partial Hospitalization (PHP) and psychiatric Outpatient Services. Coupled with last year's 12.5% reduction for PHP, the proposed rate will make it impossible to cover the costs needed to provide an intensive program.

We strongly support the position of the Association of Ambulatory Behavioral Healthcare regarding their proposed considerations, as the response from the organization goes into specific detail concerning the long reaching effects the rate cut will have on the patients who are in need of outpatient psychiatric services.

These less expensive outpatient programs need to be supported by reasonable reimbursement rates that adequately cover the costs of providing the services.

We are asking CMS to allow time and resources to develop a reasonable payment methodology by working with provider and community organizations who would welcome the opportunity to work with CMS to develop a payment rate that is fair, consistent and predictable.

Thank you, for the opportunity to respond to this critical issue.

Respectfully,

Luana Shiba-Harris,
Director-Outpatient Services

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AdvaMed
Advanced Medical Technology Association

October 6, 2006

Via Electronic and U.S. Mail

Mark McClellan, MD, PhD, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1321-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment Under Part B (CMS-1321-P)

Dear Dr. McClellan:

The Advanced Medical Technology Association (AdvaMed) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 (CMS-1321-P, *Federal Register*, Vol. 71, No. 162, Tuesday, August 22, 2006, p. 48981). AdvaMed is the world's largest association representing manufacturers that produce the medical devices, diagnostic products, and health information systems that are transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. Our members produce nearly 90 percent of the health care technology purchased annually in the United States and more than 50 percent purchased annually around the world. AdvaMed members range from the largest to the smallest medical technology innovators and companies.

AdvaMed appreciates the considerable effort you and your staff have put into the development of the proposed Medicare Physician Fee Schedule rule (PFS). While we are pleased with some of the proposed changes announced in the rule we remain concerned with others. AdvaMed supports the establishment of payment rates under the physician fee schedule that are adequate and ensure access to advanced medical technologies by Medicare beneficiaries. We will comment on the following issues raised in the proposed 2007 PFS Rule:

1. Deficit Reduction Act Proposals
2. Bone Mass Measurement (BMM) tests

3. Resource Based Practice Expense RVU Proposals
4. Clinical Diagnostic Lab Tests
5. ASP Issues

PROVISIONS

I. DRA Proposals

Proposed Adjustments for Payment to Imaging Services

A. Payment for Multiple Imaging Procedures for 2007

The Deficit Reduction Act (DRA) of 2005 contained two provisions affecting imaging services paid under the Medicare physician fee schedule. Among these was a mandate that budget neutrality provisions be waived for reductions in payment for contiguous body part imaging. Initially, CMS proposed to reduce payments for these services by 50 percent beginning in 2006. However, in the final rule CMS decided to phase in the 50 percent reduction over a period of two years. Consequently, a 25 percent reduction went into effect for 2006 and an additional 25 percent reduction was expected to be phased in as of January 1, 2007.

In the proposed 2007 PFS rule, CMS has indicated that it would be prudent to maintain the imaging discount at 25 percent for 2007 while continuing to evaluate the appropriate payment for the multiple image procedures subject to the discount. AdvaMed is pleased with this decision and commends CMS for not moving to the 50 percent discount. AdvaMed encourages CMS to be vigilant in obtaining and evaluating data relating to the costs of these procedures so that the most accurate cost information can be used in making any future determinations regarding reductions in the price of imaging services.

B. Reduction in Technical Component for Imaging services Under the PFS to OPD Payment Amount

The DRA requires that, effective January 1, 2007, the payments for the technical component of certain imaging procedures performed in a physician office be capped at the lesser of the Medicare physician fee schedule or the outpatient department (OPD) reimbursement rate. AdvaMed is concerned that capping the technical component payment at the OPD rate will lead to significant reductions in the payment for imaging procedures performed in the physician office setting and may reduce beneficiary access to these procedures.

These findings are supported by a recent report conducted by The Moran Company (Moran) in which they analyzed the impact of the DRA provisions.[1] The Moran report

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1 See Assessing the Deficit Reduction Act Limits on Image Reimbursement: Cross-Site Comparisons of Cost and Reimbursement, The Moran Company, September 2006
http://www.imagingaccess.org/reports/index.cfm

found that 87% of the procedures whose payments will be affected by the DRA caps would be paid at an amount that is less than the estimated cost of performing the procedure in the office setting. According to the Moran report, several procedures including image guided ultrasound procedures used in the diagnosis of breast cancer, PET/CT exams used to diagnose cancerous tumors, bone density studies used to diagnose osteoporosis, and MR angiography used to locate aneurysms will be cut 35% to upwards of 50% if the DRA changes are enacted. These cuts may result in diagnosis and treatment delays, increased wait times, and reduced access for patients in rural areas to critical imaging services.

AdvaMed is concerned with the impact of the DRA provisions on image guided treatment procedures. CMS has interpreted the DRA provisions regarding imaging issues as relating to both *"diagnostic"* and *"image guided"* procedures. However, this interpretation is not borne out by the MedPAC recommendations, which focus specifically on increased utilization of diagnostic imaging services. In fact, in its March 2005 report to Congress MedPAC cites the efficacy of two image guided procedures, biopsies for bone-cancer and coronary angioplasty, as examples of image guided procedures which benefit patients.[2] The MedPAC analysis did not determine whether growth in imaging utilization was due to over-utilization or appropriate expansion of imaging as a diagnostic tool.

The March 2005 MedPAC report makes several recommendations based on its review of *diagnostic* imaging services including the imposition of coding edits to detect unbundled *diagnostic* imaging services and setting standards for physicians who bill Medicare for interpreting *diagnostic* imaging studies.[3] The content of the MedPAC report coupled with their recommendations suggest that they did not identify issues related to image guided treatment procedures.

AdvaMed is concerned that capping the technical component of imaging procedures, in accordance with the DRA mandate, may interfere with patient access to necessary care. We therefore recommend that caps to the technical component of imaging services not be applied to image guided treatment procedures.[4] In order to reduce adverse patient impact, we further recommend that any caps to the technical component of imaging services be applied in the most prudent manner possible.

AdvaMed is also concerned that several Category III CPT imaging codes are incorrectly included on the list of DRA cap-eligible procedures (Addendum F). Category III CPT codes are dedicated to emerging technologies, are primarily intended for tracking purposes only, and are not assigned RVU values at the national level. While some Category III

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2 See Report to the Congress: Medicare Payment Policy, MedPAC, Page 155 (March 2005).

3 See Report to the Congress: Medicare Payment Policy, MedPAC, Pages 159 and 163 (March 2005).

4 Approximately 18 image guided treatment procedures would be affected by the DRA caps. These codes are all done in conjunction with a surgical or other procedure. Eliminating these codes from the DRA cap would have nominal impact, estimated at 2%, on total projected savings.

CPT codes are covered under Medicare and are Medicare Carrier-priced, they do not have physician fee schedule technical components and therefore would not be subject to the DRA mandated caps. Therefore, AdvaMed urges CMS to remove all Category III CPT codes from the proposed CPT/HCPCS imaging codes list.

C. Interaction of the Multiple Imaging Payment Reduction and the OPPS Cap

The proposed rule recommends that the 25% multiple procedure imaging reduction be applied prior to the OPPS cap in the case of procedures impacted by both the multiple procedure discounts and the OPPS cap. The OPPS cap would then be applied to the reduced amount. CMS has indicated that this method is being applied because the OPPS rates may already include implicit discounts. The proposed methodology would be implemented while CMS continues to explore the issue. Given the uncertainty of the OPPS data we encourage CMS to take an approach that fairly reflects the costs involved in performing imaging tests.

Proposed Addition of Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

AdvaMed is pleased that, pursuant to DRA requirements, CMS will be including screening for AAA as a covered benefit for Medicare beneficiaries meeting the established criteria effective January 1, 2007. Providing this potentially life saving screening exam is important to beneficiaries. The coverage criterion for the benefit identifies and adequately addresses the needs of the Medicare population most at risk for AAA. AdvaMed is also pleased with the recommendation to pay for this service at the same level as CPT code 76775—a service requiring resources and work intensity comparable to that of the screening procedure.

II. Bone Mass Measurement (BMM) Tests

The proposed rule revises the definition of bone mass measurement (BMM)to remove coverage for single photon absorptiometry (SPA) and to include coverage for axial skeleton measures (DXA). This change is guided by the shift in technology from SPA to DXA. AdvaMed is please that CMS recognizes the technological developments which have led to the use of DXA and other technology in accurately assessing BMM. As such, AdvaMed would also like to commend CMS for its proposal to allow use of the NCD process to identify other BMM systems which can be used to monitor patients with osteoporosis and those requiring confirmatory baseline measurements. An NCD is already in place relating to the identification of BMM indications and coverage. Allowing new devices to go through the NCD process will create consistent coverage determinations for these treatments.

AdvaMed strongly supports CMS's coverage improvement, but is concerned that reductions in the reimbursement for BMM procedures utilizing DXA technologies may compromise patient access to the technology. Specifically, we are concerned with proposed reductions in the payments for CPT codes 76075, 76077, and 76977 in 2007. In

the proposed regulation, CMS supports its decision to use DXA to monitor bone mineral density by stating that, "DXA is precise, safe, and low in radiation exposure, and permits more accurate and reliable monitoring of individuals over time." However, continuing reimbursement decreases for procedures utilizing DXA technology may limit patient access to this monitoring method and the benefits associated with its use. Therefore, AdvaMed encourages CMS to take steps to correct and prevent further reductions in payment for procedures utilizing DXA technology.

III. Resource-Based Practice Expense (PE) RVU Proposals

Payment for Splint and Cast Supplies

AdvaMed supports CMS' proposal to reinstate separate coding and payment for cast, splint, and strapping supplies under the Medicare Physician Fee Schedule in calendar year (CY) 2007. We agree with CMS' conclusion that these supplies are considered medically necessary not only for the management of fractures and dislocations, but also for serial casting, wound care, and protection. Assigning distinct HCPCS billing codes for these supplies, when furnished incident to specified professional services, will enable contractors to identify with greater accuracy those instances in which cast, splint, and strapping supplies are medically necessary and eligible for payment.

CMS has requested input from medical specialties and contractors on its proposal to pay separately for splint and casting supplies billed with Q-codes. See Federal Register, Vol. 71, No. 162 page 48987. AdvaMed is aware of a related coding issue that may result in underpayment for supplies used in wound care procedures.

As proposed, CMS' refinements to the practice expense (PE) database would exclude cast, splint, and strapping supplies used in compression therapy for venous leg ulcers from the list of separately paid supplies. Currently, CMS proposes to use HCPCS Q-codes to identify those supplies that would receive separate fee schedule payment amounts, and for which supply inputs would be excluded from the PE database. However, paste bandage supplies (also referred to as Unna-boot supplies) are currently assigned HCPCS A-codes, not HCPCS Q-codes. As a result, contractors would be unable to determine whether to make separate fee schedule payments for these supplies when billed with CPT 29580, application of paste boot. In addition, because payment for paste bandage supplies would be excluded from the PE database for CPT 29580, physicians would be underpaid for use of these supplies. AdvaMed recommends that CMS instruct contractors to make separate payment for paste bandage supplies when reported on the CMS-1500 claim form with the HCPCS A-codes listed below.

HCPCS	Paste bandage supply
A6441	Padding bandage, width >=3" but <5", per yard
A6442	Conforming bandage, non-sterile, width <3", per yard

HCPCS	Paste bandage supply
A6443	Conforming bandage, non-sterile, width >=3"but <5", per yard
A6444	Conforming bandage, non-sterile, width >=5", per yard
A6445	Conforming bandage, sterile, width <3", per yard
A6446	Conforming bandage, sterile, width >=3" but <5", per yard
A6447	Conforming bandage, sterile, width >=5", per yard
A6448	Light compression bandage, width <3", per yard
A6449	Light compression bandage, width >=3" but <5", per yard
A6450	Light compression bandage, width >=5", per yard
A6451	Moderate compression bandage, width >=3" but <5", per yard
A6452	High compression bandage, width >=3" but <5", per yard
A6453	Self-adherent bandage, width <3", per yard
A6454	Self-adherent bandage, width >=3" but <5", per yard
A6455	Self-adherent bandage, width >=5", per yard
A6456	Zinc paste impregnated bandage, width >=3" but <5", per yard

Impact of Practice Expense Changes

Changes in the PE relative value units resulting from the incorporation of supplemental survey data are expected to have a significant impact on some specialties. Other specialties' PE values will be negatively impacted as a result of the transition to a bottom-up methodology. The impact of the PE changes, though anticipated, is especially difficult given the proposal to reduce the conversion factor by 5.1% in 2007.[5] CMS has proposed to phase in the PE changes over a four-year period, 2007-2010, to avoid adverse impacts on specialty fees. However, the proposed changes will result in significant reductions in the reimbursement for several procedures and could adversely impact patient access. For example, Medicare payments for a complete course of partial breast irradiation in a freestanding center would decrease by (19% in 2007 and 56% in 2010). These decreases could result in both reduced access and options for Medicare beneficiaries. AdvaMed urges CMS to take steps to ensure that patients continue to have access to the treatments and technologies that improve their quality of life and encourages implementation of the PE changes in the most practical manner possible.

IV. Clinical Diagnostic Lab Tests

AdvaMed also wishes to comment on the implementation of section 942 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which specified improvements to CMS's current process for developing clinical laboratory fee schedule (CLFS) payment rates for new or substantially revised pathology or laboratory CPT codes. Many of AdvaMed's member companies develop clinical laboratory tests that substantially improve the quality of life for Medicare beneficiaries through the prevention and early diagnosis of disease.

5 Prior to publication of the proposed PFS rule the conversion factor was expected to be reduced by approximately 4.6%.

We appreciate the progress CMS has made to date in improving its process for developing payment rates for new or substantially revised CPT codes for clinical laboratory services under the Clinical Laboratory Services Fee Schedule (CLFS). We commend the agency for holding its annual "Laboratory Public Meeting," which provides the public a forum to present views on the tests and services that will be included in the following year's edition of CPT. We have appreciated the opportunity to present our comments at this annual public meeting for the past few years.

We believe that providing opportunities for public discussion of agency payment policy activities is crucial to an open, transparent process. The expertise that stakeholder groups offer at these meetings has resulted in more clinically appropriate payment determinations. Further, we appreciate and commend the action the agency has taken to post proposed new clinical lab payment determinations for comment, after receiving public input at the open public meeting. These measures are consistent with MMA section 942, and we believe they represent a significant improvement to CMS's process for determining new test payments.

Notwithstanding these improvements, the MMA included other provisions relating to the process for determining payment for new clinical laboratory tests that must be addressed. We will identify these provisions as we comment on the following areas: (i) the general CMS payment process for developing CLFS payment rates for new or substantially revised CPT codes; (ii) the gap-fill process; (iii)the cross-walk process ; and (iv) other overarching issues.

A. General Process Issues

a. Rationales, Data and Responses to Comments

In the preamble to the proposed PFS rule, CMS states that the "current process for providing public consultation on the establishment of payment amounts . . . is consistent with the requirements of section 1833(h)(8)(B)" of the Social Security Act (section 942 of the MMA) [71 Federal Register 49063 (Aug. 22, 2006)]. While CMS asserts that it is in full compliance with the statutory requirements, we note that both the law, and the proposed regulations [42 C.F.R. section 414.406], require that CMS post on the internet a list of proposed and final determinations of the payment amounts for tests "with the rationale for each determination, the data on which the determinations are based, and responses to comments and suggestions from the public."

We support incorporation of this language in CMS's regulations. However, we note that CMS's current practice differs from this requirement. At present, CMS posts its proposed and final determinations, but does not post the rationale, data, or responses to comments from the public. Thus, there appears to be a discrepancy between what is required by law and CMS's assertion in the preamble to these regulations that they are currently complying with the law.

Making public the rationale and the data on which CMS's proposed and final determinations are based, in addition to the CMS responses to comments from the public, would be an additional positive step towards increasing transparency and openness in CMS's payment process. This is the approach CMS follows for its other payment systems, and we strongly urge CMS to conform its practices to both the statutory requirements and its own proposed regulatory language in implementing MMA section 942. Providing this information and an explanation for specific payment determinations via the CMS website (similar to the way CMS provides this information and explanation in the regulation preambles for other payment systems, including the physician fee schedule and the hospital outpatient prospective payment system) would be one way to implement this legislative requirement. If CMS is not able to provide the rationale, data, and its responses to public comments on the internet and elsewhere, we ask that CMS explain why the information is not publicly available.

b. Web-Posting of All Public Comments or Suggestions

Additionally, we note that in the past, CMS has not posted on the internet all of the public suggestions made to the agency regarding payment rates for new or substantially revised CPT codes. Posting all such comments or suggestions made to the agency, whether before or shortly after the Laboratory Public Meeting that CMS holds annually, would be another practice that could improve the CMS payment process.

c. Announcement of Meetings and Codes to be Discussed

While we recognize that CMS is required by the MMA to announce its annual Laboratory Public Meeting in the *Federal Register* "not fewer than 30 days" prior to the meeting, we recommend announcing the meeting – and making public the new or substantially revised CPT codes that will be the subject of the meeting earlier in the year – at least 60 days in advance of the meeting. Providing such advanced notice of the codes to be discussed at the meeting will allow for the development of more meaningful and well-considered public comments. We note that these comments often require technical expertise that is often difficult to obtain within only 30 days and thus extending the notice to 60 days in advance of the meeting would be a significant improvement.

B. Gap-Fill Issues

We are disappointed that CMS did not address the methodology that contractors should use in establishing local gap-fill payment rates for new test codes. AdvaMed members believe that it is imperative that CMS set forth a clear approach to pricing these new tests. As we have stated on record at several of the open public meetings for the CLFS, stakeholders often suggest that the cross-walk process be used for new test codes instead of the gap-fill process because the gap-fill methodology is neither well-defined, nor monitored by CMS.

In the limited, previous instances when gap-fill has been used, carriers made use of a wide variety of pricing techniques. Individual carriers set prices based on the following types of information or techniques, which illustrate some of the concerns we have with the gap-fill process:

- A consultant's recommendations;
- The payment level assigned to "related code(s)" already on the fee schedule, even though Medicare officials had chosen not to cross-walk the test and issued instructions to carriers to "gap-fill" the test;
- Carrier pricing formulas based variously on relative values imputed to the test, the customary charges associated with the test, and so forth;
- Considering prevailing charge data in the carrier area, and reducing these charges to a previously set NLA for the test to which it had been "cross-walked" (this was a test that had been cross-walked initially, but then subsequently gap-filled);
- Applying an arbitrary percentage reduction in local laboratory charges for the new test;
- Carrier surveys of the rates set by other carriers for the test, which were the basis for subsequent questionable "calculations" to set carrier "gap fill" rates (e.g., these "calculations" produced rates set at the median, average, or some arbitrary percentage of the carrier rates collected);
- Carrier surveys of physicians who may not have had any experience with the test at issue;
- Carrier use of unverified data from the internet that may not reflect actual cost of providing the test in a CLIA-approved laboratory;
- Contacting only one patient to determine the time associated with the test;
- Following the personal opinion of another Carrier Medical Director; and
- Carrier Medical Director discretion.

Without guidance from CMS on the methodology that should be used by carriers in setting "gap fill" payment rates for new tests, there will continue to be uncertainty and variation in the rates that are set by carriers, leading to issues with the new test payment rates. Unless the "gap fill" price-setting methodology is based on accepted principles, the payment rates that are computed will be viewed as arbitrary. Consequently, we recommend that CMS make the following changes to improve the gap-fill process:

- Provide more specific, step-by-step direction on the methodology Carriers should use when conducting data collection, including the incorporation of external data

provided by laboratory providers (of varying size, setting, and patient mix), manufacturers, private payers, and other stakeholders;

- Provide instructions on how to incorporate charges for a given new test,
- Specify the minimum requirements this data shall meet to ensure that the data collected is valid, meaningful, and unbiased, including establishing a reasonable standard for the volume of claims that a carrier should process in developing the gap-fill payment rate;
- When newer data is available, contractors should use that data, rather than using the least costly alternative or similar standard;[6]
- Monitor the carrier's (contractor's) methodology and data reporting, providing, where needed, oversight and feedback to contractors to ensure compliance with CMS instructions and that appropriate data is being collected;
- At the close of the data collection time period, make available for public inspection and comment the proposed new national payment amount. Using informal mechanisms for requesting comment, such as the agency's web site --
    i. To facilitate meaningful comment, provide the data and methodology upon which the gap-filled amount is based;
    ii. If based on claims data, provide specific information on the number of claims, and the localities from which those claims were filed;
    iii. Provide principles to be employed to ensure that the data used by carriers are statistically significant and alternatives to follow if statistically significant data are unavailable; and
    iv. Provide any other information or data that was factored into the decision-making;
- In cases where such a contractor fails to comply with some or all of CMS-prescribed directions on the gap-fill methodology (e.g., to address instances where contractors simply cross-walk or rely on prices determined by other contractors, as opposed to collecting data individually according to CMS-set methods), that contractor's payment rate (and any "data" used to calculate it) should be excluded from the calculation of the NLA;
- Establish a mechanism to receive and review additional data, including data provided by the laboratory industry, manufacturers, and other stakeholders, in order to adjust the proposed national payment amount for the new test. This is particularly important in cases where a substantial number of contractor payment rates are excluded from the NLA calculation due to concerns with the methodology used;
- After taking into account additional data and comments received, publish the final national payment amount for the new test, with a clear explanation of the basis for

6 In particular, we note that the Conference Report to the MMA specifies that "carriers and CMS cannot substitute an alternative service for a gap filled amount." Accordingly, the least costly alternative approach is inconsistent with this report language.

its determination, again using informal publication mechanisms, such as the web site; and

- Make public the specific data and methodology upon which the gap-filled amount was based, including a listing of the local amounts used to arrive at the NLA, and any additional data or information provided during the comment period, with an opportunity for public comment thereon.

We note that CMS is currently using the gap-fill process to develop a payment rate for CPT code 83037. We believe that CMS has discretion to accept and implement many of the above-mentioned recommendations, even for the current, on-going gap-fill process. We recommend that CMS evaluate and consider additional, external data in this context.

Absent the provision of additional direction to contractors and changes to the gap-fill process as recommended above, we recommend that CMS consider an alternative approach to setting payment rates for new clinical laboratory test codes. AdvaMed supports H.R. 5369, the Clinical Laboratory Fee Schedule Improvement Act of 2006, which authorizes a demonstration project that would test a new approach to setting payment for molecular diagnostic tests. This approach would set up a stakeholder panel to advise CMS on appropriate pricing of such tests through a deliberative process that takes into account relevant data, the expertise of stakeholders with an understanding of the complexity of the tests, clinical laboratory resources involved, and the estimated impact of the test on patient care management. We have attached H.R. 5369 for your reference. We urge CMS to consider undertaking such an alternative pricing approach for unique new tests to address the longstanding problems with the gap-fill process.

C. Cross-Walk Issues

As we mentioned above, the cross-walk process is the primary method recommended by interested parties for use in pricing new or substantially revised test codes for the Medicare Clinical Laboratory Fee Schedule. This is in part because some cross-walks are suggested by stakeholders because the gap-fill process is fraught with uncertainty. Nevertheless, we commend CMS for the way it has used the cross-walk process since it began considering stakeholder comments at open public meetings and has given careful consideration to public comments and expert opinions expressed at these meetings.

Nevertheless, we see two areas for improvement in the cross-walk process:

- First, we recommend that when CMS chooses to cross-walk new or revised codes to existing codes, the cross-walk should be made to the national limitation amount (NLA) of the existing code on the fee schedule, rather than the local carrier fee schedule amounts which often vary significantly from one geographic area to another. If CMS chooses to cross-walk new tests to the NLA of existing tests on the fee schedule, this policy will prevent the geographic variation problems inherent in the CLFS from worsening.

- Second, provided that CMS makes significant changes to the gap-fill process to improve its predictability (as recommended above), we recommend that CMS provide more regulatory specificity to guide the cross-walk process. A specific definition of what "comparable" means, with the particular criteria that CMS considers, would improve the payment process overall and would provide a framework for CMS ultimately to provide the rationale for its particular cross-walk decisions. For example, it would be helpful to receive clarification regarding whether "comparable" refers to resources involved in performing the test or service (e.g., supplies, equipment, lab staff time, etc.), the type of test or service performed, or clinical similarity, among other potential factors.

We note that MMA section 942 requires CMS to set forth criteria for making new payment determinations. The MMA conference report specified that such criteria "include whether a payment rate should be established through gap-filling or cross-walking to an existing code." Clarity on the definition of what is "comparable" would also shed light on the basis for CMS's decision to cross-walk or gap-fill a new or substantially revised test code. Clarification on this point would be helpful once CMS has made significant improvements in the gap-fill process as noted above.

D. Other Overarching Issues

In addition, we urge CMS to establish a formal, timely reconsideration process to allow stakeholders to seek review of the payment determinations made by CMS or its contractors in relation to a given test code. Stakeholders should be able to request and receive a reconsideration of:

- A CMS decision to crosswalk or gap-fill a new or revised test code;
- A CMS crosswalk determination;
- A contractor determination of a gap-fill price; and/or
- A CMS calculation of the NLA for a new test.

Finally, there is considerable uncertainty surrounding how Medicare contractor reform will affect the CLFS and the process for developing payment amounts for new or substantially revised CPT codes. To improve predictability in this area, we request that CMS clarify the following:

- How will local fees be handled when new Medicare Administrative Contractors (MACs) are chosen? Will the various local fee schedules be maintained or will they be collapsed into a single price for each of the new jurisdictions? If so, what process will be used to do this?
- If a new test is gap-fill priced where there is a new MAC, will gap-fill prices continue to be set for each of the previous contractor jurisdictions?
- Will the new MACs have a separate medical director for each of the previous contractor jurisdictions who will set gap-fill prices for new test codes and maintain existing local fee schedules?

V. ASP Issues

The proposed rule recommends changes in the way Group Purchasing Organizations (GPOs) administrative fees are recognized. CMS proposes to treat GPO fees that do not satisfy the definition of bona fide service fees as price concessions.[7] AdvaMed seeks to clarify whether the proposed changes could impact the ability of manufacturers and other entities to comply with the GPO safe harbor to the anti-kickback statute found at 42 C.F.R. §1001.952(j) and requests that implementation of any changes in the treatment of administrative fees not affect the existing GPO safe harbor.

Conclusion

AdvaMed urges CMS to carefully consider our comments as well as those submitted by our member companies, as they provide a unique source of information in developing appropriate PFS and clinical diagnostic lab test payment rates. We appreciate the opportunity to submit comments on the August 22, 2006 proposed PFS rule, and look forward to working with CMS to address our concerns.

Sincerely,

Ann-Marie Lynch
Executive Vice President

cc: Herb Kuhn
Tom Gustafson
Terry Kay
Liz Richter
Laurence Wilson

Enclosures

7 CMS proposes to define the term bona fide service fee as fees paid by a manufacturer to an entity that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement, and that are not passed on, in whole or in part, to a client or customer of an entity, whether or not that entity takes title to the drug.

109TH CONGRESS
2D SESSION

H. R. 5369

To amend title XVIII of the Social Security Act to improve payments under the Medicare clinical laboratory fee schedule.

IN THE HOUSE OF REPRESENTATIVES

MAY 11, 2006

Mr. FERGUSON (for himself, Mr. ENGLISH of Pennsylvania, Mr. RUSH, and Mr. THOMPSON of California) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to improve payments under the Medicare clinical laboratory fee schedule.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Clinical Laboratory Fee Schedule Improvement Act of 2006".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—NEAR-TERM CHANGES

SEC. 101. FEE SCHEDULE AND NATIONAL LIMITATION AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) IN GENERAL.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

"(9)(A) For purposes of this paragraph:

"(i) The term 'an amount determined under this subsection' means, with respect to a clinical laboratory test, the fee schedule amount determined under paragraph (2)(A)(i) for the test or the limitation amount determined under paragraph (4)(B) for the test.

"(ii) The terms 'appropriate medicare administrative contractor' and 'medicare administrative con-

tractor' have the meaning given to such terms under section 1874A(a)(3).

"(iii) The term 'erroneous decision' means, with respect to the determination of an amount determined under this subsection, any decision, calculation, judgment or other action by the Secretary or a medicare administrative contractor that, based upon consideration of currently known facts, needs to be modified to produce a fair and equitable payment amount, except that such term does not include typographical or clerical errors.

"(iv) The term 'non-governmental party' includes—

"(I) a provider of services (as defined in section 1861(u)) that furnishes clinical diagnostic laboratory tests for which payment may be made under this subsection;

"(II) a supplier (as defined in section 1861(d)) that furnishes such tests; and

"(III) a manufacturer of a test or of any supplies or equipment that are used in performing such test.

"(B) An amount determined under this subsection may be changed solely on the basis of—

"(i) in the case of a change other than a change to correct an erroneous decision in determining such amount, the authority provided by the preceding provisions of this subsection, section 1842(b)(8), or any regulations, manual instructions, or other regulatory guidance implementing such provisions; or

"(ii) in the case of a change to correct an erroneous decision in determining such an amount, the authority provided by subparagraphs (C), (D), and (E).

"(C) Any erroneous decision in determining an amount under this subsection may be corrected only if—

"(i) a non-governmental party submits a request under subparagraph (D) or (E) for correction of the erroneous decision; and

"(ii) such party demonstrates, to an appropriate medicare administrative contractor under subparagraph (D) or the Secretary under subparagraph (E), that an erroneous decision clearly was made.

"(D)(i) Any non-governmental party may request (in such form and manner as the Secretary may require) that the appropriate medicare administrative contractor change a fee schedule amount determined under paragraph (2)(A)(i) to correct an erroneous decision in determining such amount.

"(ii) Any request under this subparagraph shall include a statement of the basis for the non-governmental party's belief that an erroneous decision was made in determining such amount, together with supporting evidence and a description of any additional data (other than data already in the possession of the appropriate medicare administrative contractor) that—

"(I) is or may be in the possession of the Secretary or another medicare administrative contractor; and

"(II) is necessary to demonstrate that such an erroneous decision exists.

"(iii) If the Secretary or another medicare administrative contractor is identified as possessing or potentially possessing additional data identified by a non-governmental party in a request under this subparagraph, the Secretary or such contractor, as the case may be, shall make available to the non-governmental party within 30 days after the date of the submission of the request any data in their possession that meet the description of the additional data identified in such request, with appropriate safeguards to protect confidential and proprietary information.

"(iv) If additional data are made available to a non-governmental party under clause (iii), such party may

amend its request under this subparagraph to incorporate such data within 30 days after the date such data are made available to such party.

"(v) An appropriate medicare administrative contractor to which a request is submitted under this subparagraph shall make a determination with respect to whether to correct the decision that is identified as erroneous in the request not later than 60 days after the date of the submission of such request, or if later, the date of the submission of an amended request under clause (iv). Such contractor shall determine that the non-governmental party submitting the request—

"(I) has demonstrated that an erroneous decision clearly was made, correct such erroneous decision, and increase the fee schedule amount as of the first day of the next calendar quarter to reflect the correction of such erroneous decision; or

"(II) has failed to demonstrate that an erroneous decision clearly was made and decline to change the fee schedule amount,

and shall provide to the non-governmental party a written explanation of the basis for such determination.

"(vi) An appropriate medicare administrative contractor to which a request is submitted under this subparagraph may not reduce a fee schedule amount pursu-

ant to such request, and may reduce such an amount only pursuant to section 1842(b)(8).

"(E)(i) Any non-governmental party may request (in such form and manner as the Secretary may require) that the Secretary—

"(I) reverse a determination of a medicare administrative contractor under subparagraph (D) that is adverse to the non-governmental party requesting it;

"(II) correct an erroneous decision in the determination of a limitation amount under paragraph (4)(B); or

"(III) reverse a determination referred to in subclause (I) and correct an erroneous decision referred to in subclause (II).

"(ii) Any request under this subparagraph shall include a statement of the basis for the non-governmental party's belief that an erroneous decision was made in determining such amount, together with supporting evidence and a description of any additional data (other than data already in the possession of the Secretary or the appropriate medicare administrative contractor reviewing the request under subparagraph (D)) that–

"(I) are or may be in the possession of the Secretary or an another medicare administrative contractor; and

"(II) are necessary to demonstrate that such an erroneous decision exists.

"(iii) If the Secretary or another medicare administrative contractor is identified as possessing or potentially possessing additional data identified by a non-governmental party in a request under this subparagraph, the Secretary or such contractor, as the case may be, shall make available to the non-governmental party within 30 days after the date of the submission of the request any data in their possession that meet the description of the additional data identified in such request, with appropriate safeguards to protect confidential and proprietary information.

"(iv) If additional data are made available to a non-governmental party under clause (iii), such party may amend its request under this subparagraph to incorporate such data within 30 days after the date such data are made available to such party.

"(v) The Secretary shall make a determination of whether to correct the erroneous decision that is the subject of a request submitted under this subparagraph not later than 60 days after the date of the submission of such

request, or if later, the submission of an amended request under clause (iv). The Secretary shall determine that the non-governmental party submitting the request—

"(I) has demonstrated that an erroneous decision clearly was made, correct such erroneous decision, and increase the fee schedule amount as of the first day of the next calendar quarter to reflect the correction of such erroneous decision; or

"(II) has failed to demonstrate that an erroneous decision clearly was made and decline to change the fee schedule amount or national limitation amount, as the case may be,

and shall provide to the non-governmental party with a written explanation of the basis for such determination.

"(vi) The Secretary may not reduce a fee schedule amount pursuant to a request under this subparagraph and may reduce such an amount only pursuant to section 1842(b)(8).

"(F)(i) There shall be no administrative or judicial review under section 1869, 1878, or otherwise of any determination made under subparagraph (D) or (E).

"(ii) Nothing in this paragraph shall be construed as precluding administrative or judicial review of determinations of the amount of benefits that are available to a Medicare beneficiary in a particular case.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to requests for corrections submitted on or after such date, without regard to whether final regulations to carry out such amendment have been issued.

SEC. 102. ISSUANCE OF REGULATIONS ON GAP-FILLING FOR MEDICARE FEE SCHEDULE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue final regulations specifying how an appropriate medicare administrative contractor (as defined in section 1874A(a)(3)(B) of the Social Security Act (42 U.S.C. 1395kk–1(a)(3)(B)) shall apply a gap-filling methodology in determining fee schedule amounts established under section 1833(h)(2)(A)(i) of such Act (42 U.S.C. 1395l(h)(2)(A)(i)). Such regulations shall specify—

(1) a process for ensuring that the resulting fee schedule amounts are fair, including a description of the types of data to be collected for use in such methodology and the minimum requirements such data shall meet in order to ensure that the data are valid, meaningful, and unbiased;

(2) the principles to be employed to ensure that such data are statistically significant and alternatives to follow if statistically significant data are unavailable;

(3) the principles to be followed in using data to calculate fee schedule amounts, including principles for excluding data that do not meet the requirements of paragraph (1) and (2);

(4) the methods the Secretary will use to oversee the application of a gap filling methodology by such contractors and the remedies that will be available in cases in which such a contractor fails to comply with regulatory requirements; and

(5) a process that provides opportunities for the public to participate in the development of fee schedule amounts through the application of gap-filling methodologies, including release to the public of data collection protocols and the data derived from such protocols with an opportunity for public comment thereon.

SEC. 103. INCREASED TRANSPARENCY OF PROCESS FOR DETERMINING FEE SCHEDULE AMOUNTS FOR NEW TESTS.

Section 1833(h)(8) of the Social Security Act (42 U.S.C. 1395l(h)(8) is amended—

(1) in subparagraph (B)(iii), by inserting "to be conducted in an inter-active format," after "meeting,";

(2) in subparagraph (B)(iv)—

(A) by inserting "(I)" after "meeting,";

(B) by striking "determination," and inserting "determination and"; and

(C) by striking "a request for" and inserting "(II) publishes in the Federal Register a notice of a period of not less than 60 days during which the Secretary will receive"; and

(3) in subparagraph (C), by striking "Under the procedures" and inserting "In the regulations".

SEC. 104. ADVANCE NOTICE OF CLINICAL DIAGNOSTIC LABORATORY TEST AMOUNTS BEING CONSIDERED FOR ADJUSTMENT UNDER INHERENT REASONABLENESS AUTHORITY.

(a) LIMIT ON INHERENT REASONABLENESS AUTHORITY.—Section 1842(b)(9)(A) of the Social Security Act (42 U.S.C. 1395u(b)(9)(A)) is amended by adding at the end the following: "Before publishing a proposed notice under subparagraph (B) with respect to any clinical diagnostic laboratory test being considered for adjustment under paragraph (8), advance notice that such test is being considered for such an adjustment shall be provided

to non-governmental parties (as defined in section 1833(h)(9)(A)(iv)) at the meeting required by section 1833(h)(8)(B)(iii), together with an opportunity for such representatives and other individuals to make oral comments on the appropriateness of such an adjustment for such test.".

(b) CONFORMING CHANGE.—Section 1833(h)(8)(B) of such Act (42 U.S.C. 1395l(h)(8)(B)) is amended by adding at the end the following:

"At the meeting required by clause (iii), the Secretary shall provide advance notice of inherent reasonableness adjustments under section 1842(b)(8) that are being considered for clinical diagnostic laboratory tests, and afford an opportunity for non-governmental parties (as defined 1833(h)(9)(A)(iv)) at the meeting to comment orally on the appropriateness of such an adjustment.".

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective on January 1, 2007, and shall apply to inherent reasonableness adjustments that have not been proposed as of such date.

TITLE II—FUTURE REFORM

SEC. 201. ESTABLISHMENT OF MEDICARE DEMONSTRATION PROJECT TO EVALUATE NEW APPROACHES TO CODING AND PAYMENT FOR CERTAIN MOLECULAR DIAGNOSTIC TESTS.

(a) ESTABLISHMENT OF DEMONSTRATION.—

(1) DEMONSTRATION OF NEW APPROACHES TO CODING AND PAYMENT.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a demonstration project under this section (in this section referred to as the "demonstration") to evaluate new approaches to coding and payment under the medicare program for clinical diagnostic laboratory tests included in the demonstration (in this section referred to as "included tests").

(2) DURATION.—The demonstration and any payment amounts assigned under the demonstration shall apply solely to claims submitted for included tests during the 12-calendar-quarter period that begins with the first day of the first calendar quarter to begin at least 250 days after the date of the enactment of this Act.

(3) SCOPE.—The demonstration shall apply on a national basis to included tests in all settings for

which payment for such tests would (but for the demonstration) be made under the fee schedules and limitation amounts established under section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)).

(4) ISSUANCE OF TEMPORARY HCPCS CODES; CONTINUED APPLICATION OF SUCH CODES.—The Secretary shall issue a temporary code or codes under the Health Care Procedure Coding System (HCPCS) when needed for an included test, and such code or codes—

(A) shall continue to apply to the test until a permanent code or codes is assigned; and

(B) shall not cease to apply solely because the demonstration ends.

(b) INCLUDED TESTS.—

(1) ELIGIBLE TESTS.—A clinical diagnostic laboratory test is eligible to be an included test under the demonstration if—

(A) the test is a new or existing molecular diagnostic test that (but for its inclusion in the demonstration) could be paid under the fee schedules and national limitation amount established under section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) for the test; and

(B) there is the prospect—

(i) for wide usage of the test in multiple geographic areas; and

(ii) that development of a new code, or payment, or both, for the test under the demonstration will result in reduced administrative complexity and improved efficiency.

(2) INCLUDED TESTS.—A clinical diagnostic laboratory test shall be treated as an included test if—

(A) an interested party submits a request to the standing panel established under subsection (c) that the test be included in the demonstration; and

(B) the standing panel determines that the test is an eligible test under paragraph (1); or

(3) DEFINITIONS.—For purposes of this section—

(A) the term "molecular diagnostic test" means a clinical diagnostic laboratory test performed on deoxyribonucleic (DNA), ribonucleic acid (RNA), or protein that is drawn from a human being or from a disease-causing organism; and

(B) the term "interested party" means, with respect to a request for inclusion of molecular diagnostic test in the demonstration, an individual entitled to benefits under title XVIII of the Social Security Act, a manufacturer of the test, a clinical laboratory offering the test, a professional society, the Centers for Medicare & Medicaid Services, a private payer for such test, and a physician or other health care practitioner.

(c) STANDING PANEL.—

(1) APPOINTMENT.—Not later than 60 days after the date of the enactment of this section, the Secretary shall appoint a standing panel (in this section referred to as the "standing panel" or "panel") to determine whether a test is an included test and make recommendations to the Secretary on the appropriate coding of, and payment for, designated clinical diagnostic laboratory tests under the demonstration.

(2) COMPOSITION OF PANEL.—

(A) IN GENERAL.—The standing panel shall be comprised of 12 members. Two of such members shall be non-voting representatives of the Administrator of the Centers for Medicare

& Medicaid Services. The Secretary shall appoint the other 10 members from—

(i) organizations representing large clinical laboratories;

(ii) organizations representing small clinical laboratories;

(iii) organizations representing physicians with expertise in clinical diagnostic laboratory tests;

(iv) organizations representing other health professionals with expertise in such tests;

(v) organizations representing manufacturers of such tests;

(vi) organizations representing individuals entitled to benefits under title XVIII of the Social Security Act;

(vii) organizations representing private payers for such tests (but not more than one member may be appointed to represent such organizations);

(viii) individuals with expertise in clinical laboratory cost accounting (both macro and micro); and

(ix) individuals with other relevant expertise.

(B) TERMS OF OFFICE.—Each member of the panel shall be appointed for the life of the panel, except that any individual appointed to fill a vacancy shall be appointed for the remainder of the term of the individual who is being replaced. Any vacancy shall be filled in the same manner, and with a representative of the same category under subparagraph (A), as the individual being replaced.

(3) RULES GOVERNING PANEL.—

(A) IN GENERAL.—The panel shall elect its chair. A quorum shall be required to conduct the business of the panel, and eight members of the panel shall constitute a quorum.

(B) COMPENSATION.—While serving on the business of the panel (including travel time), a member of the panel shall be entitled to compensation at the per diem equivalent rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a mem-

ber may be allowed travel expenses as authorized by the chair of the panel.

(C) STAFFING.—

(i) DETAILING.—The panel may seek such assistance and support of its duties from appropriate Federal Departments and agencies.

(ii) OUTSIDE EXPERTS.—The panel may retain the services of such outside experts as are necessary for the evaluation of a request under this section, and such experts shall not be voting members of the panel.

(D) MEETINGS.—The panel shall meet at the call of the chair and at such intervals (which shall not be less than quarterly) as may be necessary for the conduct of its business. The agenda of each meeting and a notice of its date shall be published at least 30 days before the date the meeting occurs, and, except as provided in subparagraph (E), meetings of the panel shall be open to the public.

(E) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the panel, but the panel may close any portion

of a meeting that could be closed if such Act applied.

(F) TERMINATION OF PANEL.—The panel shall terminate not more than 180 days after the close of the demonstration.

(d) FORM AND CONTENT OF REQUESTS FOR INCLUSION IN THE DEMONSTRATION.—A request for inclusion of a clinical diagnostic laboratory test in the demonstration shall be submitted in such form, and shall contain such information as the standing panel may require, including at least—

(1) any coding and payment determinations requested with respect to the test; and

(2) any documentation in support of—

(A) the eligibility of the test for inclusion in the demonstration; and

(B) any coding and payment determinations requested with respect to the test, including data on the typical direct and indirect laboratory costs (including test acquisition costs) of the test.

The Secretary shall cause to have published in the Federal Register and on an appropriate internet site public notice of each such request. Such information

shall be supplied to the Secretary by the standing panel.

(e) CRITERIA FOR EVALUATING REQUESTS FOR DETERMINATIONS IN CODING AND PAYMENT.—

(1) IN GENERAL.—In determining whether a requested payment determination should be granted, and what the new payment amount for a test should be, the standing panel (in making its recommendations to the Secretary) and the Secretary (in determining whether to grant such a determination) shall take into account typical direct and indirect laboratory costs (including test acquisition costs), the expected impact of the test on patient care management, and such other factors as the standing panel and the Secretary, respectively, determine to be relevant to the determination.

(2) STANDING PANEL.—Not later than 180 days after the appointment of all of the members of the panel, the panel shall, after consultation with the Secretary, establish and make available to the public—

(A) standards and parameters for determining whether to recommend to the Secretary a coding or payment determination specified in a request for inclusion of a test in the dem-

onstration, which shall include a listing of data elements necessary to support a request and a standardized procedure for collecting and submitting data on typical costs to the panel;

(B) policies and procedures for protecting the confidentiality of financial and other proprietary data submitted to the panel in support of a request; and

(C) cost intervals or cost bands (as described in subsection (g)(1)) that the panel recommends that the Secretary should use for the assignment of included tests under the demonstration.

(3) SECRETARIAL DETERMINATIONS.—The Secretary shall develop and make available to public on an internet site guidance documents on the standards and parameters that will be applied in making Secretarial determinations and on the cost intervals or cost bands to be used under the demonstration and on whether to grant a request for a payment or coding determination. Such guidance documents shall be developed, which shall be made available to the public at least 10 days before the beginning of the demonstration, in a manner similar to the manner in which guidance documents are developed

under section 701(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 371(h)).

(4) AUTHORITY TO RECOMMEND REVISIONS TO, AND TO REVISE, COST INTERVALS OR COST BANDS.—Nothing in this section shall be construed as limiting the authority of the standing panel to recommend, or the Secretary to adopt, new cost intervals or cost bands to accommodate changes in technology.

(f) REVIEW PROCESS.—

(1) REQUESTS FOR INCLUSION IN DEMONSTRATION.—An interested party may submit a request for inclusion of a test in the demonstration to the standing panel at any time during a calendar year for which the demonstration is in effect, except that the standing panel may decline to review and make recommendations or determinations with respect to any request that would result in a requested coding or payment determination being effective for a period of less than 4 calendar quarters.

(2) RECOMMENDATIONS OF STANDING PANEL.—The standing panel shall review each request for a coding or payment determination that is made with respect to an included test. Applying the standards and parameters developed under sub-

section (e)(2)(A), the panel shall make a recommendation to the Secretary with respect to each requested determination.

(3) SECRETARIAL DETERMINATIONS.—

(A) QUARTERLY DETERMINATIONS.—The Secretary shall make determinations on whether to grant requested coding and payment determinations on a quarterly basis, but is not required to make such a determination for every request made (or with respect to which a recommendation is received from the standing panel) during a particular quarter.

(B) TIME FRAMES FOR DETERMINATIONS.—Determinations of the Secretary shall be made in a timely manner in accordance with time frames developed by the standing panel taking into account factors such as when a request (and a recommendation with respect to the request) is made during a quarter, the particular type of test involved, and the staffing and resources that may be required to review the request.

(g) PAYMENT METHODOLOGY.—

(1) IN GENERAL.—Included tests shall be paid in accordance with a methodology, developed by the

standing panel, that establishes cost intervals or cost bands in a manner similar to those that are used as new technology ambulatory payment classification groups for hospital outpatient services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), with a test being assigned to the cost interval or cost band that most closely approximates the typical direct and indirect costs (including test acquisition costs) of the test for a laboratory. Tests that are included tests for purposes of this section shall be excluded from any demonstration project under section 1847(e) of such Act (42 U.S.C. 1395w–3(e)).

(2) PANEL RECOMMENDATIONS; SECRETARIAL DETERMINATIONS.—

(A) RECOMMENDATIONS; SECRETARIAL DETERMINATIONS.—The standing panel shall recommend to the Secretary a cost interval or cost band to which an included test should be assigned, and the Secretary may assign such test to such band or interval or to another band or interval the Secretary determines to more closely approximate the typical direct and indirect costs (including test acquisition costs) of the test.

(B) EXPLANATION OF DETERMINATION THAT DIFFERS FROM RECOMMENDATION.—If the Secretary assigns a test to a cost interval or band other than that recommended by the standing panel, the Secretary shall provide a detailed written explanation of the reasons for determining that such other interval or band is more appropriate.

(3) EFFECTIVE DATE OF SECRETARIAL DETERMINATION.—A determination by the Secretary with respect to a coding or payment determination for an included test shall become effective as of the first day of the calendar quarter following the calendar quarter in which the determination is made.

(4) PERIODIC LOOK-BACKS OF INTERVAL OR BAND ASSIGNMENTS.—At the request of the interested party that submitted the initial request for a test to be included in the demonstration or of a member of the standing panel, the standing panel may review the appropriateness of the payment interval or band to which the test is assigned and make a recommendation to the Secretary that the assignment be changed. The Secretary may accept or reject such recommendation, and if the recommendation is rejected, the Secretary shall provide

a detailed explanation of the reasons for such rejection.

(5) PUBLICATION OF DETERMINATIONS.—The Secretary shall publish determinations under this subsection in a timely manner on an appropriate internet site.

(h) REPORTS TO CONGRESS.—

(1) IN GENERAL.—The Secretary shall submit interim and final reports on the demonstration to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. The interim report shall be submitted not later than the close of the second year of the demonstration, and the final report shall be submitted not later than 180 days after the close of the demonstration.

(2) CONTENT OF REPORTS.—The reports submitted under paragraph (1) shall include interim and final—

(A) determinations on whether coding and payment assignments under the demonstration provide for—

(i) more equitable and accurate payment for included tests; and

(ii) reduced administrative complexity, improved efficiency, and improved access to care; and

(B) recommendations on—

(i) whether the alternative mechanism for determining payment and coding for included tests should be continued for such tests beyond the 12-calendar-quarter period the demonstration is in effect; and

(ii) whether the application of such mechanism should be expanded to include other new clinical diagnostic laboratory tests for which payment would otherwise be made under the fee schedules and limits established under section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)).

(3) COMMENTS BY STANDING PANEL.—The standing panel shall submit comments to the committees referred to in paragraph (1) on the interim and final reports of the Secretary.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of fiscal years 2007 through 2012, such sums as may be necessary to carry out this section.

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RUC Comment Letter and Attachments

Regarding:
CMS-1321-P Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment Under Part B; Proposed Notice published August 22, 2006

RUC Comments Regarding CMS-1321-P Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment Under Part B; Proposed Notice

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Bone Marrow Procedures

CPT codes 38207 – 38215, which describe a series of bone marrow and stem cell harvesting services, were created for *CPT 2003* and will be slightly modified in *CPT 2004*. The RUC had previously reviewed this series of services and had developed interim work relative value recommendations. The RUC had requested that the specialty re-survey these codes after the CPT Editorial revised the nomenclature for the codes. In the December 31, 2002 *Final Rule*, CMS announced that it had decided that relative values should not be assigned to these services.

At the April 2003 RUC meeting, the specialty informed the RUC that they were currently discussing this issue with CMS and hoped to resolve the issue regarding the assignment of work relative values to these services in the near future. Upon resolution of this issue with CMS, the specialty will conduct a survey and present relative value recommendations to the RUC. The specialty requested that the RUC's earlier "interim" recommendations remain in effect until the specialty has the opportunity to re-survey these codes. The RUC accepted this request and AMA RUC staff will monitor the specialties discussions with CMS to determine an appropriate time to re-schedule this issue on the RUC's agenda.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Codes 38207 – 38215 describe various steps used to preserve, prepare and purify bone marrow/stem cells prior to transplantation or reinfusion. Each code may be reported only once per day regardless of the quantity of bone marrow/stem cells manipulated.				
38207	X3	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage (For diagnostic cryopreservation and storage, see 88240)	XXX	0.47 (interim)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
38208	X4	thawing of previously frozen harvest, without washing (For diagnostic thawing and expansion of frozen cells, see 88241)	XXX	0.56 (interim)
38209	X5	thawing of previously frozen harvest, with washing ~~of harvest~~	XXX	0.24 (interim – based on old language, will need to be adjusted)
38210	X6	specific cell depletion within harvest, T-cell depletion	XXX	0.94 (interim)
38211	X7	tumor cell depletion	XXX	0.71 (interim)
38212	X8	red blood cell removal	XXX	0.47 (interim)
38213	X9	platelet depletion	XXX	0.24 (interim)
38214	X10	plasma (volume) depletion	XXX	0.24 (interim)
38215	X11	cell concentration in plasma, mononuclear, or buffy coat layer	XXX	0.55 (interim)
(Do not report 88180, 88182 in conjunction with 38207-38215)				

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Bone Marrow Procedures

Thirteen new CPT codes were added and two were deleted to provide greater granularity to code accurately the specific procedures performed for each patient receiving bone marrow or stem cell transplantation. The newer techniques used in a transplant laboratory under physician supervision are now captured in these new CPT codes. CPT codes 38205-38215 replace codes 38231 *Blood-derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50) and 86915 *Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (eg, T-cells, metastatic carcinoma)* to allow for different types, work, and techniques now used for different types of cell harvesting and also transplant preparation as well as the critical work and techniques involved in stem cell processing prior to a bone marrow transplant. Present codes 38231 and 86915 were not designed for modern procedures in Bone Marrow transplant and have virtually no relevance to the present stem cell harvesting and processing work and procedures. The RUC understands that these services are not commonly performed on the Medicare population and very few centers perform these services (50 centers), therefore a small sample size of 22 is expected.

38204 *Management of recipient hematopoietic proginator cell donor search and cell acquisition*
The RUC reviewed the survey results and the similarities in physician work of the reference code, 80502 *Clinical pathology consultation; comprehensive, for complex diagnostic problem, with review of patient's history and medical records* (Work RVU=1.33). The RUC believed that this service was more intense than 80502 as there was zero tolerance for error. The RUC understands that this newly reported service would be billed one time per recipient. The RUC also compared this service to CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient* ... a level 4 new patient office visit representing 45 minutes of physician time (work RVU = 2.00). The RUC agreed that the time spent on this type of per patient management reflected the specialty's recommended 25th percentile surveyed intra-service time. The RUC agreed that there is no pre- and post-service time. **The RUC recommends a relative work value of 2.00 for CPT code 38204.**

38205 *Blood derived hematopoietic proginator cell harvest for future transplantation per collection; allogeneic*
38206 *Blood derived hematopoietic proginator cell harvest for future transplantation per collection; autologous*
These two codes were previously billed as code 38231 *Blood derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50). The specialty society recommended a value of 2.0 stating code 38231 had been undervalued. The

RUC however found no compelling evidence to increase the value, and believed it had been appropriately valued by the RUC when reviewed in 1995. **The RUC recommends a relative work value of 1.50 for CPT codes 38205 and 38206.**

38210 & 38207 – 38215

The RUC reviewed CPT code 38210 *Transplantation preparation of hematopoietic progenitor cells; cryopreservation and storage; specific cell depletion within harvest, T-cell depletion* as an anchor code for family 38205 through 38215. The RUC first recognized that the vignette did not reflect an accurate description of the service of 38210, however the RUC did believe that the work involved in code 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU = 0.94) was similar. The RUC also reviewed the codes in comparison the work of evaluation and management services. The RUC was concerned regarding the accuracy of the survey data for these services. However, the RUC agreed that a repeated survey would not be appropriate as it would have to be circulated to the same physicians/centers. The RUC recommends that a consensus panel of physicians, with the participation of one or more RUC members, review these codes again for the September 2002 RUC meeting. The RUC however, felt strongly, that these services require physician work and recommends interim work values to be assigned for 38207-38215. The RUC emphasized that these interim values should not be viewed as a "ceiling" for the future review, but serve as the best alternative until future review is completed. **Considering the similarities in work of code 86077 and 38210, the RUC recommends an interim value of 0.94 for code 38210.**

The RUC compared similarities in work and intensity of codes 86077 and 38210, and then agreed with the rank order established by the specialty society for the family of codes 38207 through 38215. The RUC agreed with the specialty society's recommended rank order for the family, but also understood that the values being established were interim pending future RUC review and consideration at the September 2002 meeting. **The RUC recommends the following interim work relative values for CPT codes 38207-38215:**

38207	**0.47**
38208	**0.56**
38209	**0.24**
38210	**0.94**
38211	**0.71**
38212	**0.47**
38213	**0.24**
38214	**0.24**
38215	**0.55**

38242 *Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions*

The specialty presented a typical patient that is severely ill and in great risk. Approximately 25% of these procedures are complicated by life threatening reactions to the infusion. The RUC agreed with the specialties description of the intensity of intra-service work and 25th percentile time of 30 minutes.

The RUC also understood that this service could be compared to several other intense procedures including critical care code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.0), however, the work for this code was not quite as intense, and could be more appropriately aligned with code 99357 *Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); each additional 30 minutes (List separately in addition to code for prolonged physician service* (work RVU= 1.71) for its time and intensity. The RUC in addition, believed code 38242 was less intense than the reference code 38240 *Bone marrow or blood-derived peripheral stem cell transplantation; allogenic* (work RVU = 2.24, Harvard total time 53). **The RUC recommends a relative work value of 1.71 for code 38242,** which has the approval of the specialty society.

Practice Expense: The RUC and the specialty society agreed that these procedures do not have any practice expense inputs and are performed exclusively in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
• 38204	AV1	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	XXX	2.0
• 38205	X1	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic	000	1.50
• 38206	X2	autologous	000	1.50
• 38207	X3	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage (For diagnostic cryopreservation and storage, see 88240)	XXX	0.47 (Interim)
• 38208	X4	thawing of previously frozen harvest	XXX	0.56

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(For diagnostic thawing and expansion of frozen cells, see 88241)		(Interim)
•38209	X5	washing of harvest	XXX	0.24 (Interim)
•38210	X6	specific cell depletion within harvest, T-cell depletion	XXX	0.94 (Interim)
•38211	X7	tumor cell depletion	XXX	0.71 (Interim)
•38212	X8	red blood cell removal	XXX	0.47 (Interim)
•38213	X9	platelet depletion	XXX	0.24 (Interim)
•38214	X10	plasma (volume) depletion	XXX	0.24 (Interim)
•38215	X11	cell concentration in plasma, mononuclear, or buffy coat layer	XXX	0.55 (Interim)
~~38231~~		~~Blood-derived peripheral stem cell harvesting for transplantation, per collection~~ (38231 has been deleted. To report, use 38205-38206)	XXX	N/A
•38242	X12	Bone marrow or blood-derived peripheral stem cell	XXX	1.71

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		transplantation; allogeneic donor lymphocyte infusions		
~~86915~~		~~Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (eg, T cells, metastatic carcinoma)~~ (86915 has been deleted. To report, use 38210-38213)	XXX	N/A

CPT Code: 38204

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38204 Tracking Number: AV1 Global Period: XXX **Recommended RVW:** 2.0

CPT Descriptor: Management of recipient hematopoietic proginator cell donor search and cell acquisition

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with acute leukemia who lacks an HLA identical sibling. Because of the need for treatment of the leukemia, a search for an unrelated donor is required. The patient's acute leukemia is in relapse.
The unrelated donor registry has 30 potential donors who are AB matched and 5 who are AB DR matched but are molecular subtype mismatched. It is necessary to select potential donors for further HLA typing, review the HLA typing to determine which donor is the best possible match and select that donor as the potential donor. While a search coordinator orders the testing, the review of which prospective donors are tested and ultimate selection of a prospective donor is done by a physician. Criteria are the patient's age, the donor's age, the patient's CMV status, the donor's CMV status, and the patient's HLA typing and sub-typing. The urgency of transplantation determines how closely the donor must match the recipient to be acceptable and how long the search continues. Once a potential unrelated donor is identified, requests are made for information from the unrelated donor registry to help decide whether to acquire unrelated bone marrow or stem cells from a prospective donor. The donor size, HLA match, and status of patient's leukemia (i.e., in remission or relapse) are used to make this decision. If the source of hematopoietic progenitors is an umbilical cord blood, the ordering physician reviews how many cells are in the umbilical cord and if possible how many CD34(+) cells, before madding a decision to order that particular cord blood. The physician managing the unrelated donor search then write a prescription requesting that hematopoietic progenitor cells be collected from the prospective donor and by either a bone marrow harvest or a blood-derived peripheral blood progenitor cell collection. The requesting physician requests that the progenitor cells be collected to meet the recipient's needs. The bone marrow, stem cells or umbilical cord blood is collected, local to the donor. The physician responsible for the donor's collection then informs the physician ordering the hematopoietic progenitor what the donor is capable of donating. The recipient's physician determines if this is acceptable to meet the needs of the patient or if the search needs to continue to find a donor able to meet the recipient's needs. The donor's physician tries to balance all donor safety needs with recipient needs for the product. The risk for patient care is high.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.4

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.5 75th Percentile RVW: 3.25 Low: 1 High: 5

Median Pre-Service Time: 20 Median Intra-Service Time: 100

25th Percentile Intra-Svc Time: 52.5 75th Percentile Intra-Svc Time: 120 Low: 0 High: 300

CPT Code: 38204

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	0	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	20	No RUC data
Median Intra-Time	52.50	No RUC data
Median Immediate Post-service Time	0	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.67	4.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.67	3.80
Urgency of medical decision making	4.47	3.73

Technical Skill/Physical Effort (Mean)

Technical skill required	4.40	3.71
Physical effort required	1.67	2.21

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.73	3.86
Outcome depends on the skill and judgement of physician	4.80	3.79
Estimated risk of malpractice suit with poor outcome	3.73	2.93

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.25	3.25
Intra-Service intensity/complexity	3.92	3.38
Post-Service intensity/complexity	3.57	2.57

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38204.

FREQUENCY INFORMATION

How was this service previously reported? Not previously paid (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty_____ _____Commonly _____Sometimes _____Rarely

Specialty_____ _____Commonly _____Sometimes _____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

CPT Code: 38204

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? _X_Yes _____No

CPT Code: 38205

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38205 Tracking Number: X 1 Global Period: 000 ~~**Recommended RVW: 2.0**~~

RUC Recommended RVW: 1.50

CPT Descriptor: Blood derived hematopoietic proginator cell harvest for future transplantation per collection; allogeneic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient has AML in first relapse with an HLA identical sibling. Allogeneic bone marrow/stem cell transplant is the only curative procedure.
First, the physician evaluates whether the donor is a good donor, Hepatitis types (if any), HLA type of the donor, transmissible diseases, and donor size versus recipient size to make a decision about using an allogeneic stem cell harvest. Then the actual peripheral mononuclear stem cells are harvested from the allogeneic donor using an FDA approved apheresis device. Prior to starting the procedure that day the physician checks donor electrolytes, creatinine, CBC, and ECG. The physcian monitors the amount of RBC's removed by the machine continuously if donor and recipient are ABO mismatched. The physcian continuously monitors donor safety by evaluating blood pressure, pulse, and replaces electrolytes, especially calcium as determined by patient symptoms and ECG monitoring. Post procedure the donor CBC is checked if platelets need to be added from the product. Quality assessment of the collection procedure is performed by the physician using cell counts, cell differentials, flow cytometry, infection control cultures, etc.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.70

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 2.38 75th Percentile RVW: 4.0 Low: 2.0 High: 5.0

Median Pre-Service Time: 38 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 120 Low: 10 High: 300

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Median Post-Service Time:		
Immediate Post Service Time:	30	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	000	2.11

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

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	38	0
Median Intra-Time	45	55
Median Immediate Post-service Time	30	0
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.87	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	4.07
Urgency of medical decision making	4.20	4.13

Technical Skill/Physical Effort (Mean)

Technical skill required	4.40	4.13
Physical effort required	2.73	2.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.27	3.80
Outcome depends on the skill and judgement of physician	4.47	3.80
Estimated risk of malpractice suit with poor outcome	4.40	3.80

CPT Code: 38205

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.90	3.90
Intra-Service intensity/complexity	3.93	3.73
Post-Service intensity/complexity	3.33	3.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38205.

FREQUENCY INFORMATION

How was this service previously reported? 38231 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty_____ ____Commonly ____Sometimes ____Rarely

Specialty_____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38206 Tracking Number: X2 Global Period: 000 ~~**Recommended RVW: 2.0**~~
RUC Recommended RVW: 1.50

CPT Descriptor: Blood derived hematopoietic proginator cell harvest for future transplantation per collection; autologous

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with Hodgkin's disease in second relapse with no marrow involvement. BMT is curative. Autologous peripheral stem cell collection is treatment of choice. Recipient needs to be assessed for risk of myelodysplasia.
First, the patient's bone marrow cellularity is assessed. The hematopoietic progenitor cells are assessed for any cytogenetic defects and for any blood transmissible diseases. Blood-derived hematopoietic progenitor cells are harvested. Prior to starting the procedure that day the physcian checks patient electrolytes, creatinine, CBC, and ECG. The physcian continuously monitors patient safety by evaluating blood pressure, pulse, and replaces electrolytes, especially calcium as determined by patient symptoms and ECG monitoring. Post procedure the donor CBC is checked if platelets need to be added from the product. Quality assessment of the collection procedure is performed by the physician using cell counts, cell differentials, flow cytometry, infection control cultures, etc.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 3.0

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 2.0 75th Percentile RVW: 4.0 Low: 2.0 High: 6.0

Median Pre-Service Time: 40 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 35 75th Percentile Intra-Svc Time: 120 Low: 15 High: 300

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	XXX	4.0

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	40	15
Median Intra-Time	35	45
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.53	4.27
Urgency of medical decision making	4.40	4.20

Technical Skill/Physical Effort (Mean)

Technical skill required	4.47	4.20
Physical effort required	3.13	3.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.60	4.13
Outcome depends on the skill and judgement of physician	4.53	4.00
Estimated risk of malpractice suit with poor outcome	4.20	3.87

CPT Code: 38206

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.40	4.00
Intra-Service intensity/complexity	4.07	4.07
Post-Service intensity/complexity	3.67	3.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38206.

FREQUENCY INFORMATION

How was this service previously reported? 38231 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty _____ ____Commonly ____Sometimes ____Rarely

Specialty _____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

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

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CPT Code: 38207

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38207 Tracking Number: X3 Global Period: XXX ~~Recommended RVW: 1.0~~
RUC Recommended RVW: 0.47

CPT Descriptor: Cryopreservation and storage

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Peripheral blood stem cells or bone marrow have been collected. These cells are to be cryopreserved for later use as part of an autologous transplant where hematopoietic progenitor cells have to first be cryopreserved for a later autologous hematopoietic progenitor cell transplant. In many cases, the bone marrow or peripheral blood progenitor cells are also cryopreserved for allogeneic transplants. This ensures that the cells are ready and available when the patient needs them. The physcian writes separate prescriptions for cryropreservation and thawing of the product. A physcian supervises both cryropreservation and thawing of the product and in an emergency does these procedure himself/herself as a patient life is in jeopardy.
The cryopreservation process is begun. It is important to make sure the freezing process is performed correctly to ensure that the cells have been frozen in a safe manner to be acceptable for transplantation. This requires following validated standard operating procedures. Cryopreservation data are reviewed and quality assessment of the procedure is performed. Cells are stored at a low temperature under controlled monitored conditions until needed for transplant. The physcian may do this procedure in an emergency. The quality of the cryropreserved transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells, allogeneic t-lymphocytes) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 66% Median RVW: 1.42

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.23 75th Percentile RVW: 1.88 Low: 1.00 High: 8.00

Median Pre-Service Time: 2.5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 56.25 Low: 10 High: 420

CPT Code: 38207

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	12.5	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	2.5	No RUC data
Median Intra-Time	20	No RUC data
Median Immediate Post-service Time	12.5	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.64	3.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.54
Urgency of medical decision making	4.14	3.92

Technical Skill/Physical Effort (Mean)

Technical skill required	4.29	3.62
Physical effort required	2.43	2.08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.36	4.00
Outcome depends on the skill and judgement of physician	4.21	4.15
Estimated risk of malpractice suit with poor outcome	4.43	4.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.13	2.63
Intra-Service intensity/complexity	3.62	3.08
Post-Service intensity/complexity	3.22	2.63

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38207.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty_____ ____Commonly ____Sometimes ____Rarely

Specialty_____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

CPT Code: 38207

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? _X_Yes _____No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38208 Tracking Number: X4 Global Period: XXX ~~Recommended RVW: 1.2~~
RUC Recommended RVW: 0.56

CPT Descriptor: Thawing of previously frozen harvest

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The previously cryopreserved marrow and stem cells are thawed in a heated water bath. A sample is obtained for post-thaw quality assessment such as nucleated cell count and viability. Cells are infused immediately post-thaw. The physician may do this procedure in an emergency. The quality of the thawed transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells, allogeneic t-lymphocytes) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 76% Median RVW: 1.42

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.00 75th Percentile RVW: 2.58 Low: 0.37 High: 5

Median Pre-Service Time: 5 Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 24 75th Percentile Intra-Svc Time: 60 Low: 5 High: 150

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	5	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	5	No RUC data
Median Intra-Time	24	No RUC data
Median Immediate Post-service Time	5	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	3.19
Urgency of medical decision making	4.19	3.06

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	3.19
Physical effort required	2.56	2.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.06	3.19
Outcome depends on the skill and judgement of physician	3.75	3.38
Estimated risk of malpractice suit with poor outcome	4.00	3.31

CPT Code: 38208

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.10	2.50
Intra-Service intensity/complexity	3.75	3.13
Post-Service intensity/complexity	3.20	2.50

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38208.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty _____ ____Commonly ____Sometimes ____Rarely

Specialty _____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38209 Tracking Number: X5 Global Period: XXX ~~Recommended RVW: 0.5~~
RUC Recommended RVW: 0.24

CPT Descriptor: Washing of harvest

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Blood derived hematopoietic progenitor cells have been harvested but the patient mobilizes very poorly with few stem cells. Thus, it is necessary to freeze them in multiple aliquots. Such harvest material contains a significant number of neutrophils or mature granulocytes, which are not capable of restoring hematopoiesis. Only the primitive cells are able to do this. DMSO is necessary for the cyropreservation. Because the cells have been frozen in multiple aliquots (multiple bags of these products were frozen over many days and then thawed later), the total content of DMSO is large and the patient gets a large exposure to DMSO. Such large amounts of DMSO in the transplant can potentially cause projectile vomiting and other injury to the patient. Thus it is necessary to wash the harvest cells to minimize the DMSO content] A physcian writes a prescription for this procedure based on the review of the cryropreserved product and whether recipient needs to maximize cell dose or minimize DMSO toxicity. The physcian may do this procedure n an emergency.
The thawed cells are washed using an automated cell washer. During the wash process, cells are concentrated and resuspended in infusible grade solutions such as saline/albumin. The physcian may do this procedure in an emergency. Quality assessment of the washed product is performed. The quality of the thawed transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new or additional product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 57% Median RVW: 1.25

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 0.99 75th Percentile RVW: 2.20 Low: 0.50 High: 4.00

Median Pre-Service Time: 5 Median Intra-Service Time: 37.5

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 60 Low: 0 High: 240

CPT Code: 38209

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
85097	Bone marrow, smear interpretation	XXX	0.94

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	5	No RUC data
Median Intra-Time	25	No RUC data
Median Immediate Post-service Time	10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	2.82
Urgency of medical decision making	4.00	3.09

Technical Skill/Physical Effort (Mean)

Technical skill required	3.92	3.09
Physical effort required	2.42	2.18

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.08	3.36

Outcome depends on the skill and judgement of physician	3.50	3.18
Estimated risk of malpractice suit with poor outcome	3.83	3.27

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	3.20
Intra-Service intensity/complexity	3.55	2.90
Post-Service intensity/complexity	3.43	3.17

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38209.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty_____ ____Commonly ____Sometimes ____Rarely

Specialty_____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

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

Specialty _____ Frequency: No Medicare Data on code

CPT Code: 38209

Specialty _____ Frequency _____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38210 Tracking Number: X6 Global Period: XXX ~~Recommended RVW: 2.0~~
RUC Recommended RVW: 0.94

CPT Descriptor: Specific cell depletion within harvest; T-cell depletion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 10 year old boy with DiGeorge's Syndrome who needs a bone marrow/peripheral blood progenitor stem cell transplant from his father. The marrow has to be T-cell depleted for this allogeneic graft to reduce the risk of graft versus host disease. The physcian writes a prescription ordering this procedure based on recipient needs and the degree of HLA mismatching with the donor. In an emergency the physcian may do this procedure.
T-cell depletion is performed using various methods such as the Baxter Isolex device. This instrument enriches the stem cells (CD34+) and passively removes unwanted cells such as T-cells. In an emergency the physcian may do this procedure. Quality assessment of the product is performed. . The quality of the T-lymphocyte depleted hematopoietic progenitor cell product (bone marrow or blood-derived) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells and T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.50

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.50 75th Percentile RVW: 3.25 Low: 1.08 High: 10

Median Pre-Service Time: 10 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 23 75th Percentile Intra-Svc Time: 210 Low: 0 High: 600

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	10	No RUC data
Median Intra-Time	23	No RUC data
Median Immediate Post-service Time	20	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.13	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	3.47
Urgency of medical decision making	4.40	3.47

Technical Skill/Physical Effort (Mean)

Technical skill required	4.60	4.14
Physical effort required	2.67	2.21

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.73	3.93
Outcome depends on the skill and judgement of physician	4.47	3.79
Estimated risk of malpractice suit with poor outcome	4.27	3.79

CPT Code: 38210

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.20	2.89
Intra-Service intensity/complexity	4.21	3.47
Post-Service intensity/complexity	3.70	2.80

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38210.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty_____ ____Commonly ____Sometimes ____Rarely

Specialty_____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38211 Tracking Number: X 7 Global Period: XXX ~~Recommended RVW: 1.5~~
RUC Recommended RVW: 0.71

CPT Descriptor: Tumor Cell Depletion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 25 year old male with B-cell lymphoma or breast cancer metastatic to the bone marrow. The patient needs an autologous peripheral blood stem cell harvest with later transplant but there is known tumor contamination in the bone marrow. A physcian writes a prescription for this procedure based on review of the patient's disease and risk of tumor contamination. In an emergency, a physcian may do this procedure.
Tumor cell depletion is performed using various methods such as the Baxter Isolex device, which has been FDA approved for tumor depletion. The instrument enriches for stem cells (CD34+) and passively removes unwanted cells such as tumor cells. Quality assessment of the product is performed. In an emergency a physcian may do this procedure. The quality of the tumor cell depleted hematopoietic progenitor cell product (bone marrow or blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells and or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.27

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.63 75th Percentile RVW: 2.75 Low: 1.00 High: 6.00

Median Pre-Service Time: 5 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 105 Low: 0 High: 360

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	5	No RUC data
Median Intra-Time	25	No RUC data
Median Immediate Post-service Time	10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.36
Urgency of medical decision making	4.07	3.21

Technical Skill/Physical Effort (Mean)

Technical skill required	4.57	4.00
Physical effort required	2.57	2.15

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	3.86
Outcome depends on the skill and judgement of physician	3.93	3.57
Estimated risk of malpractice suit with poor outcome	3.80	3.79

CPT Code: 38211

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.90	2.60
Intra-Service intensity/complexity	4.14	3.47
Post-Service intensity/complexity	3.50	2.80

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38211.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty _____ ____Commonly ____Sometimes ____Rarely

Specialty _____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

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

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CPT Code: 38212

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38212 Tracking Number: X 8 Global Period: XXX ~~Recommended RVW: 1.0~~
RUC Recommended RVW: 0.47

CPT Descriptor: Red blood cell removal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old female with leukemia is blood type O and requires a peripheral blood stem cell transplant. The donor is blood type A. With such a stem cell harvest, ABO blood group barriers are routinely crossed. If fresh bone marrow containing Type A red blood cells is given to the patient, those type A cells will be immediately hemolyzed. This would cause renal failure and ultimately death to the patient because they could not receive post transplant immunosuppression therapy. Because of the different blood types, red blood cell depletion is required from the harvest. The stem cell harvest is then performed. A physcian writes an order for this procedure and supervises it. In an emergency, a physcian may do this procedure.
The red cell depletion can be done by various methods such as mononuclear cell concentration using an FDA approved apheresis device, mononuclear cell enrichment using density gradient solution, hydroxyethel starch which is FDA approved as an infusible solution. In an emergency a physcian may do this procedure. Quality assessment of the product is performed. The quality of the hematopoietic progenitor cells (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are hematocrit, red cell count, nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.50

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.00 75th Percentile RVW: 2.10 Low: 0.50 High: 3.00

Median Pre-Service Time: 5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 12.5 75th Percentile Intra-Svc Time: 120 Low: 0 High: 150

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
90935	Hemodialysis procedure with single physician evaluation	000	1.22

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

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	5	0
Median Intra-Time	12.5	21
Median Immediate Post-service Time	15	0
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.00
Urgency of medical decision making	3.60	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	3.80	3.53
Physical effort required	2.27	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.07	4.07
Outcome depends on the skill and judgement of physician	3.80	3.67
Estimated risk of malpractice suit with poor outcome	4.33	3.47

CPT Code: 38212

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.70
Intra-Service intensity/complexity	3.50	3.27
Post-Service intensity/complexity	3.40	2.80

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38212.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty_____ ____Commonly ____Sometimes ____Rarely

Specialty_____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38213 Tracking Number: X 9 Global Period: XXX ~~Recommended RVW: 0.5~~
RUC Recommended RVW: 0.24

CPT Descriptor: Platelet depletion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with leukemia who requires an allogeneic peripheral blood stem cell transplant. The donor is much smaller than the intended recipient, thus requiring multiple days of harvesting. Because multiple successive days of stem cell collection causes the donor's platelets to become severely depleted, prior platelet depletion of the donor is required. The physcian assesses both donor needs and recipient needs as this procedure will deplete some of the hematopoietic progenitors collected. A physcian writes a prescription for a platelet addback to be obtained and separated from the blood-derived hematopoietic progenitor cell product. A physcian supervises this procedure. In an emergency a physcian does this procedure.
The collected apheresis product is depleted of platelets using a centrifugation method. The separated platelets are infused back to the donor and the stem cells are used for transplantation for the patient. In an emergency a physcian does this procedure. Quality assessment on both products is performed. It is critical to be sure that the donor is not harmed by an excessively low platelet count as part of the transplant process. The physician has to ascertain whether there is a quality platelet product obtained from the donor with minimal risk to the transplant product. . The quality of the platelets (bone marrow or blood-derived) must be assessed prior to release of product. Examples of quality assurance are platelet count, hematocrit,nucleated cell count, viability, and sterility. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product is suitable for infusion.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 52% Median RVW: 1.20

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.00 75th Percentile RVW: 1.75 Low: 0.80 High: 3.50

Median Pre-Service Time: 10 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 67.5 Low: 0 High: 180

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	10	No RUC data
Median Intra-Time	20	No RUC data
Median Immediate Post-service Time	10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.27	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.18	3.73
Urgency of medical decision making	3.91	3.73

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.82
Physical effort required	2.55	2.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.82
Outcome depends on the skill and judgement of physician	3.55	3.73

Estimated risk of malpractice suit with poor outcome	4.00	3.45

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	3.17
Intra-Service intensity/complexity	3.30	3.45
Post-Service intensity/complexity	3.33	3.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38213.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty_____ ____Commonly ____Sometimes ____Rarely

Specialty_____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

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

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CPT Code: 38214

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38214 Tracking Number: X 10 Global Period: XXX ~~Recommended RVW: 0.50~~
RUC Recommended RVW: 0.24

CPT Descriptor: Plasma (volume) depletion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with leukemia who is type A and requires a bone marrow transplant. The only available donor is type O. The donor's type O plasma has sufficient anti-A that it may cause hemolysis with infusion of the marrow product. The plasma needs to be depleted from this product so that there can be a safe transplant. A physcian writes a prescription for and supervises this procedure. In an emergency a physcian does this procedure.
Plasma/volume depletion can be done by various methods (i.e. centrifugation or nucleated cell concentration using an FDA approved apheresis device. In this process, stem cells are concentrated and plasma/excess volume are removed. In an emergency a physcian does this procedure. Quality assessment of the product is performed. The quality of the plasma depleted hematopoietic progenitor cell transplantation product (bone marrow-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells or T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if the procedure needs to be repeated.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.30

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.00 75th Percentile RVW: 1.66 Low: 0.50 High: 2.80

Median Pre-Service Time: 5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 60 Low: 0 High: 120

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	5	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	5	No RUC data
Median Intra-Time	10	No RUC data
Median Immediate Post-service Time	5	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.27	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.13
Urgency of medical decision making	3.73	3.07

Technical Skill/Physical Effort (Mean)

Technical skill required	3.80	3.67
Physical effort required	2.20	2.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	3.93
Outcome depends on the skill and judgement of physician	3.67	3.60
Estimated risk of malpractice suit with poor outcome	4.07	3.60

CPT Code: 38214

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.60
Intra-Service intensity/complexity	3.36	3.27
Post-Service intensity/complexity	3.22	2.78

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38214.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty_____ ____Commonly ____Sometimes ____Rarely

Specialty_____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38215 Tracking Number: X 11 Global Period: XXX ~~Recommended RVW: 1.18~~
RUC Recommended RVW: 0.55

CPT Descriptor: Cell concentration in plasma, mononuclear, or buffy coat layer

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with leukemia who is type B and requires a peripheral blood stem cell transplant. The only available donor is type A. Thus, to prevent transplant problems, a purified hematopoietic progenitor cell population (with minimal red cell and plasma contamination) is needed for the graft. A physcian writes an order for this procedure and supervises. In an emergency a physcian may do this procedure.

In this scenario, to avoid hemolytic transfusion reaction, both the RBCs and plasma must be removed. This can be achieved by various methods such as mononuclear cell concentration using an FDA approved apheresis device or density gradients solutions. In this process, stem cells are concentrated and plasma/excess volumes are removed. In an emergency a physcian may do this procedure. Quality assessment of the product is performed. The quality of the mononuclear cell preparation of the hematopoietic progenitor cell transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are hematocrit,nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells and T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if the procedure needs to be repeated or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.50

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.18 75th Percentile RVW: 1.99 Low: 0.50 High: 3.60

Median Pre-Service Time: 5 Median Intra-Service Time: 40

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 110 Low: 0 High: 150

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	5	No RUC data
Median Intra-Time	25	No RUC data
Median Immediate Post-service Time	15	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.47	3.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.27
Urgency of medical decision making	4.00	3.53

Technical Skill/Physical Effort (Mean)

Technical skill required	4.20	3.80
Physical effort required	2.53	2.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.40	4.33
Outcome depends on the skill and judgement of physician	4.20	3.93
Estimated risk of malpractice suit with poor outcome	4.20	3.93

CPT Code: 38215

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.60
Intra-Service intensity/complexity	3.64	3.20
Post-Service intensity/complexity	3.20	2.60

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38215.

FREQUENCY INFORMATION

How was this service previously reported? 86915 _____ (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty_____ ____Commonly ____Sometimes ____Rarely

Specialty_____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty_____ Frequency_____

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

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

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CPT Code: 38242

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38242 Tracking Number: X 12 Global Period: XXX ~~Recommended RVW: 2.0~~
RUC Recommended RVW: 1.71

CPT Descriptor: Allogeneic donor lymphacyte infusion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female who has previously received an allogeneic bone marrow transplant for chronic myelogenous leukemia. Post-transplant, the patient relapses with the return of the Philadelphia chromosome positive cells. A lymphocyte infusion transplant procedure is recommended because of this relapse. An allogeneic donor is found for the lymphocyte infusion and the donor has undergone one day of pheresis to produce the transplant material.
Allogeneic lymphocytes are collected using FDA approved apheresis devices. The T-cell content of the product is determined by flow cytometry. The precise dose of T-cells depends on the type of donor and whether the patient is being treated for infection or relapsed malignancy. Quality assessment of the product is performed.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.3

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

25th Percentile RVW: 2.2 75th Percentile RVW: 3.0 Low: 1.5 High: 9.0

Median Pre-Service Time: 30 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 10 High: 150

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic	XXX	2.24

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

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	30	No RUC Data
Median Intra-Time	30	No RUC Data
Median Immediate Post-service Time	20	No RUC Data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.73	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.87
Urgency of medical decision making	4.20	3.87

Technical Skill/Physical Effort (Mean)

Technical skill required	3.73	3.60
Physical effort required	2.60	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.47	3.67
Outcome depends on the skill and judgement of physician	4.47	3.80
Estimated risk of malpractice suit with poor outcome	3.53	2.87

CPT Code: 38242

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.90	3.90
Intra-Service intensity/complexity	3.67	3.40
Post-Service intensity/complexity	3.50	3.10

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38242.

FREQUENCY INFORMATION

How was this service previously reported? 38231 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty_____ ____Commonly ____Sometimes ____Rarely

Specialty_____ ____Commonly ____Sometimes ____Rarely

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

Specialty _____ Frequency:_____

Specialty _____ Frequency_____

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

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/Specialty Society RVS Update Committee
Summary of Recommendations

Intracranial Angioplasty and Stenting

The CPT Editorial Panel created five new CPT Codes to describe new procedures involving intracranial angioplasty and stenting. Prior to the Panel's action, there were no codes to describe this treatment of patients with impaired cerebral circulation due to arterial narrowing. Angioplasty and stenting of the arteries supplying the brain is more complex than peripheral and coronary angioplasty and stenting cases.

61630 and 61635
The RUC first reviewed codes 61630 *Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous* and 61635 Transcatheter placement of intravascular stent(s) , intracranial (eg, athersosclerotic stenosis), including balloon angioplasty if performed. Both codes were reviewed in comparison to their key reference service 61624 *Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)* (000 day global, Work RVU = 20.12), their intra-service work per unit of time, and physician time. Several of the surveyed respondents chose the specialty society's reference service as the code that they believed best represented the intensity of this service. The RUC believed that the specialty's survey results were well distributed reflected the intensity of these services. However, the RUC and the presenters agreed, that the specialty's survey results of 61630 and 61635, needed some adjustments in physician time and recommended work value to reflect the typical patient encounter. **The RUC recommends a reduction in the level of one hospital visit from a level two to a level one, and the reduction of the level four office visit to a level three, for codes 61630 and 61635.** This reduction in the levels of post operative visits were used to reduce the physician work recommendation below the surveyed, and specialty recommended, 25th percentile work relative value of 21.50. **In addition, the RUC recommends relative work values of 21.08 for code 61630 and 23.08 for code 61635.**

61640
The presenters stated that CPT Code 61640 *Balloon dilatation of intracranial vasospasm, percutanous, initial vessel* was surveyed as a 090 day global code prior to the change in the global to a 000 day global code. CMS representatives at the RUC meeting were comfortable with the code having a 000 day global period. The specialty society's survey results reflected the work of a 090 global code which skewed the median work RVU upward. The RUC compared code 61640 to RUC reviewed code 37216 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection* (090 day global, Work

RVU = 17.98), and realized the intensity for the new code was high, but not as high as code 37216. The RUC discussed the specialty's recommended value and believed reductions in physician time and recommended work value were necessary to reflect the 000 day global period and the typical patient encounter. **The RUC recommends the pre-service evaluation and positioning be reduced from 70 and 18 minutes to 45 and 12 minutes respectively.** While agreeing with the pre-service time change specialty society suggested a building block approach consisting of an IWPUT of 0.107, to arrive at the work RVU. The RUC agreed with the intensity recommended by the specialty and from the changes in pre-service time, the RUC used the following building block approach to establish a work relative value for code 61640.

Building Block Approach
57 minutes of pre-service evaluation and positioning at an intensity of 0.0224 = 1.28
20 minutes of pre-service scrub and dress at an intensity of 0.0081 = 0.16
90 minutes of intra-service work at an intensity of 0.107 = 9.54
60 minutes of immediate post service work with an intensity of 0.0224 = 1.34
The RUC recommends a relative work value of 12.32 for code 61640.

61641 and 61642
The RUC reviewed the two add-on codes 61641 *Balloon dilatation of intracranial vasospasm, percutanous, initial vessel; each additional vessel in same vascular family* and 61642 *Balloon dilatation of intracranial vasospasm, percutanous, initial vessel; each additional vessel in different vascular family* and believed that the intensity for the codes was justified as there is no surgical rescue for procedural complications that occur in the cerebral vasculature. The RUC agreed that based on the specialty society's survey results indicating a very high intensity, and the RUC reviewed comparison service of 37216 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection* (090 day global, Work RVU = 17.98), the intensity of these two add on codes was approximately 0.144. The RUC multiplied the physician time in the intra-service period by the agreed upon intensity to arrive at a relative work value for each code. The resulting work RVUs were deemed appropriate even though they were below the median survey results. The RUC and the specialty also agreed that although the survey results indicated pre and post service physician time, the typical patient encounter did not include this time, and it was extracted from the survey results. **The RUC recommends a relative work value of 4.33 for code 61641 and 8.66 for code 61642.**

Practice Expense
The RUC approved the standard inputs for all of these facility only codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
61624		*Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)* *(See also 37204)* *(For radiological supervision and interpretation, use 75894)*	000	20.12 (No Change)
61626		*non-central nervous system, head or neck (extracranial, brachiocephalic branch)* *(See also 37204)* *(For radiological supervision and interpretation, use 75894)*	000	16.60 (No Change)
•61630	RR1	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	090	21.08
•61635	RR2	Transcatheter placement of intravascular stent(s) , intracranial (eg, athersosclerotic stenosis), including balloon angioplasty if performed (61630 and 61635 include all selective vascular catheterization of the target vascular family, all diagnostic imaging for arteriography of the target vascular family and all related radiological supervision and interpretation. When diagnostic arteriogram (including imaging and selective catheterization) confirms the need for angioplasty or stent placement, 61630 and 61635 are inclusive of these services. If angioplasty or stenting are not indicated, then the appropriate codes for selective catheterization and imaging should be reported in lieu of 61630 and 61635)	090	23.08
•61640	RR3	Balloon dilatation of intracranial vasospasm, percutanous, initial vessel	000	12.32
•+61641	RR4	each additional vessel in same vascular family (List separately in addition to code for primary procedure)	ZZZ	4.33

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•+61642	RR5	each additional vessel in different vascular family (List separately in addition to code for primary procedure) (Use 61641 and 61642 in conjunction with 61640) (61640, 61641, 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for the balloon dilatation)	ZZZ	8.66

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:61640 Tracking Number: RR3 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **12.71**
RUC RVU: **12.32**

CPT Descriptor: Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel

(61640, 61641, and 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42 year-old female with recent subarachnoid hemorrhage deteriorates clinically. She undergoes complete cerebral angiography (separately reportable even if performed on the same day), which demonstrates significant spasm of the supraclinoid segment of the right internal carotid artery. After reporting this finding to the attending neurosurgeon, he requests balloon dilatation of the spastic segment.

NOTE: The proposed new code includes all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: · The interventional suite is checked to ensure proper function and configuration of the imaging equipment including compliance with all radiation safety issues. · The physician ensures that all technical personnel have been familiarized with the technique and are fully familiar with all required devices. Prior films/studies are located and reviewed.· Don radiation protection· Position (or supervise proper positioning of) patient

Description of Intra-Service Work: · The common femoral artery is accessed and a sheath placed under sterile conditions.· A bolus dose of intravenous heparin is administered.· The ACT is checked. Additional heparin is given as necessary throughout the procedure, and the ACTs are monitored at appropriate intervals.· Pressurized, continuous heparin/saline flush systems are prepared. Meticulous examination of these systems is performed by the physician to exclude the possibility of residual air bubbles.· Left common carotid artery selectively catheterized with 5 Fr catheter.· Biplane AP and lateral angiograms of the cervical common carotid artery are obtained. If necessary, oblique views are obtained to profile carotid the carotid bifurcation. Biplane AP and lateral (and possibly oblique) angiograms of the intracranial vessels are also obtained to determine that no interval change has occurred since the original diagnostic angiogram.· Advance catheter into the external carotid artery over a steerable guidewire.· Utilizing an exchange wire placed into the external carotid artery, a neuroguide catheter is placed into the common carotid artery.·A common carotid artery angiogram is obtained to confirm appropriate positioning of the guide catheter below the carotid bifurcation and to exclude the possibility of arterial spasm, dissection or thromboembolus during guide catheter placement.· The guide catheter is then advanced into the internal carotid artery over a steerable guide wire. · A cervical internal carotid artery angiogram is obtained to confirm appropriate positioning of the guide catheter and to exclude the possibility of arterial spasm, dissection or thromboembolus.· Guide catheter is placed on continuous heparin flush utilizing a flow control Y-connector.· Biplane AP, lateral and oblique angiograms of the cerebral vessels are obtained. High magnification biplane angiograms are then obtained, centered upon the arterial stenosis. The target lesion must be carefully reassessed for subtle changes that indicate the development of subacute intraluminal thrombus, which is a contraindication to performance of angioplasty. Precise, quantitative measurements of the stenotic artery are obtained to determine the proper diameter and length of the angioplasty balloon to be used. External reference markers may be placed on the skin in order to calculate the precise dimensions. · Prepare appropriate size angioplasty balloon. Meticulous preparation is done by the physician to eliminate the air within the

balloon.· Advance a steerable micro-guidewire and a low profile microcatheter through the guide catheter into the intracranial arteries using an angiographic roadmap.· Gently advance micro-guidewire and microcatheter across the arterial stenosis.· Remove the guidewire and replace with an exchange length wire, leaving the wire tip beyond the stenotic area.· Remove microcatheter.· Advance micro-angioplasty balloon over the exchange wire and across the stenosis. · Slowly inflate balloon to dilate the lesion under fluoroscopic control while monitoring balloon pressure.· Deflate balloon and withdraw into internal carotid artery, leaving the guidewire across the stenosis.· Obtain post-angioplasty angiograms by injecting contrast through the guide catheter to confirm satisfactory dilation of vessel lumen and antegrade filling of distal blood vessels. · Wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosois.· If evidence of rebound stenosis, replace balloon to re-dilate the lesion or exchange for a larger angioplasty balloon if needed.· Again wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosois.· After a fifteen-minute period of observation with no further evidence of restenosis or acute arterial occlusion, remove the balloon and wire; then obtain final angiograms of the regional circulation to check for possible embolic complications.· Remove guide catheter. · All fluoroscopy, contrast injection, angiography and image interpretation associated with the arterial stenosis treated is included in the procedure up to this point

Description of Post-Service Work: · A brief operative note is made in the medical record.· Write post-op orders. · Communicate with family & referring physicians· A complete neurological examination is repeated as soon as the patent has emerged from the effects of the anesthesia.· Angiographic imaged are reviewed and post-processed including quantitative measurement of any residual arterial stenosis. Final copies are stored in the permanent patient record.· A detailed operative note is dictated.· The femoral artery sheath is removed after the ACT has returned to an acceptable level.· Review, revise, sign final report· Send formal report to PCP and referring providers

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2005					
Presenter(s):	John Barr, MD; John Wilson, MD; Robert Vogelzang, MD					
Specialty(s):	American Society of Interventional and Therapeutic Neuroradiology, American Society of Neuroradiology, American Association of Neurological Surgeons, Society of Interventional Radiology					
CPT Code:	61640					
Sample Size:	175	**Resp n:** 41		**Response:**	%	
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		9.47	19.00	**20.00**	25.00	40.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**17.0**		
Pre-Service Scrub, Dress, Wait Time:				**20.0**		
Intra-Service Time:		30.00	60.00	**90.00**	150.00	240.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**60.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
61624	000	20.12

CPT Descriptor Transcatheter permanent occlusion or embolization (eg, for tumor destruction to achieve hemostatis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU
37216	090	17.98

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection.

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

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

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 56.0 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 61640	Key Reference CPT Code: 61624
Median Pre-Service Time	77.00	0.00
Median Intra-Service Time	90.00	0.00
Median Immediate Post-service Time	60.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**227.00**	**0.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.10	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.15	3.60
Urgency of medical decision making	4.85	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.67	4.10
Physical effort required	4.15	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.83	3.98
Outcome depends on the skill and judgment of physician	4.75	4.10
Estimated risk of malpractice suit with poor outcome	4.45	4.03

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.03	3.73
Intra-Service intensity/complexity	4.53	4.15
Post-Service intensity/complexity	3.95	3.53

ADDITIONAL RATIONALE

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

Overview:

Surveys were distributed to physicians representing specialties and sub-specialties in radiology and surgery. Response rate was excellent, and the data are tightly clustered. The procedure selected most often as reference services were CPT 61624 transcatheter embolization, and CPT 37216 carotid stent placement, which was recently surveyed by the RUC. The transcatheter embolization comparison is appropriate from a clinical perspective since the microvascular surgical

techniques using the balloon in the intracranial artery are similar. Both procedures have a similar level of extreme intensity and potential patient risk to the patient

Rationale and IWPUT Analysis

We believe that the survey results and the following IWPUT analysis serve to justify 12.71 as an appropriate RVW for this new service if valued with a 000-day global. Although a 90-day global period was assigned to the intracranial vasospasm code we believe that this assignment was done in error and had subsequently asked for pre-facilitation to discuss this matter. A 90-day global for this code is problematic for several reasons: the typical patient has previously undergone a procedure for definite treatment of a ruptured aneurysm. The patient subsequently develops cerebral vasospasm during the 90-day global period of the original procedure. The patients that will undergo this new procedure are symptomatic from cerebral ischemia, are in an ICU and are refractory to medical management consisting of hypertensive, hypervolemic therapy. These patients are generally critically ill. After undergoing cerebral angioplasty for treatment of this vasospasm they will still require intensive, and potentially prolonged, medical management that will still fall under the original 90-day global period. These patients may subsequently develop vasospasm in other vascular territories or recurrent vasospasm within the treated vessel(s). Balloon dilatation may thus be required on more than one occasion. This may be performed by another physician because a group of physicians is typically available to provide continuous coverage of this procedure. It was clear that our survey respondents had enormous difficulty quantifying the post-procedure care. We feel this was because there is enormous variability both in the length of stay and the level of post-operative E&M visits. We felt that a 000-day global was most appropriate for this code, however, it was assigned a 90-day global by CMS. We surveyed this code with the 90-day global and have included that data in this summary recommendation form. We requested pre-facilitation in an attempt to address the issue of the global period. At the pre-facilitation committee meeting, CMS indicated a willingness to reconsider the global period. We have calculated what we feel is an appropriate value for 6162X3 with a 000-day global utilizing a reverse building block analysis in which we backed out the value of all of the post procedure E&M not accounted for in a 000-day global. On the basis of this analysis, we are recommending an RVW of 12.71 with a calculated IWPUT of 0.106. This value is appropriate relative to the key reference service of 61624 in terms of rank order comparison. Unfortunately, this key reference service does not have RUC survey data and is not on the RUC MPC. We did compare this code to several 000-day global codes on the MPC and our values look appropriate in comparison (see the following table) .

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799

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

Specialty IR/Rad/Neurorad How often? Sometimes

Specialty Neurosurgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty IR/Rad/Neurorad Frequency 20000 Percentage %

Specialty Neurosurgery Frequency 20000 Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty IR/Rad/Neurorad Frequency 15000 Percentage %

Specialty Neurosurgery Frequency 15000 Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

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

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:61641 Tracking Number: RR4 Global Period: ZZZ

Recommended Work Relative Value
Specialty Society RVU: **5.00**
RUC RVU: **4.33**

CPT Descriptor: Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in the same vascular family (List separately in addition to code for primary procedure)

(Use 61641 and 61642 in conjunction with 61640)
(61640, 61641, and 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year-old male with recent subarachnoid hemorrhage. Complete cerebral angiography (separately reportable even if performed on the same day) demonstrated significant vasospasm in the supraclinoid left internal carotid artery and the M1 segment of the left middle cerebral artery. After reporting this finding to the attending neurosurgeon, he/she requests balloon dilatation of the spastic segments. The internal carotid spasm balloon dilatation is completed (separately reportable) and the M1 segment spasm is now to be balloon dilated.

NOTE: 61641 is considered an ADD-ON procedure code that should be reported in conjunction with 61640. Additionally, the proposed new code includes all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: · A second bolus dose of intravenous heparin may be administered.· The ACT is checked. Additional heparin is given as necessary throughout the procedure, and the ACTs are monitored at appropriate intervals.· Biplane AP, lateral and oblique angiograms of the cerebral vessels are obtained. High magnification biplane angiograms are then obtained, centered upon the arterial stenosis. The target lesion must be carefully reassessed for subtle changes that indicate the development of subacute intraluminal thrombus, which is a contraindication to performance of angioplasty. Precise, quantitative measurements of the stenotic artery are obtained to determine the proper diameter and length of the angioplasty balloon to be used. External reference markers may be placed on the skin in order to calculate the precise dimensions. · Prepare appropriate size angioplasty balloon. Meticulous preparation is done by the physician to eliminate the air within the balloon.· Advance a steerable micro-guidewire and a low profile microcatheter through the guide catheter into the 2nd target intracranial arterie(s) (additional vessel, same vascular family) using an angiographic roadmap.· Gently advance micro-guidewire and microcatheter across the arterial stenosis.· Remove the guidewire and replace with an exchange length wire, leaving the wire tip beyond the stenotic area.· Remove microcatheter.· Advance micro-angioplasty balloon over the exchange wire and across the stenosis.· Slowly inflate balloon to dilate the lesion under fluoroscopic control while monitoring balloon pressure.· Deflate balloon and withdraw into internal carotid artery, leaving the guidewire across the stenosis.· Obtain post-angioplasty angiograms by injecting contrast through the guide catheter to confirm satisfactory dilation of vessel lumen and antegrade filling of distal blood vessels. · Wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosois.· If evidence of rebound stenosis, replace balloon to re-dilate the lesion or exchange for a larger angioplasty balloon if needed.· Again wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosois.· After

a fifteen-minute period of observation with no further evidence of restenosis or acute arterial occlusion, remove the balloon and wire; then obtain final angiograms of the regional circulation to check for possible embolic complications.·

Remove guide catheter. · All fluoroscopy, contrast injection, angiography and image interpretation associated with the arterial stenosis treated is included in the procedure up to this point

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2005					
Presenter(s):	John Barr, MD; John Wilson, MD; Robert Vogelzang, MD					
Specialty(s):	American Society of Interventional and Therapeutic Neuroradiology, American Society of Neuroradiology, American Association of Neurological Surgeons, Society of Interventional Radiology					
CPT Code:	61641					
Sample Size:	175	**Resp n:** 41		**Response:** 23.42 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		4.00	5.00	**9.95**	13.00	37.89
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		8.00	30.00	**30.00**	60.00	180.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**0.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
61624	000	20.12

CPT Descriptor Transcatheter permanent occlusion or embolization (eg, for tumor destruction to achieve hemostatis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU
37216	090	17.98

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection.

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

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

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 56.0 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 61641	Key Reference CPT Code: 61624
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	30.00	0.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**30.00**	**0.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.68
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.36
Urgency of medical decision making	4.91	3.32

Technical Skill/Physical Effort (Mean)

Technical skill required	4.70	4.14
Physical effort required	4.04	3.73

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.91	3.77
Outcome depends on the skill and judgment of physician	4.74	4.05
Estimated risk of malpractice suit with poor outcome	4.39	3.82

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.85	3.70
Intra-Service intensity/complexity	4.43	4.05
Post-Service intensity/complexity	3.45	3.45

ADDITIONAL RATIONALE

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

Overview Surveys were distributed to physicians representing specialties and sub-specialties in radiology and surgery. Response rate was excellent, and the data are tightly clustered. The procedure selected most often as reference services were CPT 61624 transcatheter embolization, and CPT 37216 carotid stent placement, which was recently surveyed by the RUC. The transcatheter embolization comparison is appropriate from a clinical perspective since the microvascular surgical techniques using the balloon in the intracranial artery are similar. Both procedures have a similar level of extreme intensity and potential patient risk to the patient. However, the RUC will have to take into consideration the

fact that 61624 has a 90-day global period and the intracranial vasospasm code is an add-on procedure with a ZZZ global period.

We will be offering comparisons to other ZZZ codes of similar values from the RUC MPC.

Rationale and IWPUT Analysis

The median survey response of 9.95 seemed too high relative to the base code and other ZZZ codes in the MPC. The 25th percentile RVW of 5.00 seemed more appropriate. However, the survey respondents included 20 minutes of additional pre-service time and 10 minutes of additional post-service time. The pre-facilitation committee that discussed this code questioned the appropriateness of this additional pre and post-service time. A multi-specialty consensus panel was unable to justify this additional pre and post-service evaluation time. Using a reverse building block methodology, we backed the value of this pre and post-service time out of the value of 5.00 to arrive at our final recommendation of 4.33.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 Unlisted procedure, vascular surgery

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

Specialty IR/Rad/Neurorad How often? Sometimes

Specialty Neurosurgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty IR/Rad/Neurorad Frequency 20000 Percentage 0.00 %

Specialty Neurosurgery Frequency 20000 Percentage 0.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty IR/Rad/Neurorad Frequency 15000 Percentage 0.00 %

Specialty Neurosurgery Frequency 15000 Percentage 0.00 %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

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

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:61642 Tracking Number: RR4 Global Period: ZZZ

Recommended Work Relative Value
Specialty Society RVU: **9.03**
RUC RVU: **8.66**

CPT Descriptor: Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family (List separately in addition to code for primary procedure)

(Use 61641 and 61642 in conjunction with 61640)
(61640, 61641, and 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year-old male with recent subarachnoid hemorrhage. Complete cerebral angiography (separately reportable even if performed on the same day) demonstrated significant vasospasm in the supraclinoid LEFT internal carotid artery and the M1 segment of the RIGHT middle cerebral artery. After reporting this finding to the attending neurosurgeon, he/she requests balloon dilatation of the spastic segments. The LEFT internal carotid spasm balloon dilatation is completed (separately reportable) and the RIGHT M1 segment spasm is now to be dilated.

NOTE: 61642 is considered an ADD-ON procedure code that should be reported in conjunction with 61640. Additionally, the proposed new code includes all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for balloon dilatation).

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: · A second bolus dose of intravenous heparin may be administered.· The ACT is checked. Additional heparin is given as necessary throughout the procedure, and the ACTs are monitored at appropriate intervals.· Pressurized, continuous heparin/saline flush systems are prepared. Meticulous examination of these systems is performed by the physician to exclude the possibility of residual air bubbles.· Left common carotid artery selectively catheterized with 5 Fr catheter.· Biplane AP and lateral angiograms of the cervical common carotid artery are obtained. If necessary, oblique views are obtained to profile carotid the carotid bifurcation. Biplane AP and lateral (and possibly oblique) angiograms of the intracranial vessels are also obtained to determine that no interval change has occurred since the original diagnostic angiogram.· Advance catheter into the external carotid artery over a steerable guidewire.· Utilizing an exchange wire placed into the external carotid artery, a neuroguide catheter is placed into the common carotid artery. · A common carotid artery angiogram is obtained to confirm appropriate positioning of the guide catheter below the carotid bifurcation and to exclude the possibility of arterial spasm, dissection or thromboembolus during guide catheter placement.· The guide catheter is then advanced into the internal carotid artery over a steerable guide wire.· A cervical internal carotid artery angiogram is obtained to confirm appropriate positioning of the guide catheter and to exclude the possibility of arterial spasm, dissection or thromboembolus.· Guide catheter is placed on continuous heparin flush utilizing a flow control Y-connector.·

Biplane AP, lateral and oblique angiograms of the cerebral vessels are obtained. High magnification biplane angiograms are then obtained, centered upon the arterial stenosis. The target lesion must be carefully reassessed for subtle changes that indicate the development of subacute intraluminal thrombus, which is a contraindication to performance of angioplasty. Precise, quantitative measurements of the stenotic artery are obtained to determine the proper diameter and length of the angioplasty balloon to be used. External reference markers may be placed on the skin in order to calculate the precise dimensions. · Prepare appropriate size angioplasty balloon. Meticulous preparation is

done by the physician to eliminate the air within the balloon.· Advance a steerable micro-guidewire and a low profile microcatheter through the guide catheter into the additional vessel, in different vascular family from vessel coated in 6162X3.· Gently advance micro-guidewire and microcatheter across the arterial stenosis.· Remove the guidewire and replace with an exchange length wire, leaving the wire tip beyond the stenotic area. · Remove microcatheter.· Advance micro-angioplasty balloon over the exchange wire and across the stenosis.· Slowly inflate balloon to dilate the lesion under fluoroscopic control while monitoring balloon pressure.·Deflate balloon and withdraw into internal carotid artery, leaving the guidewire across the stenosis.·Obtain post-angioplasty angiograms by injecting contrast through the guide catheter to confirm satisfactory dilation of vessel lumen and antegrade filling of distal blood vessels. · Wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosois.· If evidence of rebound stenosis, replace balloon to re-dilate the lesion or exchange for a larger angioplasty balloon if needed.· Again wait fifteen minutes and repeat angiogram to exclude the possibility of hyperacute thrombotic occlusion or rebound stenosois.· After a fifteen-minute period of observation with no further evidence of restenosis or acute arterial occlusion, remove the balloon and wire; then obtain final angiograms of the regional circulation to check for possible embolic complications.· Remove guide catheter. · All fluoroscopy, contrast injection, angiography and image interpretation associated with the arterial stenosis treated is included in the procedure up to this point

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2005					
Presenter(s):	John Barr, MD; John Wilson, MD; Robert Vogelzang, MD					
Specialty(s):	American Society of Interventional and Therapeutic Neuroradiology, American Society of Neuroradiology, American Association of Neurological Surgeons, Society of Interventional Radiology					
CPT Code:	61642					
Sample Size:	175	**Resp n:** 41		**Response:** 23.42 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		5.00	10.00	**13.50**	20.00	37.89
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		20.00	45.00	**60.00**	90.00	180.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**0.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
61624	000	20.12

CPT Descriptor Transcatheter permanent occlusion or embolization (eg, for tumor destruction to achieve hemostatis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU
37216	090	17.98

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection.

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

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

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 56.0 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 61642	Key Reference CPT Code: 61624
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	60.00	0.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**60.00**	**0.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.20	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.32	3.54
Urgency of medical decision making	4.84	3.46

Technical Skill/Physical Effort (Mean)

Technical skill required	4.72	4.05
Physical effort required	4.16	3.74

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.85	3.85
Outcome depends on the skill and judgment of physician	4.78	4.08
Estimated risk of malpractice suit with poor outcome	4.48	3.95

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.32	3.48
Intra-Service intensity/complexity	4.63	4.09
Post-Service intensity/complexity	4.30	3.27

ADDITIONAL RATIONALE

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

Overview:

Surveys were distributed to physicians representing specialties and sub-specialties in radiology and surgery. Response rate was excellent, and the data are tightly clustered. The procedure selected most often as reference services were CPT 61624 transcatheter embolization, and CPT 37216 carotid stent placement, which was recently surveyed by the RUC. The transcatheter embolization comparison is appropriate from a clinical perspective since the microvascular surgical

techniques using the balloon in the intracranial artery are similar. Both procedures have a similar level of extreme intensity and potential patient risk to the patient. However, the RUC will have to take into consideration the fact that 61624 has a 90-day global period and the intracranial vasospasm code is an add-on procedure with a ZZZ global period.

We will be offering comparisons to other ZZZ codes of similar values from the RUC MPC.

Rationale and IWPUT Analysis

The median survey response of 13.50 seemed too high relative to the base code and other ZZZ codes in the MPC. The 25th percentile RVW of 10.00 seemed more appropriate. However, the survey respondents included 20 minutes of additional pre-service time and 23 minutes of additional post-service time. The pre-facilitation committee that discussed this code questioned the appropriateness of this additional pre and post-service time. A multi-specialty consensus panel was unable to justify this additional pre and post-service evaluation time. Using a reverse building block methodology, we backed the value of this pre and post-service time out of the value of 10.00 to arrive at our final recommendation of 9.03.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 Unlisted procedure, vascular surgery

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

Specialty IR/Rad/Neurorad How often? Sometimes

Specialty Neurosurgery How often? Sometimes

Specialty How often?

AMA RUC Recommendation

	A	B	C	D	E	F	G	H	I
1									
2				61630		61635		61640	
3		CMS 2005 STAFF TYPE, MED SUPPLY, OR EQUIP CODE		Balloon angioplasty, intracranial (eg, artherosclerotic stenosis), percutaneous		Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection		Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel	
4	LOCATION			Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			90	90	90	90	0	0
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	132	0	132	0	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	60	0	60	0	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0	0	0	0	0	0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	72	0	72	0	0
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		0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		0
17	Other Clinical Activity (please specify)								
18	End:When patient enters office/facility for surgery/procedure								
19	SERVICE PERIOD								
20	Start: When patient enters office/facility for surgery/procedure								
21	Pre-service services								
22	Review charts								
23	Greet patient and provide gowning								
24	Obtain vital signs								
25	Provide pre-service education/obtain consent								
26	Prepare room, equipment, supplies								
27	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV								
29	Sedate/apply anesthesia								
30	Intra-service								
31	Assist physician in performing procedure								
32	Post-Service								
33	Monitor pt. following service/check tubes, monitors, drains								
34	Clean room/equipment by physician staff								
35	Clean Scope								
36	Clean Surgical Instrument Package								
37	Complete diagnostic forms, lab & X-ray requisitions								
38	Review/read X-ray, lab, and pathology reports								
39	Check dressings & wound/-home care instructions /coordinate office visits /prescriptions								
40	Discharge day management 99238 –12 minutes 99239 –15 minutes								
41	Other Clinical Activity (please specify)								
42	End: Patient leaves office								

	A	B	C	D	E	F	G	H	I
2				61630		61635		61640	
3		CMS 2005 STAFF TYPE, MED SUPPLY, OR EQUIP CODE		Balloon angioplasty, inracranial (eg, artherosclerotic stenosis), percutaneous		Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection		Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel	
4	**LOCATION**			Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
43	**POST-SERVICE Period**								
44	**Start: Patient leaves office/facility**								
45	Conduct phone calls/call in prescriptions								
46	*Office visits:*								
47	*List Number and Level of Office Visits*								
48	99211 16 minutes		16						
49	99212 27 minutes		27						
50	**99213 36 minutes X 1 (6162X1-X2)**		36		72		72		
51	**99214 53 minutes X 1 (6162X1) X 2 (6162X2)**		53		0		0		
52	99215 63 minutes		63						
53	Other								
54									
55	*Total Office Visit Time*	L037D	RN/LPN/MTA		72		72		
56	Other Activity (please specify)								
57	**End: with last office visit before end of global period**								
58	**MEDICAL SUPPLIES**								
59	PEAC multispecialty supply package				2		2		2
60									
61	**EQUIPMENT**								
62	exam table		E11001		1		1		1

	A	B	C	J	K	L	M
1							
2				61641		61642	
3		CMS 2005 STAFF TYPE, MED SUPPLY, OR EQUIP CODE		Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in the same vascular family		Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in a different vascular family	
4	LOCATION			Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			0	0	0	0
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0	0	0	0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		0		0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		0		0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		0		0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		0		0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		0		0
17	Other Clinical Activity (please specify)						
18	End:When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters office/facility for surgery/procedure						
21	Pre-service services						
22	Review charts						
23	Greet patient and provide gowning						
24	Obtain vital signs						
25	Provide pre-service education/obtain consent						
26	Prepare room, equipment, supplies						
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV						
29	Sedate/apply anesthesia						
30	Intra-service						
31	Assist physician in performing procedure						
32	Post-Service						
33	Monitor pt. following service/check tubes, monitors, drains						
34	Clean room/equipment by physician staff						
35	Clean Scope						
36	Clean Surgical Instrument Package						
37	Complete diagnostic forms, lab & X-ray requisitions						
38	Review/read X-ray, lab, and pathology reports						
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
40	Discharge day management 99238 --12 minutes 99239 --15 minutes						
41	Other Clinical Activity (please specify)						
42	End: Patient leaves office						

	A	B	C	J	K	L	M
2				61641		61642	
3		CMS 2005 STAFF TYPE, MED SUPPLY, OR EQUIP CODE		Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in the same vascular family		Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in a different vascular family	
4	**LOCATION**			Non Facility	Facility	Non Facility	Facility
43	**POST-SERVICE Period**						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions						
46	*Office visits:*						
47	*List Number and Level of Office Visits*						
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	**99213 36 minutes X 1 (6162X1-X2)**		36				
51	**99214 53 minutes X 1 (6162X1) X 2 (6162X2)**		53				
52	99215 63 minutes		63				
53	Other						
54							
55	*Total Office Visit Time*	L037D	RN/LPN/MTA				
56	Other Activity (please specify)						
57	**End: with last office visit before end of global period**						
58	**MEDICAL SUPPLIES**						
59	PEAC multispecialty supply package				0		0
60							
61	**EQUIPMENT**						
62	exam table		E11001		0		0

	A	B	C	D	E
1					
2				92551	
3				Screening test, pure tone, air ony	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**				
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MA**	**19.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**19.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
10					
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms				
13	Coordinate pre-surgery services				
14	Schedule space and equipment in facility				
15	Provide pre-service education/obtain consent				
16	Follow-up phone calls & prescriptions				
17	Other Clinical Activity (please specify)				
18	**End:When patient enters office/facility for surgery/procedure**				
19					
20	**Start: When patient enters office/facility for surgery/procedure**				
21	**Pre-service services**				
22	Review charts				
23	Greet patient and provide gowning			**0**	**0**
24	Obtain vital signs				
25	Provide pre-service education/obtain consent			**2**	**0**
26	Prepare room, equipment, supplies			**2**	**0**
27	Setup scope (non facility setting only)				
28	Prepare and position patient/ monitor patient/ set up IV			**2**	**0**
29	Sedate/apply anesthesia				
30	**Intra-service**				
31	Assist physician in performing procedure			**10**	**0**
32	**Post-Service**				
33	Monitor pt. following service/check tubes, monitors, drains				
34	Clean room/equipment by physician staff			**3**	**0**
35	Clean Scope				
36	Clean Surgical Instrument Package				
37	Complete diagnostic forms, lab & X-ray requisitions				
38	Review/read X-ray, lab, and pathology reports				
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
40	Discharge day management 99238 –12 minutes 99239 --15 minutes				
41	Other Clinical Activity (please specify)				
42	**End: Patient leaves office**				
43					
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions				
46	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care				
47	*List Number and Level of Office Visits*				
48	99211 16 minutes		16		
49	99212 27 minutes		27		
50	99213 36 minutes		36		
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54					
55	*Total Office Visit Time*			**0**	**0**
56	Other Activity (please specify)				
57	**End: with last office visit before end of global period**				

	A	B	C	D	E
2				92551	
3				Screening test, pure tone, air ony	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
58	[redacted]	[redacted]	[redacted]	[redacted]	
59	Eartip insert with sound tube	SD047		2	0
60	Specula tips, otoscope	SM025		0	0
61	Swab-pad, alchol	SJ053		2	0
62	[redacted]	[redacted]	[redacted]	[redacted]	
63	Audiometer, clinical-diagnostic	EQ053		10	0
64	Audiometric soundproof booth	EQ054		0	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2005

Education and Training for Patient Self Management

The CPT Editorial Panel created three new codes to describe educational and training services prescribed by a physician and provided by a qualified, non-physician healthcare professional. There is no physician work associated with these services. The RUC considered recommendations for direct practice expense inputs only. The RUC reviewed inputs for CPT code 98960 *Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient*, 98961 *2-4 patients* and 98962 *5-8 patients*. **The RUC assessed and modified the practice expense inputs, which are attached to this recommendation.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•98960	K1	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	XXX	0.00 (PE Inputs Only)
•98961	K2	2-4 patients	XXX	0.00 (PE Inputs Only)
•98962	K3	5-8 patients	XXX	0.00 (PE Inputs Only)

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

CPT Long Descriptor: Education and training for patient self-management by a qualified, non-physician health care professional, e.g. RD or RN, using a standardized curriculum

[Note: The CPT panel approved this generic code set with the intent it would be used by many qualified health care professionals. While the code is 'generic,' there may be instances where the service includes different equipment based on the practitioner's skill set, the patient/client's educational objectives/desired outcomes, and the specific nature of the education and training provided.]

The American Dietetic Association (ADA) and the American Association of Clinical Endocrinologists (AACE) compiled this PE summary of recommendations which represents the "typical" clinical labor time, supplies and equipment performed by clinical endocrinologists and dieticians.

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

Both the American Dietetic Association (ADA) and the American Association of Clinical Endocrinologists (AACE) individually convened expert practice expense panels to collect data for the Education and Training codes. Both groups' expert panelists represent a variety of practice settings and geographic locations.

Once each group's data was obtained, ADA and AACE then compiled each group's respective data obtained from the PE expert panel for clinical labor time, supplies and equipment.

CPT Long Descriptor:
Education and training for patient self-management by a qualified, non-physician health care professional e.g. RD or RN, using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes;

98961	Group 2-4
98962	Group 5-8

[Note: The CPT panel approved this generic code set with the intent it would be used by many qualified health care professionals. While the code is 'generic,' there may be instances where the service includes different equipment based on the practitioner's skill set, the patient/client's educational objectives/desired outcomes, and the specific nature of the education and training provided.]

The American Dietetic Association (ADA) and the American Association of Clinical Endocrinologists (AACE) compiled this PE summary of recommendations, which represents the "typical" clinical labor time, supplies and equipment performed by registered dietitians and clinical endocrinologists' staff.

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

Both the American Dietetic Association (ADA) and the American Association of Clinical Endocrinologists (AACE) individually convened expert practice expense panels to collect data for the Education and Training codes. Both groups' expert panelists represent a variety of practice settings and geographic locations.

Once each group's data was obtained, ADA and AACE then compiled each group's respective data obtained from the PE expert panel for clinical labor time, supplies and equipment.

Please describe the clinical activities of your staff:

98960 Disease Education Vignette
Typical Patient: A 35 year-old woman with a symptomatic established illness or disease, e.g. diabetes or asthma, or the desire to delay disease co-morbidities, e.g. cardiovascular co-morbidities, is referred by a physician to a qualified, non-physician health care professional for education/training, eg. RD or RN.

The qualified, non-physician health care professional:
Pre-Service

- Reviews relevant parts of the patient's medical record
- Reviews the physician referral

Intra-Service

- Assesses the individual's psychological, social, environmental factors, lifestyle habits, health literacy, and learning styles;
- Using a standardized curriculum, provides education/training to self-manage the illness/disease, or delay the disease co-morbidities, or use a device;
- Answers the patient's questions as part of the education and training group session

Post-Service

- Establishes a plan for follow-up evaluation and ongoing assessment of outcomes, and communicates to the patient;
- Documents the education/training provided and describes the plan for follow-up

98961 and 98962 Group Education & Training Vignette

Typical Patient: A 60 year-old man with a symptomatic established illness or disease, e.g. diabetes or asthma, or the desire to delay disease co-morbidities, e.g. cardiovascular co-morbidities, is referred by a physician to a qualified, non-physician health care professional, e.g. RD or RN, for group education/training.

The qualified, non-physician health care professional:
Pre-Service

- Reviews relevant parts of the patient's medical record for all patients involved in the group
- Reviews the physician referral for each patient

Intra-Service

- Assesses the groups' psychological, social, environmental factors, lifestyle habits, health literacy, and learning styles;
- Using a standardized curriculum, provides education/training to self-manage the illness/disease, or delay the disease co-morbidities, or use a device;
- Answers the patients' questions as part of the education and training group session

Post-Service

- Establishes a plan for follow-up evaluation and ongoing assessment of outcomes, and communicates to each patient in the group;
- Documents the education/training provided and describes the plan for follow-up education/training for each patient in the group.

	A	B	C	D
1				
2				
3				
4				CPT Code
5	RUC April/May 2005			98960 --Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
6	LOCATION	CMS Code	Staff Type	Non Facility
7	GLOBAL PERIOD			
8	TOTAL CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	38.0
9	TOTAL PRE-SERV CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	3.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	30.0
11	TOTAL POST-SERV CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	5.0
12				
13	Start: Following visit when decision for surgery or procedure made			
14	Complete pre-service diagnostic & referral forms			3
15	Coordinate pre-surgery services			
16	Schedule space and equipment in facility			
17	Provide pre-service education	RD (L043B) and RN (LO51A)		
18	Follow-up phone calls & prescriptions			
19	Other Clinical Activity (please specify)	RD (L043B) and RN (LO51A)		
20	End:When patient enters office/facility for surgery/procedure			
21				
22	Start: When patient enters office/facility for surgery/procedure			
23	Pre-service services			
24	Review charts			
25	Greet patient			
26	Obtain vital signs			
27	Provide pre-service education/obtain consent			
28	Prepare room, equipment, supplies			
29	Setup scope (non facility setting only)			
30	Prepare and position patient/ monitor patient/ set up IV			
31	Sedate/apply anesthesia			
32	Intra-service			
33	Perform education	RD (L043B) and RN (LO51A)	RD & RN	30
34	Post-Service			
35	Monitor pt. following service/check tubes, monitors, drains			
36	Clean room/equipment, store equipment/models; media equipment			
37	Clean Scope			
38	Clean Surgical Instrument Package			
39	Complete diagnostic forms, lab & X-ray requisitions: documentation & record outcomes data	RD (L043B) and RN (LO51A)	RD & RN	
40	Review/read X-ray, lab, and pathology reports			
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			
42	Discharge day management 99238 --12 minutes 99239 --15 minutes			
43	Other Clinical Activity (please specify)			
44	End: Patient leaves office			

	A	B	C	D
4				CPT Code
5	RUC April/May 2005			98960 --Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
6	LOCATION	CMS Code	Staff Type	Non Facility
45				
46	Start: Patient leaves office/facility			
47	Conduct phone calls/call in prescriptions	RD (L043B) and RN (LO51A)	RD & RN	1
48	documentation and recording outcomes			4
49	*List Number and Level of Office Visits*			
50	99211 16 minutes		16	
51	99212 27 minutes		27	
52	99213 36 minutes		36	
53	99214 53 minutes		53	
54	99215 63 minutes		63	
55	Other			
56				
57	*Total Office Visit Time*			
58	Other Activity (please specify)			
59	End: with last office visit before end of global period			
60				
61	patient education booklet	SK062	item	1
62				
63				
64				
65				
66	computer, desktop, with monitor	ED021	1	1
67	printer, laser, paper	ED032	1	1
68	software	EQ187	1	1
69	PC projector ($1700)	new item- see cost data	1	1
70	equipment and/or models	EQ123	1	1
71	scale	EF016	1	
72				
73				
74				
75				
76				

	A	B	C	E	F
1					
2					
3					
4				CPT Code	
5	RUC April/May 2005			for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; group 2-4 (AVERAGE SIZE IS 3)	98962– Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; group 5-8 (AVERAGE SIZE IS 6)
6	LOCATION	CMS Code	Staff Type	Non Facility	Non Facility
7	GLOBAL PERIOD				
8	TOTAL CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	18 (for each individual in the group)	13 (for each individual in the group)
9	TOTAL PRE-SERV CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	3.0	3.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	10.0	5.0
11	TOTAL POST-SERV CLINICAL LABOR TIME	RD (L043B) and RN (LO51A)	RD & RN	5.0	5.0
12					
13	Start: Following visit when decision for surgery or procedure made				
14	Complete pre-service diagnostic & referral forms			3	3
15	Coordinate pre-surgery services				
16	Schedule space and equipment in facility				
17	Provide pre-service education	RD (L043B) and RN (LO51A)			
18	Follow-up phone calls & prescriptions				
19	Other Clinical Activity (please specify)	RD (L043B) and RN (LO51A)			
20	End:When patient enters office/facility for surgery/procedure				
21					
22	Start: When patient enters office/facility for surgery/procedure				
23	Pre-service services				
24	Review charts				
25	Greet patient				
26	Obtain vital signs				
27	Provide pre-service education/obtain consent				
28	Prepare room, equipment, supplies				
29	Setup scope (non facility setting only)				
30	Prepare and position patient/ monitor patient/ set up IV				
31	Sedate/apply anesthesia				
32	Intra-service				
33	Perform education	RD (L043B) and RN (LO51A)	RD & RN	10	5
34	Post-Service				
35	Monitor pt. following service/check tubes, monitors, drains				
36	Clean room/equipment, store equipment/models; media equipment				
37	Clean Scope				
38	Clean Surgical Instrument Package				
39	Complete diagnostic forms, lab & X-ray requisitions: documentation & record outcomes data	RD (L043B) and RN (LO51A)	RD & RN		
40	Review/read X-ray, lab, and pathology reports				
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
42	Discharge day management 99238 –12 minutes 99239 –15 minutes				
43	Other Clinical Activity (please specify)				
44	End: Patient leaves office				

	A	B	C	E	F
4				CPT Code	
5	RUC April/May 2005			for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; group 2-4 (AVERAGE SIZE IS 3)	96962– Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; group 5-8 (AVERAGE SIZE IS 6)
6	LOCATION	CMS Code	Staff Type	Non Facility	Non Facility
45					
46	Start: Patient leaves office/facility				
47	Conduct phone calls/call in prescriptions	RD (L043B) and RN (LO51A)	RD & RN	1	1
48	documentation and recording outcomes			4	4
49	*List Number and Level of Office Visits*				
50	99211 16 minutes		16		
51	99212 27 minutes		27		
52	99213 36 minutes		36		
53	99214 53 minutes		53		
54	99215 63 minutes		63		
55	Other				
56					
57	*Total Office Visit Time*				
58	Other Activity (please specify)				
59	End: with last office visit before end of global period				
60					
61	patient education booklet	SK062	item	1	1
62					
63					
64					
65					
66	computer, desktop, with monitor	ED021	1	33%	17%
67	printer, laser, paper	ED032	1	17%	8%
68	software	EQ187	1	33%	17%
69	PC projector ($1700)	new item- see cost data	1	33%	27%
70	equipment and/or models	EQ123	1	33%	27%
71	scale	EF016	1	7%	3%
72					
73					
74					
75					
76					

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Analysis of Computer Transmitted Data

The CPT Editorial Panel created a new code 99091 *Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time* to specifically describe the review of data sent to the physician electronically from a patient and/or caregiver for their analysis and interpretation. This service may be reported only once per month and may not be reported in conjunction with an Evaluation and Management service on the same day. This service may also not be reported in conjunction with a care plan oversight code (99374-99380).

The RUC carefully reviewed the survey results from 58 internists and endocrinologists. The survey median reflected a work relative value of 1.20, however, the specialty recommended that the code be valued similar to the care plan oversight services at 1.73. The RUC reviewed the time involved and did not agree that this was an appropriate comparison. The RUC reviewed the time data of 5 minutes pre-time, 20 minutes intra-time, and 5 minutes post-time and compared this to the physician time and intensity involved in CPT code 99214 *Level 4 Established Office Visit* (work RVU = 1.10) with intra-time of 25 minutes, and a total time of 38 minutes, and determined that 99091 should be valued at this level. The RUC also agreed that the intra-service time for this code should be modified to be 30 minutes as the CPT descriptor clearly states that the physician must spend a minimum of 30 minutes to report this service. **The RUC recommends a work relative value of 1.10 for code 99091.**

Practice Expense:

There are no direct practice expense inputs related to this service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
99090		Analysis of ~~information~~ clinical data stored in computers (eg, ECGs, blood pressures, hematologic data) (For physician/health care professional collection and interpretation of physiologic data stored/transmitted by patient/caregiver, see 99091)	XXX	N/A HCFA considers this a bundled service and provides no separate payment	N/A

American College of Physicians–American Society of Internal Medicine
American Association of Clinical Endocrinology

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 990XX Tracking Number: AA1 Global Period: XXX Recommended RVW: ~~1.73~~
RUC Rec: 1.10

CPT Descriptor: Collection and interpretation of physiologic data (e.g. ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time.

CPT Instructions:

Code 990XX should be reported no more than once in a 30 day period to include the physician or health care provider time involved with data accession and review, data interpretation, modification of care plan as necessary (including communication to patient and/or caregiver) and associated documentation.

If the services described by code 990XX are provided on the same day the patient presents for an E/M service, these services should be considered part of the E/M service and not separately reported.

Do not report 990XX if it occurs within 30 days of care plan oversight services 99374-99380. Do not report 990XX if other more specific CPT codes exist, (eg, 93014, 93227, 93233, 93272 for cardiographic services; 926X1 for continuous glucose monitoring). Do not report 990XX for transfer and interpretation of data from hospital or clinical laboratory computers.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 67-year old male with labile diabetes is utilizing a home glucose-monitoring device to capture multiple glucose readings during the course of a month in association with diary data of symptoms, medication, exercise, and diet. The data is transmitted from home computer to physician's office by email, downloaded by physician and data reviewed. Pre-service work includes chart review concerning prior glucose control methods. Intra-service work involves the physician spending 35 minutes during a 30-day period for the review, interpretation and report based on the physiologic data and diary. Separate time spent typically involves at least one contact with patient (e.g. telephone call or e-mail exchange) with further advice about medical management and monitoring recommendations. Post-service work includes associated chart documentation.

Description of Pre-Service Work: The pre-service period includes chart review regarding patient condition and prior treatment.

Description of Intra-Service Work: The intra-service period includes your review, interpretation, and report of the data digitally stored and/or transmitted by the patient. The intra-service period involves at least one communication (e.g. phone call or e-mail exchange) with the patient to provide medical management and monitoring recommendations.

Description of Post-Service Work: The ~~post-service~~ period includes documenting the service in the ~~patient's medical record~~ and arranging for further services.

CPT Code: 990XX Tracking Number: AA1

SURVEY DATA:

Presenter(s):ACP-ASIM and AACE

Specialty(s): Internal Medicine, Endocrinology, (This service will be provided by most physician specialties).

Sample Size: 58/170 Response Rate: (%): 34.1% Median RVW: 1.2

Type of Sample (Bold One): random, panel, **convenience.**

Explanation of sample size: Survey mailed to 170 AACE and ACP-ASIM members who indicated they were interested in participating in such surveys.

25th Percentile RVW: 0.9 75th Percentile RVW: 1.6 Low: 0.38 High: 3.60

Median Pre-Service Time: 5 minutes Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 35 minutes

Intra-Svc Time Low: 6 minutes High: 46 minutes

Median Post-Service Time: 5 minutes

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
99375	Care Plan Oversight, 30 minutes or more, home health patient	1.73
99378	Care Plan Oversight, 30 minutes or more, hospice patient	1.73

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference* CPT Code:
Median Pre-Time	5	10
Median Intra-Time	30	38
Median Immediate Post-service Time	5	10
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.13	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.33
Urgency of medical decision making	3.20	3.17

Technical Skill/Physical Effort (Mean)

Technical skill required	3.09	3.17
Physical effort required	2.27	2.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.36	3.33

Outcome depends on the skill and judgement of physician	3.75	3.22
Estimated risk of malpractice suit with poor outcome	3.25	2.78

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.69	2.89
Intra-Service intensity/complexity	3.5	2.56
Post-Service intensity/complexity	2.74	2.78

ADDITIONAL RATIONALE

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

ACP-ASIM and AACE recommend that the RUC approve a RVW of 1.73, which is the same RVW as care plan oversight (99375 and 99378). Please note that intensity and complexity measures of the surveyed code (990XX) and the care plan oversight reference codes are almost identical, with a few exceptions demonstrating greater complexity for the surveyed code (990XX). Most notable is that the intra-service intensity/complexity is significantly higher for the surveyed code (990XX), 3.5 versus 2.56. Both the surveyed code (990XX) and the reference codes are by definition a minimum of 30 minutes a month. Therefore following the CPT definition and the complexity/intensity measures, the surveyed code (990XX) should have the same RVW as care plan oversight or higher.

In addition, the ACP-ASIM and AACE Committees reviewing the survey data believe that the physicians who completed the survey understated the amount of time involved with providing service 990XX because the survey vignette mentions "at least one contact with patient (e.g. telephone call or e-mail exchange) with further advice about medical management and monitoring recommendations." ACP-ASIM and AACE believe this statement encouraged survey respondents to describe the minimum amount of time involved with this service (one physician-patient electronic encounter), rather than the typical time, which may include multiple physician-patient electronic encounters.

FREQUENCY INFORMATION

How was this service previously reported? As care plan oversight in limited settings or as pre- and post- service work in conjunction with an office visit. However, this code was created for circumstances in which physician review of data pertaining to a previous visit exceeds the review involved with typical pre- and post- service E/M service work and /or for on-going monitoring of patient data not in conjunction with an office visit.

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

Specialty Internal Medicine ___X__Commonly _____Sometimes _____Rarely

Specialty Endocrinology ___X__Commonly _____Sometimes _____Rarely

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

Specialty: Internal Medicine (including endocrinology) Frequency: 570,000

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

Specialty: Internal Medicine (including endocrinology) Frequency: 350,000

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2005

Moderate (Conscious) Sedation

The CPT Editorial Panel created six new codes to accurately report the two separate families of moderate sedation distinguished by provision of moderate sedation services by the physician who is performing the diagnostic or therapeutic service and supervising an independent trained observer; or moderate sedation services performed by a physician (other than an anesthesiologist) other than the physician performing diagnostic or therapeutic service. These codes would consist of two separate time-based base codes in each family, distinguished by patient age, with a single add-on code in each family to report additional time. These new codes replace CPT codes 99141 *Sedation with or without analgesia (conscious sedation); intravenous, intra-muscular or inhalation*, (work relative value = 0.80) and 99142 *Sedation with or without analgesia (conscious sedation); oral, rectal and/or intranasal* (work relative value = 0.60).

The CPT Editorial Panel and the RUC have reviewed the moderate sedation issue over the past five years. This work included development of an appendix in CPT to identify the services in which moderate sedation is an inherent component. The practice expense refinement has resulted in consistent direct practice expense inputs for the provision of the sedation in each of these codes. CPT instructions note that CPT codes 99143 – 99145 may not be used in addition to the codes listed in the appendix, as the resources utilized in providing these services have already been included in the procedure code. In addition, CPT instructions indicate that 99148 – 99150 may not be reported with the codes listed in the appendix when performed in the non-facility as the resources for this site-of-service are incorporated in the procedure code.

The RUC also continues to advocate that CMS consider a change in payment policy to allow separate payment for conscious sedation, utilizing the stand-alone CPT codes 99143 – 99150, when this service is provided in conjunction with a procedure where conscious sedation is not an inherent component. We welcome the opportunity to retrospectively review utilization data once these codes are active to review data regarding the procedure codes that are routinely reported with moderate sedation codes. The RUC understands that 99143 – 99150 will reported with codes for procedures where conscious sedation is not inherently a part of the procedure. This is to be taken into consideration in reviewing the relative value recommendation for these new moderate sedation codes. The provision of sedation would not be the normal course of action and that implies a different intensity of work for these services than would be the case when it is inherent to the procedure.

The RUC first reviewed the code family describing the provision of moderate sedation services by a physician other than the physician performing the diagnostic or therapeutic service:

99149

The RUC reviewed the specialty societies' recommendations to the RUC for 99149 *Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; first 30 minutes intra-service time.* The specialty societies reviewed the survey time data and felt that the RVU value reflected in the survey data was over-valued. Therefore, the specialty societies recommended using a building block methodology. This methodology included using the surveyed pre, intra and post service times, 15, 20 and 15 minutes respectively.

The RUC agreed that the pre-service work was comparable to 99241 *Office consultation for a new or established patient* (23 minutes total time, Work RVU=0.64). The RUC agreed with the specialty society recommendation to consider the majority of the intra-service time as related to monitoring. This monitoring time was felt to be similar in intensity to the anesthesia intensity level 2 (0.031) approved for 19 anesthesia services utilized in the previous Five-Year Review. The RUC agreed that five minutes of elevated intensity was appropriate for the induction period. Although the RUC was comfortable with the time allotted for post-service time, 15 minutes, the RUC felt that using the full value for 99241 in the pre-service work would lead to a duplication in the post-service time work (as 99241 includes 4 minutes of post-service time). Therefore the RUC recommended that 4 minutes of time at the usual post-service IWPUT of 0.0224 be removed from the specialty societies recommended post-service time work value. This time change was reflected in the following building block methodology:

Pre-service median time	15 minutes Pre-service reference code: 99241	0.64
Intra-service time	20 minutes: 5 minutes for induction (0.057) 15 minutes of monitoring (0.031)	 0.29 0.47
Post-service median time	11* minutes of post-service intensity (0.0224) (*15 minutes less 4 minutes of post-service time already built into the 99241 code)	0.25
	Total	**1.65 RVUs**

The RUC reviewed this methodology and felt that it accurately captured the intensity and complexity of this service **The RUC recommends a work RVU of 1.65 for 99149.**

99148

The specialty societies' recommendation for this procedure 99148 *Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time* was based on the extrapolation of the relationship between "under age five" and the "five and over" central venous access codes (36555-36571). The specialty society determined the relative relationship between the pediatric and non-pediatric central venous access codes to be approximately 1.065. The specialty society applied this scaling factor to the 99149, 1.65 work relative value, which results in a work RVU recommendation of 1.75 work RVUs for 99148.

RUC recommended Work RVU for 99149	1.64
Specialty Society Scaling Factor from central venous access code age differentiation	x 1.065
Specialty Society Recommended Work RVU of 99148	1.75

The RUC reviewed this methodology and felt that it accurately captured the intensity and complexity of this service **The RUC recommends a work value of 1.75 for 99148.**

99150

The specialty societies' recommendation for this procedure 99150 *Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; each additional 15 minutes intra-service time or Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; each additional 15 minutes intra-service time* includes multiplying the 15 minutes of intra-service time the same intensity utilized for monitoring time in the base code (0.031).

Specialty Society Recommended Intra-Service Time	15 Minutes
Monitoring intensity as described in 99149	0.031
Specialty Society Recommended Work RVU	0.47

The RUC reviewed this methodology and felt that it accurately captured the intensity and complexity of this service. **The RUC recommends a work relative value of 0.47 for CPT code 99150.**

99144

The RUC discussed 99144 *Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time.* The RUC felt that their should be a reduction in the intensity associated with the pre and post-service times of this code. The specialty society agreed that the intensity of the pre and post service time should be reduced by 50% (from 0.0224 to 0.0112) to account for the duplicative work associated when this service is performed with another procedural code by the same provider. However, the specialty society did state that they tried to account for this duplication by decreasing the surveyed pre-service time of 15 minutes to 10 minutes. As the intensity decrease will now account for this duplication, the specialty society requests that the surveyed pre-service time of 15 minutes be reinstated. In addition, the specialty societies explained that the intra-service work for the new code should reflect a 50% reduction in the intra-service work calculated for 99149 (RUC Approved work relative value for intra-service = 0.76) to account for the multiple procedures performed by a single provider, resulting in an intra-service work RVU of 0.38. Therefore, the following times and intensities were used to develop the RUC's recommendation of 0.66 work relative value for 99144.

Pre-Service	15 minutes x 0.0112	0.168
Intra-Service	(5 minutes x 0.057 + 15 minutes x 0.031) x 0.50	0.380
Post Service	10 minutes x 0.0112	0.112
	Total	0.66

The RUC recommends a work relative value of 0.66 work for 99144.

99143

The RUC discussed 99143 *Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time.* The specialty societies based their work recommendation for this code on the extrapolation of the relationship between the "under age five" and "the five and over" central venous access codes (36555-36571). The specialty society determined the relative relationship between the pediatric and non-pediatric central venous access codes to be approximately 1.065.

The specialty society applied this scaling factor to the newly recommended work RVU of 99144, 0.66 RVU which results in a work RVU recommendation of 0.70 for 99143. The RUC agrees that this is appropriate as it is also the mean of the work relative values from the codes that previously were utilized to report this service 99141 (work relative value = .80) and 99142 (work relative value = 0.60).

Facilitation Committee Recommended Work RVU for 99144	0.66
Specialty Society Scaling Factor from central venous access code age differentiation	x 1.065
Facilitation Committee Recommended Work RVU for 99143	0.70

The RUC recommends a work relative value of 0.70 for 99143.

99145

The RUC discussed 99145 *Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; each additional 15 minutes intra-service time.* The specialty societies agreed that this procedure should be crosswalked to 99150 however, they felt that to account for the multiple procedures being performed by a single provider the intensity associated with 99150, 0.031, should be reduced by 50% resulting in an intensity of 0.0155. This new value should be applied to the 15 minute increment of intra-service time for this procedure resulting in a work relative value of 0.23.

Specialty Society Recommended Intra-Service Time	15
50% reduction of the Intensity of Intra-Service Work of 99150	0.0155
Facilitation Committee Recommended Work RVU for 99145	0.23

The RUC recommends a work relative value of 0.23 for 99145.

Practice Expense:
The practice expense inputs were reviewed by the RUC. Modifications were made to the specialty societies' recommendations to reflect PEAC standards for conscious sedation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time		
∅•99149	FF5	age 5 years or older; first 30 minutes intra-service time	XXX	1.65
+•99150	FF6	each additional 15 minutes intra-service time (List separately in addition to code for primary service) (Use 99150 in conjunction with 99148, 99149)	ZZZ	0.47

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99143 Tracking Number: FFF1 Global Period: XXX Specialty Society RVU: **0.85**

RUC RVU: **0.70**

CPT Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2-year old patient undergoes a procedure that requires moderate sedation to complete safely and with minimal emotional trauma. The physician will supervise and direct an independent trained observer who will assist in monitoring the patient's level of consciousness and physiologic status throughout the procedure.

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

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The procedural/sedating physician performs and documents a thorough patient assessment to assure that moderate sedation can be safely provided outside of an operating room setting. This assessment includes a review of the patient's current and past medical history (eg, concurrent acute illness or chronic diseases, current medications, allergy history, immunization status, prior medical and surgical history, response to any previous sedative or analgesic agents, etc.) The timing of the patient's last meal must also be determined. A physical exam is completed with an emphasis on underlying pathology that might negatively impact the induction or recovery from the sedative. Based upon this assessment, and the sedation and/or analgesia requirements of the procedure, the physician must then determine the appropriate pharmacologic agent(s) to be used, including dosing and route of administration. The sedation process, including the risks and benefits, are explained to the parent(s) or legal guardian and consent is obtained. The patient is verbally prepared for the procedure and the appropriate monitoring equipment (heart rate, respiration, pulse oximetry, intermittent blood pressure) is connected to the patient. The physician confirms that the independent observer has assured the availability and the appropriate functioning of oxygen, suctioning equipment, artificial airways, masks, and resuscitation bags.

Description of Intra-Service Work: The physician supervises the administration and induction of the sedating agent, with or without an analgesic, initiated by the independent trained observer.The patient is assessed continuously until an effective and safe level of moderate sedation and/or analgesia is achieved. Additional doses of sedating and/or analgesic agent(s) are ordered by the physician as needed. The physician's intra-service time ends when the procedure is complete, the patient is physiologically stable, and face-to-face physician time is no longer required.

Description of Post-Service Work: Upon completion of the procedure, the independent observer continues to monitor the patient. The physician returns and re-assesses the patient until the patient reaches a pre-sedation level of consciousness. The physician then establishes if pre-determined discharge criteria have been met. These assessments and the final assessment are documented in the procedural records and discharge instructions are provided to the parent(s) or legal guardian

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2005
Presenter(s):	Steven Krug, MD; Charles Mick, MD; Lanny Garvar, DMD; Timothy Shahbazian, DDS

Specialty(s):	American Academy of Pediatrics, American College of Emergency Physicians, North American Spine Society, American Association of Oral and Maxillofacial Surgeons					
CPT Code:	99143					
Sample Size:	196	**Resp n:** 42		**Response:** 21.42 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.00	2.00	**3.00**	3.97	5.00
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		5.00	25.00	**30.00**	37.50	67.50

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

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

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 99213

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99145 Tracking Number: FFF3 Global Period: ZZZ

Recommended Work Relative Value
Specialty Society RVU: **0.27**

RUC RVU: **0.23**

CPT Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient 5 years of age or older presents with a complaint necessitating performance of some procedure or service (i.e., the "supported procedure"), in support for which moderate sedation is deemed clinically appropriate. The treating physician will perform both the supported procedure and the moderate sedation service.

Percentage of Survey Respondents who found Vignette to be Typical:

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: The physician, assisted by the independent trained observer, continually assesses the patient's level of consciousness and physiological status throughout performance of the supported procedure. Additional doses of sedating agent are ordered by the physician, as needed to maintain the achieved level of sedation for the supported procedure.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2005					
Presenter(s):	Steven Krug, MD; Charles Mick, MD; Lanny Garvar, DMD; Timothy Shahbazian, DDS					
Specialty(s):	American College of Emergency Physicians, North American Spine Society, American Association of Oral and Maxillofacial Surgeons, American Academy of Pediatrics					
CPT Code:	99145					
Sample Size: 0	**Resp n:** 0		**Response:** %			
Sample Type:						
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:						
Pre-Service Evaluation Time:			0.0			
Pre-Service Positioning Time:			0.0			
Pre-Service Scrub, Dress, Wait Time:			0.0			
Intra-Service Time:			15.00			
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	0.00					

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

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

KEY REFERENCE SERVICE:

Key CPT Code Global Work RVU

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.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 99145	Key Reference CPT Code: ____
Median Pre-Service Time	0.00	
Median Intra-Service Time	15.00	
Median Immediate Post-service Time	0.00	
Median Critical Care Time	0.0	
Median Other Hospital Visit Time	0.0	
Median Discharge Day Management Time	0.0	
Median Office Visit Time	0.0	
Median Total Time	**15.00**	**75.00**

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

Technical Skill/Physical Effort (Mean)

Technical skill required		
Physical effort required		

Psychological Stress (Mean)

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

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

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

ADDITIONAL RATIONALE

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

Please see attached revised rationale.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99141-99142

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

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 99212

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99148 Tracking Number: FFF4 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.84**

RUC RVU: **1.75**

CPT Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 3-year old patient undergoes a procedure that requires moderate sedation to complete safely and with minimal emotional trauma. The physician performing the procedure requests that the sedation be delivered and monitored by a second physician.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The sedating physician first performs and documents a thorough patient assessment to assure that moderate sedation can be safely provided outside of an operating room setting. This assessment includes a detailed review of the patient's current and past medical history (eg, historical factors necessitating the procedure, concurrent acute illness or chronic diseases, current medications, allergy history, immunization status, prior medical and surgical history, and response to any previous sedative or analgesic agents, etc). The timing of the patient's last meal must also be determined. A physical exam is completed with an emphasis on underlying pathology that might negatively impact the induction or recovery from the sedative. Based upon this assessment, and the sedation and/or analgesia requirements of the procedure, the sedating physician must then determine the appropriate pharmacologic agent(s) to be used, including dosing and route of administration. The sedation process, including the risks and benefits, are explained to the parent(s) or legal guardian and consent is obtained. The patient is verbally prepared for the procedure and the appropriate monitoring equipment (heart rate, respiration, pulse oximetry, intermittent blood pressure) is connected to the patient. The availability and the appropriate functioning of oxygen, suctioning equipment, artificial airways, masks, and resuscitation bags are confirmed.

Description of Intra-Service Work: The sedating agent(s) with or without an analgesic agent is administered and the patient is assessed continuously until an effective and safe level of moderate sedation and/or analgesia is achieved. The patient is closely monitored by the sedating physician and additional doses of sedating and/or analgesic agent(s) are delivered as needed. The sedating physician's intra-service time ends when the procedure is complete, the patient is physiologically stable, and face-to-face time with the sedating physician is no longer required.

Description of Post-Service Work: Upon completion of the sedation and when the patient is physiologically stable, patient monitoring is returned to the procedural physician and/or clinical staff. The sedating physician returns and re-assesses the patient until the patient reaches a pre-sedation level of consciousness. The sedating physician then establishes if pre-determined discharge criteria have been met. These assessments and the final assessment are documented in the procedural records and post-sedation instructions are provided to the parent(s) or legal guardian. This information is then communicated to the procedural physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2005
Presenter(s):	Steven Krug, MD; Charles Mick, MD; Lanny Garvar, DMD; Timothy Shahbazian, DDS

Specialty(s):	American Academy of Pediatrics, American College of Emergency Physicians, North American Spine Society, American Association of Oral and Maxillofacial Surgeons					
CPT Code:	99148					
Sample Size:	71	**Resp n:** 31		**Response:** 43.66 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.20	1.96	**3.00**	3.62	5.55
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		10.00	30.00	**30.00**	45.00	95.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**15.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99291	XXX	3.99

CPT Descriptor Critical care, evaluation and management of the critically ill or injured patient; first 30-74 minutes

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Work RVU
92004	XXX	1.67

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits

MPC CPT Code 2	Global	Work RVU
71275	XXX	1.92

CPT Descriptor 2 Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

Other Reference CPT Code	Global	Work RVU
99284	XXX	1.95

CPT Descriptor Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

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

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

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 32.2 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 99148	Key Reference CPT Code: 99291
Median Pre-Service Time	20.00	15.00
Median Intra-Service Time	30.00	45.00
Median Immediate Post-service Time	15.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**65.00**	**75.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.79	4.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	4.03
Urgency of medical decision making	4.10	4.14

Technical Skill/Physical Effort (Mean)

Technical skill required	4.38	4.10
Physical effort required	3.31	3.31

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.52	4.24
Outcome depends on the skill and judgment of physician	4.76	4.28
Estimated risk of malpractice suit with poor outcome	4.86	4.31

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.69	3.31
Intra-Service intensity/complexity	4.45	4.21
Post-Service intensity/complexity	3.24	3.14

ADDITIONAL RATIONALE

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

Please see attached revised rationale.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

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

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

Specialty Pediatrics 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? 35000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Pediatrics Frequency 15000 Percentage %

Specialty Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Pediatrics Frequency 50 Percentage %

Specialty Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

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

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 99284

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99149 Tracking Number: FFF5 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.73**

RUC RVU: **1.64**

CPT Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; first 30 minutes intra-service time

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient 5 years of age or older presents with a complaint necessitating performance of some procedure or service (i.e., the "supported procedure"), in support for which moderate sedation is deemed clinically appropriate. One health care professional will perform the supported procedure, while a different physician will provide the moderate sedation service.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The sedation process, including risks and benefits, is explained to the patient, family, and/or legal guardian, and consent is obtained. The physician providing sedation performs and documents a patient assessment to assure that moderate sedation can be safely provided outside of an operating room setting. This assessment involves a medical history review (e.g., current medications, allergies, prior medical and surgical history, response to any previous sedative or analgesic agents, time since the most recent meal, etc.), as well as a physical exam with emphasis on underlying pathology that might negatively impact the induction with or recovery from sedating agents. Based upon the patient's age, presenting problem(s), medical history, examination, and the type of sedation-supported procedure and its projected duration, the physician determines the appropriate sedating agent(s), route of administration, and respective dosage to be used. The patient is verbally prepared for the sedation procedure. The physician directs that monitoring technology be implemented as needed. The availability and appropriate functioning of any materiel necessary for cardiorespiratory intervention are confirmed.

Description of Intra-Service Work: Administration of the sedating agent, with or without an analgesic, is initiated. The patient is observed until a safe and effective level of moderate sedation is achieved. The physician continuously face-to-face assesses the patient's level of consciousness and physiological status throughout performance of the supported procedure. Additional doses of sedating agent are ordered by the physician, as needed to maintain the achieved level of sedation for the supported procedure.

Description of Post-Service Work: If, following cessation of continuous face-to-face assessment of the patient's level of consciousness and physiological status, there are any untoward reactions resulting from sedation, the physician providing sedation determines the appropriate patient care management. The physician reassesses the patient's clinical condition to assure that the patient has returned to the pre-sedation level of consciousness. This assessment is documented in the medical record, and discharge instructions are provided for the patient, family, and/or legal guardian.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2005
Presenter(s):	Steven Krug, MD; Charles Mick, MD; Lanny Garvar, DMD; Timothy Shahbazian, DDS
Specialty(s):	American College of Emergency Physicians, North American Spine Society, American Association of Oral and Maxillofacial Surgeons, American Academy of Pediatrics

CPT Code:	99149					
Sample Size:	251	Resp n: 51		Response: 20.31 %		
Sample Type:	Convenience					
		Low	25th pctl	Median*	75th pctl	High
Survey RVW:		0.33	1.78	**2.45**	3.70	7.98
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		5.00	15.00	**20.00**	30.00	90.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	11.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

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

Other time if appropriate		42.00

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

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

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

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

FREQUENCY INFORMATION

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

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

Specialty ACEP	How often? Commonly
Specialty NASS	How often? Sometimes
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 41000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty ACEP	Frequency 40000	Percentage	%
Specialty NASS	Frequency 1000	Percentage	%
Specialty	Frequency 0	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty ACEP	Frequency 6000	Percentage	%
Specialty NASS	Frequency 500	Percentage	%
Specialty	Frequency 0	Percentage	%

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

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 99284

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99150 Tracking Number: FFF6 Global Period: ZZZ

Recommended Work Relative Value
Specialty Society RVU: **0.47**

RUC RVU: **0.47**

CPT Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Percentage of Survey Respondents who found Vignette to be Typical:

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

Is conscious sedation inherent in your reference code?

Description of Pre-Service Work:

Description of Intra-Service Work: The patient is closely monitored by the sedating physician and additional doses of sedating and/or analgesic agent(s) are delivered as needed. The sedating physician's intra-service time ends when the procedure is complete, the patient is physiologically stable, and face-to-face time with the sedating physician is no longer required.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2005					
Presenter(s):	Steven Krug, MD; Charles Mick, MD; Lanny Garvar, DMD; Timothy Shahbazian, DDS					
Specialty(s):	American Academy of Pediatrics, American College of Emergency Physicians, North American Spine Society, American Association of Oral and Maxillofacial Surgeons					
CPT Code:	99150					
Sample Size:	0	**Resp n:** 0		**Response:** 0.00 %		
Sample Type:						
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:						
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:				**15.00**		

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**

Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

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

KEY REFERENCE SERVICE:

Key CPT Code Global Work RVU

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.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 99150	Key Reference CPT Code: ____
Median Pre-Service Time	0.00	
Median Intra-Service Time	15.00	
Median Immediate Post-service Time	0.00	
Median Critical Care Time	0.0	
Median Other Hospital Visit Time	0.0	
Median Discharge Day Management Time	0.0	
Median Office Visit Time	0.0	
Median Total Time	**15.00**	**75.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

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

Technical Skill/Physical Effort (Mean)

Technical skill required		
Physical effort required		

Psychological Stress (Mean)

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

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

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

ADDITIONAL RATIONALE

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

Please see attached revised rationale.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

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

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

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 99213

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

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

CPT Long Descriptor: **Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time**

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

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

After discussion and analysis by an expert panel consisting of representatives from AAP, ACEP, NASS, and AAOMS, the PEAC standard conscious sedation direct practice expense inputs were crosswalked to codes 99143-991450.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **Two minutes to initiate sedation (*PEAC standard*)**

Intra-Service Clinical Labor Activities: **Clinical labor time equal to the physician intra service time for monitoring during the procedure (*PEAC standard*) and 15 minutes of follow-up monitoring for each hour monitored following the procedure (*PEAC standard*)**

Post-Service Clinical Labor ~~Activities~~: **N/A**

CPT Code: 99144

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

CPT Long Descriptor: **Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time**

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

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

After discussion and analysis by an expert panel consisting of representatives from AAP, ACEP, NASS, and AAOMS, the PEAC standard conscious sedation direct practice expense inputs were crosswalked to codes 991443-991450.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **Two minutes to initiate sedation (*PEAC standard*)**

Intra-Service Clinical Labor Activities: **Clinical labor time equal to the physician intra service time for monitoring during the procedure (*PEAC standard*) and 15 minutes of follow-up monitoring for each hour monitored following the procedure (*PEAC standard*)**

Post-Service Clinical Labor Activities: **N/A**

AMA/Specialty Society Update Process
PEAC Summary of Recommendation
ZZZ Global Period
Non Facility Direct Inputs

CPT Long Descriptor: **Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)**

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

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

After discussion and analysis by an expert panel consisting of representatives from AAP, ACEP, NASS, and AAOMS, the PEAC standard conscious sedation direct practice expense inputs were crosswalked to codes 99143-991450.

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities: **Clinical labor time equal to the physician intra service time for monitoring during the procedure (*PEAC standard*) and 15 minutes of follow-up monitoring for each hour monitored following the procedure (*PEAC standard*)**

	A	B	C	D	E	F	G	H	I
1									
2	**TAB C (REVISED 04/30/05)**			**CPT Code: 99143**		**CPT Code: 99144**		**CPT Code: 99145**	
3	**Meeting Date: April 2005 RUC**			**Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time**		**Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time**		**Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**								
6	**TOTAL CLINICAL LABOR TIME**	**L051A**	**RN**	**47.00**	**0.00**	**47.00**	**0.00**	**15.00**	**0.00**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**47.00**	**0.00**	**47.00**	**0.00**	**15.00**	**0.00**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
10	[illegible]								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity: **Initiate sedation**			**0**	**0**	**0**	**0**	**0**	**0**
18	**End:When patient enters office/facility for surgery/procedure**								
19	[illegible]								
20	**Start: When patient enters office/facility for surgery/procedure**								
21	**Pre-service services**								
22	Review charts								
23	Greet patient and provide gowning								
24	Obtain vital signs								
25	Provide pre-service education/obtain consent								
26	Prepare room, equipment, supplies								
27	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV								
29	Sedate/apply anesthesia	**L051A**	**RN**	**2**	**0**	**2**	**0**	**0**	**0**
30	**Intra-service**								
31	**Clinical staff time equal to physician intra-service time**	**L051A**	**RN**	**30**	**0**	**30**	**0**	**15**	**0**
32	**Post-Service**								
33	Monitor pt. following service/check tubes, monitors, drains								
34	Clean room/equipment by physician staff								
35	Clean Scope								
36	Clean Surgical Instrument Package								
37	Complete diagnostic forms, lab & X-ray requisitions								
38	Review/read X-ray, lab, and pathology reports								
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
40	Discharge day management 99238 –12 minutes 99239 –15 minutes								
41	Other Clinical Activity: **15 minutes of follow-up monitoring for each hour monitored following the procedure**	**L051A**	**RN**	**15.00**	**0.00**	**15.00**	**0.00**	**0.00**	**0.00**
42	**End: Patient leaves office**								
43	[illegible]								
44	**Start: Patient leaves office/facility**								
45	Conduct phone calls/call in prescriptions								
46	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care								
47	*List Number and Level of Office Visits*								
48	99211 16 minutes		16						
49	99212 27 minutes		27						
50	99213 36 minutes		36						
51	99214 53 minutes		53						
52	99215 63 minutes		63						

	A	B	C	D	E	F	G	H	I
2	**TAB C (REVISED 04/30/05)**			**CPT Code: 99143**		**CPT Code: 99144**		**CPT Code: 99145**	
3	**Meeting Date: April 2005 RUC**			**Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time**		**Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time**		**Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
53	Other								
54									
55	*Total Office Visit Time*			0	0	0	0	0	0
56	Other Activity (please specify)								
57	**End: with last office visit before end of global period**								

	A	B	C	J	K	L	M	N	O
2	**TAB C (REVISED 04/30/05)**			**CPT Code: 99148**		**CPT Code: 99149**		**CPT Code: 99150**	
3	**Meeting Date: April 2005 RUC**			**Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time**		**Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; first 30 minutes intra-service time**		**Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
53	Other								
54									
55	*Total Office Visit Time*			0	0	0	0	0	0
56	Other Activity (please specify)								
57	**End: with last office visit before end of global period**								

	A	B	C	J	K	L	M	N	O
2	**TAB C (REVISED 04/30/05)**			CPT Code: 99148		CPT Code: 99149		CPT Code: 99150	
3	**Meeting Date: April 2005 RUC**			Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time		Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; first 30 minutes intra-service time		Code Descriptor: Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
58									
59	**Conscious Sedation Package (Previously Approved by PEAC)**								
60									
61									
62									
63									
64	**Pulse oximeter with printer**	**EQ211**							
65	**IV infusion pump**	**EQ032**							
66	**Oxygen system, portable**	**EQ192**							
67	**Cardio-respiratory monitor**								
68									
69									
70									
71									
72									

4/29/05

Tab C: Moderate Sedation
99148-99150 (FFF4-FFF6)

Background: April 1997 RUC Rationale For Codes 99141-99142

The RUC considered two new CPT codes for conscious sedation; 99141, Sedation with or without analgesia (conscious sedation); intravenous, intra-muscular or inhalation, and 99142, oral, rectal and/or intranasal. The RUC agreed that conscious sedation represents the lowest end of the spectrum of anesthesia services and the only comparable codes would be anesthesia codes. However, the intra service portion for the sedation alone is not as intense as an anesthesia service because the physician's attention is devoted to the principal procedure and the pre and post work for conscious sedation is more similar to an evaluation and management service.

The RUC chose to evaluate 99141 and 99142 by assigning what was believed to be appropriate intra-service work per-unit of time (IWPUT) for the pre-, intra-, and post-service periods. When reviewing intra-service work, the RUC recommends 50% of the accepted anesthesia intra-work intensity, .5(.017)=.0085, and 20 minutes of intra-service work. Half of the anesthesia work intensity was selected because physicians do not spend all their time and effort on anesthesia, in that they are involved with the primary service. Twenty minutes of intra-service time is supported by the pediatric survey data and adequately distinguishes the provision of sedation from the primary procedure.

For both pre and post-service work the RUC recommends assigning an IWPUT equivalent to an evaluation and management service (0.027) and assuming 10 minutes for both pre and post time. The RUC arrived at 10 minutes of work because it is supported in the survey data which show median time in excess of 10 minutes and because it was felt that some of the pre and post-work for the primary service overlaps with work for conscious sedation. It was expressed that the survey results of 1.80 and 2.40 did not recognize the overlap of time with the primary procedure.

The resulting calculation is: 10(.027) + 20(.0085) + 10(.027) = 0.71 RVUs. The RUC viewed the value of 0.71 RVUs as a middle range. The value was adjusted up for 99141 to 0.80 and down for 99142 to 0.60. This adjustment compensated for the varying levels of difficulty associated with the two routes for administration of the sedation.

April 2005 Moderate Sedation Revised Rationale

A coalition of diverse specialties who perform moderate sedation for a wide spectrum of indications met and reviewed the survey data.

99149 (FFF5)

We believe the median survey times are correct, but the median recommended work RVU is too high. The most commonly selected reference code was 99284 (by 27.4%) of respondents. We do not think this is a good choice because there is no RUC time data for this code. 99149 is a sedation code and the most appropriate reference code should come from this section of CPT. We reviewed anesthesia codes and selected eight anesthesia codes for which intravenous sedation (monitored anesthesia care or deep sedation) is often administered. In many situations, the anesthesiologist performing these codes is providing the sedation for the same index procedure that a non-anesthesiologist would use 99149.

CPT Code	Long Descriptor	Time Source	Anes Base Units	Pre-Time	Intra-Time	Post-Time	Pre- & Post-Times	Total Time	RUC Meeting Date	Vignette	RUC Review
00142	Anesthesia for procedures on eye; lens surgery	No data	4								NO
00635	Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture	RUC time	4	15	42.5	15	27.5	70	October 2000	Yes	YES
00640	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine	RUC time 2003	3	15	27.5	10			Feb02	Yes	YES
01112	Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest	No data	5	15					October 2000		YES
01820	Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones	No data	3								NO
01905	Anesthesia for myelography, diskography, vertebroplasty	RUC time	5	15	60	15	30	90	April 2001	Yes	YES
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position	RUC time 2003	3	15	30	10			Feb02	Yes	YES
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position	RUC time 2003	5	15	30	10			Feb02	Yes	YES

Our expert panel believes that anesthesia codes 01991 and 01992 are much better reference codes to use for comparison. They were recently reviewed by the RUC and typically the procedures for which the anesthesia is required and level of anesthesia administered are similar to the survey code. Our survey times are similar to that of these codes.

	Moderate Sedation Code 99149	Anesthesia Code 01991	Anesthesia Code 01992
Pre-service time	15	15	15
Intra-service time	20	30	30
Post-service time	15	10	10
	4 base units	3 base units	5 base units

The values for these codes are 3 and 5 anesthesia base units, respectively. Code 01992 is strictly for prone procedures and is typically more complex. We believe 4 base units, an average of these two codes best represents the spectrum of cases for which 99149 will be used. Anesthesia coding

also includes a time factor (one base unit for each 15 minute of "continuous hands on care"). We have added two time units for 99149 for a total of 6 base units. Anesthesia base units can be converted to RVUs using the following formula:

RVUs = anesthesia units x (anesthesia CF/fee CF) x 0.7805 (anesthesia work fraction)

6 base units x (17.76/37.8975) x 0.7805 = 2.19 RVUs

Alternate methodology
We have also applied the same building block methodology used by anesthesia during the previous Five-Year Review.

Pre-service median time Pre-service reference code: 99241	15 minutes	0.64
Intra-service time	20 minutes: 5 minutes of Anesthesia Induction Level of Intensity (0.057) 15 minutes of Anesthesia Intensity Level 2 (0.031)	 0.29 0.47
Post-service median time	11* minutes of Anesthesia Intensity Level 1 (0.0224) (*15 minutes less 4 minutes of post-service time already built into the 99241 code)	0.25
	Total	**1.65 RVUs**

Our multispecialty expert panel believes that the RVU value based upon evaluation of anesthesia base units is too high for 99149. This does, however, identify an upper limit for a very similar service. The patients who receive sedation from anesthesiologists may have additional comorbidities that may increase the complexity of the service provided.

Therefore, we have opted to recommend the building block methodology to arrive at the lower recommendation of 1.65RVUs for 99149.

99148 (FFF4)

99148 is a similar service to 99149 but performed on patients under age five. We believe that the median survey times for this code are correct. The increased pre- and intra-service times are explained by the needs of younger patients and their parents.

We have calculated a work recommendation for 9919X4 based on extrapolation of the relationship between the "under age five" and "age five and over" central venous access codes. We determined the relative relationship between the pediatric and the non-pediatric central venous access codes to be 1.065. Applying this scaling factor to 99148 results in a work recommendation of 1.76.

1.65 x 1.065 = 1.76 RVUs

99150 (FFF6)

99150 is an add-on code for each additional 15-minute increment of intra-service time. We believe that there is physician work in this code due additional medical decision making and the need for additional dosing of sedation agents and/or use of reversal agents.

We have calculated a work recommendation for 99150 by multiplying 15 minutes by Anesthesia Intensity Level 2 (0.031).

15 minutes x 0.031 = 0.47 RVUs

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
May 1999

VISION SCREENING

Work Relative Value Recommendations

A new CPT code 99173 *Screening test of visual acuity, quantitative, bilateral (The screening test used must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g. Snellen Chart). Other identifiable services unrelated to this screening test provided at the same time may be reported separately (eg, preventive medicine services). When acuity is measured as part of a general ophthalmological service or of an E/M service of the eye, it is a diagnostic examination and not a screening test)* was established to document a vision test which previously had been included as part of an evaluation and management service. The RUC concluded that assigning work RVUs to this code would represent an unbundling of evaluation and management services and the code should be used for reporting purposes only. The RUC agreed that this important service should be distinct so it can be used as a quality measure for reporting purposes, but the RUC concluded there is no separate physician work involved in this code. The RUC is therefore not submitting a work recommendation for this code.

Practice Expense Recommendations

The RUC examined the practice expense involved in providing this service and agreed that there are clinical labor, supplies and procedure specific equipment expenses. The RUC recommends that the attached list of direct inputs accurately describes the clinical staff time involved in providing the service as well as the supplies and equipment utilized in this service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•99173	O1	Screening test of visual acuity, quantitative, bilateral (The screening test used must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g. Snellen Chart). Other identifiable services unrelated to this screening test provided at the same time may be reported separately (eg, preventive medicine services). When acuity is measured as part of a general ophthalmological service or of an E/M service of the eye, it is a diagnostic examination and not a screening test.)	XXX	**No Recommendation**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION
Direct Practice Expense Inputs (April 1999)

CPT Code: 9917X (01) **Global Period:** XXX

CPT Descriptor: Screening test of visual acuity, quantitative, bilateral
[The screening test used must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (eg, Snellen chart). Other identifiable services unrelated to this screening test provided at the same time may be reported separately (eg, preventive medicine services). When acuity is measured as part of a general ophthalmological service or of an E/M service of the eye, it is a diagnostic examination and not a screening test.]

Reference Code 1: 92002

Reference Code 2: 92081

Specialty(s): American Academy of Pediatrics

CLINICAL LABOR (IN MINUTES)

Clinical Staff	Staff Code	~~Pre-IN Office~~	TOTAL IN Office	~~Post-IN Office~~	Pre OUT Office	Intra OUT Office	Post OUT Office
RN/LPN/MA	10130	–	12	–	n/a	n/a	n/a

MEDICAL SUPPLIES

HCFA Supply Code	Supply Description	Unit	Quantity used IN-OFFICE for procedure AND pre- & post-op visits	QUANTITY used OUT-OF-OFFICE for pre- & post-op visits ONLY
11515	occluder	item	1	n/a

PROCEDURE SPECIFIC MEDICAL EQUIPMENT

HCFA Equip Code	Procedure-specific Description	Quantity used IN-OFFICE for procedure AND pre- & post-op visits	QUANTITY used OUT-OF-OFFICE for pre- & post-op visits ONLY
NEW	Titmus vision screen machine	1	n/a

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2005

Care Plan Oversight

The limitation of the existing care plan oversight codes for children and adults with special health care needs is not in the definition of the service, but in the restriction on setting – patients must be under the care of a home health agency, in hospice or in a nursing facility. While a significant number of children and adults with special health care needs and chronic medical conditions for the care model and the care plan oversight service code requirements that the patient be under the care of a multidisciplinary care modality, many patients are not under the care of a home health agency, in a hospice or in a nursing facility. Thus the limitation of the care plan oversight codes is not in the definition of the typical activities and services provided, but in the restriction on setting and circumstance. Therefore, the CPT Editorial Panel created two new codes to address this limitation of the existing care plan oversight codes.

99339

The RUC reviewed the survey results of 64 pediatricians, geriatricians and home care physicians in regard to the valuation of 99339 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes* and determined that the reference code 99374 *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes* (Work RVU=1.10) was reasonable. When comparing the surveyed code to the reference code, it was determined that the surveyed code has more total time than the reference code, 40 and 34 minutes respectively. Furthermore, the RUC recognized that the surveyed code required more mental effort, and judgement and higher technical skill than the reference code. Therefore, due to increased times and greater intensity and complexity measures, the RUC recommends the median survey value of 1.25 work RVUs for 99339. The

RUC agreed with the specialty societies' recommendation and felt that this value appropriately places this service relative to other procedures. In addition, the specialty societies recommended and the RUC agreed that it is reasonable to expect that the proposed work values should be more than the existing care plan oversight codes because of an absence of a home health agency to provide organizational support for the physician. **The RUC recommends 1.25 work RVUs for 99339.**

99340

The RUC reviewed the survey results of 61 pediatricians, geriatricians and home care physicians in regard to the valuation of 99340 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more* and determined that the reference code 99375 *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more* (Work RVU=1.73) was reasonable. When comparing the surveyed code to the reference code, it was determined that the surveyed code has more total time than the reference code, 60 and 57 minutes respectively. Furthermore, the RUC recognized that the surveyed code required more mental effort, and judgement and higher technical skill than the reference code. Therefore, due to increased times and greater intensity and complexity measures, the specialty societies recommends the median survey value of 1.80 work RVUs for 99340. The RUC agreed with the specialty societies' recommendation and felt that this value appropriately places this service relative to other procedures. In addition, the specialty societies recommended and the RUC agreed that it is reasonable to expect that the proposed work values should be more than the existing care plan oversight codes because of an absence of a home health agency to provide organizational support for the physician. **The RUC recommends 1.80 work RVUs for 99340.**

Practice Expense

The specialty society recommended that the practice expense inputs for the new codes, 99339 and 99340, be crosswalked to the existing care plan oversight codes 99374 and 99375. The RUC agreed with this crosswalk. The practice expense recommendations are attached to this report.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommen-dation
For instructions on the use of codes 99339, 99340, see introductory notes for codes 99374-99380 For care plan oversight services for patients under the care of a home health agency, hospice or nursing facility, see codes 99374-99380				
•99339	DDD1	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	XXX	1.25
•99340	DDD2	30 minutes or more (Do not report 99339, 99340 for patients under the care of a home health agency, enrolled in a hospice program, or for nursing facility residents)	XXX	1.80

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99339 Tracking Number: DDD1 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.25**

RUC RVU: **1.25**

CPT Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: PEDIATRIC VIGNETTE: A 21-year old with Down Syndrome who is transitioning from home care and public special education to a sheltered work program operated by the community service agency. He is moderately mentally retarded and ongoing medical problems include hypothyroidism and sensorineural hearing loss. Over the past two months his behavior his become progressively disruptive. His previously developed care plan includes the active medical and educational/vocational problems with ongoing adjustments being made based on feedback from the family and other health care professionals and service providers. The primary care physician (internal medicine, family physician, pediatrician) delivers primary care services and manages and coordinates care plan activities. Typical ongoing care plan oversight activities include:

- Review of reports including a new audiology assessment and endocrine consultation report
- Telephone call to the audiologist about results of the most recent hearing assessment and recommendations to provide hearing amplification to the patient
- Completion of medical forms for the vocational program listing medical problems, general cognitive and physical abilities, and recommendations for behavior management
- Discussion by phone with the family of recent appetite and weight gain noted by the family after beginning a new behavior medication, and subsequent call to the psychiatric nurse practitioner at the mental health center who recommends a dose change and a dietary consultation
- Review of endocrine recommendations to increase the thyroid dosage, with ensuing phone call to family and the pharmacy to prescribe a different dose form of Synthroid

The physician documents the relevant information in the record that summarizes the above activities. GERIATRIC VIGNETTE: The patient is an 84-year old female who lives with her daughter. She has advanced Alzheimer's Disease and is dependent in all IADL and most ADL. She has begun to become increasingly agitated. She could not cooperate sufficiently to be brought to the office for evaluation so a home visit was made (reported separately). Over the next month the doctor will need to review the care of the patient assessing progress and the effects of the interventions. This requires contact with the caregiver to review impacts and to support the caregiver to avoid hospitalization and the likely cycle of delirium and nursing home placement that would result. Between 15 and 29 minutes are spent and documented in these activities.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review of subsequent reports of patient status; review of related laboratory and other studies

Description of Intra-Service Work: Communication for purposes of assessment or care decisions with health care professional(s), family member(s), and or key caregivers(s); development/revision of care plan

Description of Post-Service Work: Integration of new information into the patient chart

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2005					
Presenter(s):	Steve Krug, MD, and Meghan Gerety, MD					
Specialty(s):	American Academy of Pediatrics; American Geriatric Society; American Academy of Home Care Physicians					
CPT Code:	99339					
Sample Size:	106	**Resp n:** 64		**Response:** 60.37 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.90	1.10	**1.25**	1.60	2.50
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		0.00	12.25	**20.00**	25.00	60.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99374	XXX	1.10

CPT Descriptor Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU
99377	XXX	1.10

CPT Descriptor Physician supervision of hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

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

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

Number of respondents who choose Key Reference Code: 58 **% of respondents:** 90.6 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 99339	Key Reference CPT Code: 99374
Median Pre-Service Time	10.00	5.00
Median Intra-Service Time	20.00	20.00
Median Immediate Post-service Time	10.00	9.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**40.00**	**34.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.74	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.74
Urgency of medical decision making	3.33	3.21

Technical Skill/Physical Effort (Mean)

Technical skill required	3.56	3.44
Physical effort required	2.47	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.53	3.49
Outcome depends on the skill and judgment of physician	4.09	3.88
Estimated risk of malpractice suit with poor outcome	3.14	3.09

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.74	2.65
Intra-Service intensity/complexity	3.60	3.42
Post-Service intensity/complexity	3.19	2.95

ADDITIONAL RATIONALE

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

An expert panel consisting of members of the American Academy of Pediatrics (AAP), the American Geriatrics Society (AGS), and the American Academy of Home Care Physicians (AAHCP) reviewed the survey results. Based on the consistency of the survey data, they recommend the survey median of 1.25 work RVUs.

The new service should be valued higher than its reference service code (99374 = 1.10 work RVUs) since providing care plan oversight in the absence of a home health agency increases the complexity/intensity of the physician work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99374, 99377, or 99379

How often do 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? Sometimes

Specialty Geriatrics How often? Sometimes

Specialty Home Care Physicians How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 175000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Pediatrics Frequency 60000 Percentage 34.28 %

Specialty Geriatrics Frequency 115000 Percentage 65.71 %

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? 80,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Pediatrics Frequency 50 Percentage 0.06 %

Specialty Geriatrics Frequency 79000 Percentage 98.75 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

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

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99340 Tracking Number: DDD2 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.80**

RUC RVU: **1.80**

CPT Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: PEDIATRIC VIGNETTE: A 21-year old with Down Syndrome who is transitioning from home care and public special education to a sheltered work program operated by the community service agency. He is moderately mentally retarded and ongoing medical problems include hypothyroidism and sensorineural hearing loss. Over the past two months his behavior his become progressively disruptive. His previously developed care plan includes the active medical and educational/vocational problems with ongoing adjustments being made based on feedback from the family and other health care professionals and service providers. The primary care physician (internal medicine, family physician, pediatrician) delivers primary care services and manages and coordinates care plan activities. Typical ongoing care plan oversight activities include:

- Review of reports including a new audiology assessment and endocrine consultation report
- Telephone call to the audiologist about results of the most recent hearing assessment and recommendations to provide hearing amplification to the patient
- Completion of medical forms for the vocational program listing medical problems, general cognitive and physical abilities, and recommendations for behavior management
- Discussion by phone with the family of recent appetite and weight gain noted by the family after beginning a new behavior medication, and subsequent call to the psychiatric nurse practitioner at the mental health center who recommends a dose change and a dietary consultation
- Review of endocrine recommendations to increase the thyroid dosage, with ensuing phone call to family and the pharmacy to prescribe a different dose form of Synthroid

The physician documents the relevant information in the record that summarizes the above activities. GERIATRIC VIGNETTE: The patient is an 84-year old female who lives with her daughter. She has advanced Alzheimer's Disease and is dependent in all IADL and most ADL. She has begun to become increasingly agitated. She could not cooperate sufficiently to be brought to the office for evaluation so a home visit was made (reported separately). Over the next month the doctor will need to review the care of the patient assessing progress and the effects of the interventions. This requires contact with the caregiver to review impacts and to support the caregiver to avoid hospitalization and the likely cycle of delirium and nursing home placement that would result. Thirty minutes or more are spent and documented in these activities.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

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

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review of subsequent reports of patient status; review of related laboratory and other studies

Description of Intra-Service Work: Communication for purposes of assessment or care decisions with health care professional(s), family member(s), and or key caregivers(s); development/revision of care plan

Description of Post-Service Work: Integration of new information into the patient chart

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2005					
Presenter(s):	Steve Krug, MD, and Meghan Gerety, MD					
Specialty(s):	American Academy of Pediatrics; American Geriatric Society; American Academy of Home Care Physicians					
CPT Code:	99340					
Sample Size:	106	**Resp n:** 61		**Response:** 57.54 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.30	1.73	**1.80**	2.00	3.00
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		0.00	17.50	**30.00**	40.00	60.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**15.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99375	XXX	1.73

CPT Descriptor Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
99378	XXX	1.73

CPT Descriptor Physician supervision of hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

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

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

Number of respondents who choose Key Reference Code: 57 **% of respondents:** 93.4 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 99340	Key Reference CPT Code: 99375
Median Pre-Service Time	15.00	10.00
Median Intra-Service Time	30.00	32.00
Median Immediate Post-service Time	15.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**60.00**	**57.00**
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	3.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.36	4.08
Urgency of medical decision making	3.46	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	3.59	3.59
Physical effort required	2.64	2.56

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.77	3.74
Outcome depends on the skill and judgment of physician	4.26	4.08
Estimated risk of malpractice suit with poor outcome	3.23	3.15

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.95	2.82
Intra-Service intensity/complexity	3.95	3.77
Post-Service intensity/complexity	3.41	3.10

ADDITIONAL RATIONALE

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

An expert panel consisting of members of the American Academy of Pediatrics (AAP), the American Geriatrics Society (AGS), and the American Academy of Home Care Physicians (AAHCP) reviewed the survey results. Based on the consistency of the survey data, they recommend the survey median of 1.80 work RVUs.

The new service should be valued higher than its reference service code (99375 = 1.73 work RVUs) since providing care plan oversight in the absence of a home health agency increases the complexity/intensity of the physician work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99375, 99378, or 99380

How often do 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? Sometimes

Specialty Geriatrics How often? Sometimes

Specialty Home Physicians How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 175000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Pediatrics Frequency 60000 Percentage 34.28 %

Specialty Geriatrics Frequency 115000 Percentage 65.71 %

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? 80,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Pediatrics Frequency 50 Percentage 0.06 %

Specialty Geriatrics Frequency 79000 Percentage 98.75 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

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

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

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

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

CPT Long Descriptor: **Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes**

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

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

After discussion and analysis by an expert panel consisting of representatives from AAP, AGS, and AAHCP, the PEAC-approved direct practice expense inputs for codes 99374 and 99375 were crosswalked to the new codes, 99339 and 99340, respectively.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **Selecting appropriate patient chart; telephone calls to patient/family, other health care professionals, pharmacy, and/or preauthorization calls to payors; completing forms not otherwise completed by the physician**

Intra-Service Clinical Labor Activities: **N/A**

Post-Service Clinical Labor Activities: **Selecting appropriate patient chart; telephone calls to patient/family, other health care professionals, pharmacy, and/or payors; completing forms not otherwise completed by the physician**

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

CPT Long Descriptor: **Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**

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

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

After discussion and analysis by an expert panel consisting of representatives from AAP, AGS, and AAHCP, the PEAC-approved direct practice expense inputs for codes 99374 and 99375 were crosswalked to the new codes, 99339 and 99340, respectively.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **Selecting appropriate patient chart; telephone calls to patient/family, other health care professionals, pharmacy, and/or preauthorization calls to payors; completing forms not otherwise completed by the physician**

Intra-Service Clinical Labor Activities: **N/A**

Post-Service Clinical Labor Activities: **Selecting appropriate patient chart; telephone calls to patient/family, other health care professionals, pharmacy, and/or payors; completing forms not otherwise completed by the physician**

	A	B	C	D	E	F
1						
2				Crosswalk Reference Code: 99374		CPT Cod
3	**Meeting Date: April 2005 RUC**			**Code Descriptor: Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes**		**Code Descriptor: I supervision of a p present) in home, home (eg, assist requiring complex a care modalities i physician developme care plans, review of of patient status, laboratory and communication (in calls) for purposes care decisions professional(s), f surrogate decision guardian) and/or involved in patient's new information treatment plan an medical therapy, month; 15-**
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**
5	**GLOBAL PERIOD**					
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**30.0**	**0.0**	**30.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**15.0**	**0.0**	**15.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**15.0**	**0.0**	**15.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**
10	[redacted]					
11	**Start: Following visit when decision for surgery or procedure made**					
12	Complete pre-service diagnostic & referral forms					
13	Coordinate pre-surgery services					
14	Schedule space and equipment in facility					
15	Provide pre-service education/obtain consent					
16	**Follow-up phone calls & prescriptions**	**L037D**				**9**
17	Other Clinical Activity (please specify): **Completing forms not otherwise completed by the physician**	**L037D**				**6**
18	**End:When patient enters office/facility for surgery/procedure**					
19	[redacted]					
20	**Start: When patient enters office/facility for surgery/procedure**					
21	**Pre-service services**					
22	Review charts					
23	Greet patient and provide gowning					
24	Obtain vital signs					
25	Provide pre-service education/obtain consent					
26	Prepare room, equipment, supplies					
27	Setup scope (non facility setting only)					
28	Prepare and position patient/ monitor patient/ set up IV					
29	Sedate/apply anesthesia					
30	**Intra-service**					
31	Assist physician in performing procedure					
32	**Post-Service**					
33	Monitor pt. following service/check tubes, monitors, drains					
34	Clean room/equipment by physician staff					
35	Clean Scope					
36	Clean Surgical Instrument Package					
37	Complete diagnostic forms, lab & X-ray requisitions					
38	Review/read X-ray, lab, and pathology reports					
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
40	Discharge day management 99238 --12 minutes 99239 --15 minutes					
41	Other Clinical Activity (please specify): **Completing forms not otherwise completed by the physician; follow-up phone calls and prescriptions**	**L037D**				**15**
42	**End: Patient leaves office**					
43	[redacted]					
44	**Start: Patient leaves office/facility**					
45	Conduct phone calls/call in prescriptions					
46	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care					
47	*List Number and Level of Office Visits*					
48	99211 16 minutes					

	A	B	C	D	E	F
2				Crosswalk Reference Code: 99374		CPT Cod
3	**Meeting Date: April 2005 RUC**			Code Descriptor: Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes		Code Descriptor: In supervision of a p present) in home, home (eg, assist requiring complex a care modalities i physician developme care plans, review of of patient status, laboratory and communication (in calls) for purposes care decisions v professional(s), f surrogate decision guardian) and/or involved in patient's new information treatment plan an medical therapy, month; 15-
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility
49	99212 27 minutes		27			
50	99213 36 minutes		36			
51	99214 53 minutes		53			
52	99215 63 minutes		63			
53	Other					
54						
55	*Total Office Visit Time*			0	0	0
56	Other Activity (please specify)					

	A	B	C	D	E	F
2				Crosswalk Reference Code: 99374		CPT Cod
3	Meeting Date: April 2005 RUC			Code Descriptor: Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes		Code Descriptor: I supervision of a p present) in home, home (eg, assist requiring complex a care modalities physician developme care plans, review of of patient status, laboratory and communication (in calls) for purposes care decisions professional(s), f surrogate decision guardian) and/or involved in patient's new information treatment plan an medical therapy, month; 15-
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility
57	End: with last office visit before end of global period					
58	[redacted]	[redacted]	[redacted]			
59	N/A					
60	[redacted]	[redacted]	[redacted]			
61	N/A					
62						
63						
64						
65						
66						
67						
68						
69						

	A	B	C	G	H	I
1						
2				e: 99339	Crosswalk Reference Code: 99375	
3	**Meeting Date: April 2005 RUC**			dividual physician atient (patient not domiciliary or rest ed living facility) nd multidisciplinary nvolving regular nt and/or revision of subsequent reports review of related other studies, cluding telephone of assessment or vith health care amily member(s), maker(s) (eg, legal key caregiver(s) care, integration of into the medical /or adjustment of within a calendar 9 minutes	*Code Descriptor:* Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Facility**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**					
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**36.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**18.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**18.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**
10	[redacted]					
11	**Start: Following visit when decision for surgery or procedure made**					
12	Complete pre-service diagnostic & referral forms					
13	Coordinate pre-surgery services					
14	Schedule space and equipment in facility					
15	Provide pre-service education/obtain consent					
16	**Follow-up phone calls & prescriptions**	**L037D**		**0**		
17	Other Clinical Activity (please specify): **Completing forms not otherwise completed by the physician**	**L037D**		**0**		
18	**End:When patient enters office/facility for surgery/procedure**					
19	[redacted]					
20	**Start: When patient enters office/facility for surgery/procedure**					
21	**Pre-service services**					
22	Review charts					
23	Greet patient and provide gowning					
24	Obtain vital signs					
25	Provide pre-service education/obtain consent					
26	Prepare room, equipment, supplies					
27	Setup scope (non facility setting only)					
28	Prepare and position patient/ monitor patient/ set up IV					
29	Sedate/apply anesthesia					
30	**Intra-service**					
31	Assist physician in performing procedure					
32	**Post-Service**					
33	Monitor pt. following service/check tubes, monitors, drains					
34	Clean room/equipment by physician staff					
35	Clean Scope					
36	Clean Surgical Instrument Package					
37	Complete diagnostic forms, lab & X-ray requisitions					
38	Review/read X-ray, lab, and pathology reports					
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
40	Discharge day management 99238 –12 minutes 99239 –15 minutes					
41	Other Clinical Activity (please specify): **Completing forms not otherwise completed by the physician; follow-up phone calls and prescriptions**	**L037D**		**0**		
42	**End: Patient leaves office**					
43	[redacted]					
44	**Start: Patient leaves office/facility**					
45	Conduct phone calls/call in prescriptions					
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47	*List Number and Level of Office Visits*					
48	99211 16 minutes					

	A	B	C	G	H	I
2				e: 99339	Crosswalk Reference Code: 99375	
3	Meeting Date: April 2005 RUC			dividual physician atient (patient not domiciliary or rest ed living facility) nd multidisciplinary nvolving regular nt and/or revision of subsequent reports review of related other studies, cluding telephone of assessment or with health care mily member(s), maker(s) (eg, legal key caregiver(s) care, integration of into the medical /or adjustment of within a calendar 29 minutes	Code Descriptor: Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	
4	LOCATION	CMS Code	Staff Type	Facility	Non Facility	Facility
49	99212 27 minutes		27			
50	99213 36 minutes		36			
51	99214 53 minutes		53			
52	99215 63 minutes		63			
53	Other					
54						
55	*Total Office Visit Time*			0	0	0
56	Other Activity (please specify)					

	A	B	C	G	H	I
2				e: 99339	Crosswalk Reference Code: 99375	
3	Meeting Date: April 2005 RUC			dividual physician atient (patient not domiciliary or rest ed living facility) nd multidisciplinary nvolving regular nt and/or revision of subsequent reports review of related other studies, cluding telephone of assessment or vith health care mily member(s), maker(s) (eg, legal key caregiver(s) care, integration of into the medical /or adjustment of within a calendar 29 minutes	Code Descriptor: Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	
4	LOCATION	CMS Code	Staff Type	Facility	Non Facility	Facility
57	End: with last office visit before end of global period					
58	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
59	N/A					
60	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
61	N/A					
62						
63						
64						
65						
66						
67						
68						
69						

	A	B	C	J	K
1					
2				CPT Code: 99340	
3	**Meeting Date: April 2005 RUC**			**Code Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**				
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**36.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**18.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**18.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
10	**PRE-SERVICE PERIOD**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms				
13	Coordinate pre-surgery services				
14	Schedule space and equipment in facility				
15	Provide pre-service education/obtain consent				
16	**Follow-up phone calls & prescriptions**	**L037D**		**12**	**0**
17	Other Clinical Activity (please specify): **Completing forms not otherwise completed by the physician**	**L037D**		**6**	**0**
18	**End:When patient enters office/facility for surgery/procedure**				
19	**SERVICE PERIOD**				
20	**Start: When patient enters office/facility for surgery/procedure**				
21	**Pre-service services**				
22	Review charts				
23	Greet patient and provide gowning				
24	Obtain vital signs				
25	Provide pre-service education/obtain consent				
26	Prepare room, equipment, supplies				
27	Setup scope (non facility setting only)				
28	Prepare and position patient/ monitor patient/ set up IV				
29	Sedate/apply anesthesia				
30	**Intra-service**				
31	Assist physician in performing procedure				
32	**Post-Service**				
33	Monitor pt. following service/check tubes, monitors, drains				
34	Clean room/equipment by physician staff				
35	Clean Scope				
36	Clean Surgical Instrument Package				
37	Complete diagnostic forms, lab & X-ray requisitions				
38	Review/read X-ray, lab, and pathology reports				
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
40	Discharge day management 99238 –12 minutes 99239 –15 minutes				
41	Other Clinical Activity (please specify): **Completing forms not otherwise completed by the physician; follow-up phone calls and prescriptions**	**L037D**		**18**	**0**
42	**End: Patient leaves office**				
43	**POST-SERVICE PERIOD**				
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions				
46	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care				
47	*List Number and Level of Office Visits*				
48	99211 16 minutes				

	A	B	C	J	K
2				CPT Code: 99340	
3	**Meeting Date: April 2005 RUC**			**Code Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**
49	99212 27 minutes		27		
50	99213 36 minutes		36		
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54					
55	*Total Office Visit Time*			0	0
56	Other Activity (please specify)				

	A	B	C	J	K
2				CPT Code: 99340	
3	Meeting Date: April 2005 RUC			Code Descriptor: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
57	End: with last office visit before end of global period				
58	[redacted]	[redacted]	[redacted]		
59	N/A				
60	[redacted]	[redacted]	[redacted]		
61	N/A				
62					
63					
64					
65					
66					
67					
68					
69					

AMA SPECIALTY SOCIETY RVS UPDATE PROCESS

TABLE 1

SUMMARY OF RECOMMENDATIONS
JULY 1993

PROLONGED SERVICES - TAB 1

Prolonged physician service codes are to be used when a physician provides prolonged service to a patient above and beyond what is usually required of that service in either the inpatient or outpatient setting. The RUC noted that the addition of these codes fills a void in the current coding system, since there is presently no way to report evaluation and management services that extend beyond the service described by the Level V codes. The RUC also concluded that, given appropriate coverage and payment policies, the addition of these codes by CPT, particularly the outpatient codes, would help ensure that services were provided in the most appropriate setting and reduce the incidence of more costly emergency room visits and hospital admissions.

The recommendations are derived from a survey primarily of family physicians and internists, as well as a small group process involving extensive assessment of the relationship between the work involved in the new codes and that involved in the key reference services, including each of the four dimensions of work. The RUC's discussion of the relative value recommendations focused on various aspects of the time factor involved in the prolonged service codes and the relationship between time and work. The idea that the time spent by the physician is not necessarily continuous was taken into consideration by the RUC and it was clear that only the actual face-to-face physician time for the services described by 99354-99357 would be counted in using these codes.

Tracking #	CPT Code (● New)	CPT Descriptor	Coding Change	Global Period	RVW Recommen-dation
		PROLONGED PHYSICIAN SERVICE WITH DIRECT (FACE-TO-FACE) PATIENT CONTACT Codes 99354-99357 are used when a physician provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. This service is reported in addition to other physician service, including evaluation and management services at any level. Appropriate codes should be selected for supplies provided or procedures performed in the care of the patient during this period. Codes 99354-99357 are used to report the total duration of face-to-face time spent by a physician on a given date providing prolonged service, even if the time spent by the physician on that date is not continuous. Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service. Either code also may be used to report a total duration of prolonged service of 30-60 minutes on a given date. Either code should be used only once per date, even if the time spent by the physician is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes. Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. Either code also may be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. The following examples illustrate the correct reporting of prolonged physician service with direct patient contact in the office setting: Total Duration of Prolonged Services — Code(s) a. less than 30 minutes (less than 1/2 hour) — Not reported separately b. 30-74 minutes (1/2 hr. - 1 hr. 14 min.) — 99354 X 1 c. 75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.) — 99354 X 1 and 99355 X 1 d. 105-134 minutes (1 hr. 45 min. - 2 hr. 14 min.) — 99354 X 1 and 99355 X 2 e. 135-164 minutes (2 hr. 15 min. - 2 hr. 44 min.) — 99354 X 1 and 99355 X 3 f. 165-194 minutes (2 hr. 45 min. - 3 hr. 14 min.) — 99354 X 1 and 99355 X 4			
	99150	~~Prolonged physician attendance requiring physician detention beyond usual service(eg, operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gases during surgery, standby for newborn care following cesarean section, or maternal-fetal monitoring), 30 minutes to one hour~~	deleted	XXX	N/A

Tracking #	CPT Code (• New)	CPT Descriptor	Coding Change	Global Period	RVW Recommendation
	99151	~~more than one hour~~ (99150, 99151 have been deleted. To report, see 99354-99360)	deleted	XXX	N/A
TT1	•99354	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (eg, prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour	new	XXX	2.33
TT2	•99355	each additional 30 minutes	new	XXX	1.20
TT3	•99356	Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); first hour	new	XXX	3.00
TT4	•99357	each additional 30 minutes	new	XXX	1.50
PROLONGED PHYSICIAN SERVICE WITHOUT DIRECT (FACE-TO-FACE) CONTACT Codes 99358 and 99359 are used when a physician provides prolonged service not involving direct (face-to-face) contact that is beyond the usual service in either the inpatient or outpatient setting. This service is to be reported in addition to other physician service, including evaluation and management services at any level. Codes 99358 and 99359 are used to report the total duration of non face-to-face time spent by a physician on a given date providing prolonged service, even if the time spent by the physician on that date is not continuous. Code 99359 is used to report the first hour of prolonged service on a given date regardless of the place of service. It also may be used to report a total duration of prolonged service of 30-60 minutes on a given date. It should be used only once per date even if the time spent by the physician is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported. Code 99359 is used to report each additional 30 minutes beyond the first hour regardless of the place of service. It also may be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.					
TT5	•99358	Prolonged evaluation and management service before and\or after direct (face-to-face) patient contact (eg, review of extensive records and tests, communication with other professionals and/or the patient/family); first 30-60 minutes	new	XXX	2.10
TT6	•99359	each additional 30 minutes (To report telephone calls, see 99371-99373)	new	XXX	1.00

Tracking #	CPT Code (• New)	CPT Descriptor	Coding Change	Global Period	RVW Recommen-dation
PHYSICIAN STANDBY SERVICES Code 99360 is use to report physician standby service that is requested by another physician and that involves prolonged physician attendance without direct (face-to-face) patient contact. The physician may not be providing care or services to other patients during this period. This code is not used to report time spent proctoring another physician. It also is not used if the period of standby ends with the performance of a procedure subject to a "surgical package" by the physician who was on standby. Codes 99360 is used to report the total duration of time spent by a physician on a given date on standby. Standby service of less than 30 minutes total duration on a given date is not reported separately. Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of service reported.					
TT7	•99360	Physician standby service, requiring prolonged physician attendance; each 30 minutes (eg, operative standby, standby cesarean delivery for newborn care)	new	XXX	1.20

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
CONSENSUS RECOMMENDATION

Tracking Number: TT1 CPT Code: ●993X1 Global Period: XXX

CPT Descriptor: Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g. prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour

Clinical Description of Service (including pre- intra- and post-service work, and typical patient):

20 year old female with a history of asthma presents with acute bronchospasm and moderate respiratory distress. Initial evaluation and management shows respiratory rate 30, labored breathing and wheezing heard in all lung fields. Office treatment is initiated which includes intermittent bronchio dilation and subcutaneous epinephrine. Requires intermittent physician face-to-face time with patient over a period of 2-3 hours. Patient is returned home subsequent to stabilization.

KEY REFERENCE SERVICES(S):

CPT Code	CPT Descriptor	RVW
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to face with the patient and/or family.	2.36
99244	Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.	2.30

Relationship to Key Reference Service(s):

Compared to reference codes 99205 and 99244, the time required for TT1 is approximately the same; the technical and physical effort is slightly less; the mental effort approximately the same while the stress associated with stabilizing and managing the asthmatic crisis would be substantially greater. Thus, compared to values of 2.30 (99244) and 2.36 (99205) the median surveyed value of 2.33 appears appropriate.

SURVEY DATA:

SPECIALTY: Family Practice and Internal Medicine

Median Intra-Service Time: 60 Low: 30 High: 180

Median Pre-Service Time: N/A Median Post-Service Time: N/A

Length of Hospital Stay: N/A

Number & Level of Post-Hospital Visits: N/A

Other Data:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
CONSENSUS RECOMMENDATION

Tracking Number: TT2 CPT Code: ●993X2 Global Period: XXX

CPT Descriptor: Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting); each additional 30 minutes

Clinical Description of Service (including pre- intra- and post-service work, and typical patient):

20 year old female with a history of asthma presents with acute bronchospasm and moderate respiratory distress. Initial evaluation and management shows respiratory rate 30, labored breathing and wheezing heard in all lung fields. Office treatment is initiated which includes intermittent bronchio dilation and subcutaneous epinephrine. Requires intermittent physician face-to-face time with patient over a period of 2-3 hours. Patient is returned home subsequent to stabilization.

KEY REFERENCE SERVICES(S):

CPT Code	CPT Descriptor	RVW
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.	0.98
99233	Subsequent hospital care per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.	1.30

Relationship to Key Reference Service(s):

Compared to reference code 99214 (.98 RVW) the time, technical and physical effort and, the mental effort are equivalent; while the stress of stabilizing and managing the asthmatic would be substantially greater. For 99233 (1.3 RVW), the committee determined that all four components were essentially equivalent to those for the surveyed code. Therefore, the recommended value of 1.2 (equal to approximately 50% of TT1), while higher than the surveyed median, is appropriate.

SURVEY DATA:

SPECIALTY: Family Practice and Internal Medicine

Median Intra-Service Time: 30 Low: 10 High: 180

Median Pre-Service Time: N/A Median Post-Service Time: N/A

Length of Hospital Stay: N/A

Number & Level of Post-Hospital Visits: N/A

Other Data:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
CONSENSUS RECOMMENDATION

Tracking Number: TT3 CPT Code: ●993X3 Global Period: XXX

CPT Descriptor: Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (e.g., maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); first hour

Clinical Description of Service (including pre- intra- and post-service work, and typical patient):

34 year old primigravida presents to hospital in early labor. Admission history and physical reveals severe preeclampsia. Physician supervises management of preeclampsia, IV magnesium initiation and maintenance, labor augmentation with pitocin, and close maternal-fetal monitoring. Physician face-to-face involvement includes 40 minutes of continuous bedside care until the patient is stable, then is intermittent over several hours until the delivery. Care involves patient evaluation, monitoring and interpretation of laboratory results, and adjustment of therapy as needed.

KEY REFERENCE SERVICES(S):

CPT Code	CPT Descriptor	RVW
99285	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and mental status: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	2.71

Relationship to Key Reference Service(s):

Compared to reference code 99285 (2.71 RVW) the time required for TT3 would be equivalent for a similar ER patient; that the physical and technical effort would be equivalent; and that the average mental effort and level of stress associated with TT3 would equal or slightly exceed that for an average 99285. Accordingly, the joint committee recommendation of 3.0 is judged to be appropriate.

SURVEY DATA:

SPECIALTY: Family Practice and Internal Medicine

Median Intra-Service Time: 60 Low: 30 High: 480

Median Pre-Service Time: Median Post-Service Time:

Length of Hospital Stay:

Number & Level of Post-Hospital Visits:

Other Data:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
CONSENSUS RECOMMENDATION

Tracking Number: TT4 CPT Code: ●993X4 Global Period: XXX

CPT Descriptor: Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (e.g., maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); each additional 30 minutes

Clinical Description of Service (including pre- intra- and post-service work, and typical patient):

34 year old primigravida presents to hospital in early labor. Admission history and physical reveals severe preeclampsia. Physician supervises management of preeclampsia, IV magnesium initiation and maintenance, labor augmentation with pitocin, and close maternal-fetal monitoring. Physician face-to-face involvement includes 40 minutes of continuous bedside care until the patient is stable, then is intermittent over several hours until the delivery. Care involves patient evaluation, monitoring and interpretation of laboratory results, and adjustment of therapy as needed.

KEY REFERENCE SERVICES(S):

CPT Code	CPT Descriptor	RVW
99233	Subsequent hospital care per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.	1.30
99243	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) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.	1.53

Relationship to Key Reference Service(s):

Compared to reference code 99233 (1.3 RVW) time and mental effort are approximately the same while technical/physical effort is somewhat greater and stress substantially greater owing to the average severity of the condition being managed. Compared to 99243 (1.53 RVW), TT4 involves less time and physical/technical effort but more mental effort and stress. Thus, the joint committee recommendation of 1.50 RVW (50% of TT3), while slightly higher than the surveyed median, is appropriate.

SURVEY DATA:

SPECIALTY : Family Practice and Internal Medicine

Median Intra-Service Time: 30 Low: 15 High: 480

Median Pre-Service Time: Median Post-Service Time:

Length of Hospital Stay:

Number & Level of Post-Hospital Visits:

Other Data:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
CONSENSUS RECOMMENDATION

Tracking Number: TT5 CPT Code: ●993X5 Global Period: XXX

CPT Descriptor: Prolonged evaluation and management service before and\or after direct (face-to-face) patient contact (e.g., review of extensive records and tests, communication with other professionals and/or the patient/family); first 30-60 minutes

Clinical Description of Service (including pre- intra- and post-service work, and typical patient):

A 65 year old new patient with multiple complicated medical problems, brought to the office by her daughter, has been seen and examined by the physician. After the visit, the physician requires extensive time to talk with the daughter, to review complex and detailed medical records transferred from the patient's previous physicians and to complete a comprehensive treatment plan. This plan also requires the physician to personally initiate and coordinate the care plan with a local home health agency and a dietician.

KEY REFERENCE SERVICES(S):

CPT Code	CPT Descriptor	RVW
99244	Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.	2.30

Relationship to Key Reference Service(s):

TT5, TT6 and TT7 proved particularly challenging to justify key reference services using the "worksheet" approach. The key reference services involved face-to-face time, the surveyed codes do not. Never-the-less, the joint committee concluded that TT5 involved the same amount of time, less technical/physical effort and stress but involved more mental effort than 99244 (2.3 RVW). The surveyed median of 2.10 is thus a reasonable work value.

SURVEY DATA:

SPECIALTY: Family Practice and Internal Medicine

Median Intra-Service Time: N/A Low: N/A High: N/A

Median Pre-Service Time: 25 Median Post-Service Time: 40

Length of Hospital Stay: N/A

Number & Level of Post-Hospital Visits:

Other Data:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
CONSENSUS RECOMMENDATION

Tracking Number: TT6 CPT Code: ●993X6 Global Period: XXX

CPT Descriptor: Prolonged evaluation and management service before and/or after direct (face-to-face) patient contact (e.g., review of extensive records and tests, communication with other professionals and/or the patient/family); each additional 30 minutes

(To report telephone calls, see 99371-99373)

Clinical Description of Service (including pre- intra- and post-service work, and typical patient):

A 65 year old new patient with multiple complicated medical problems, brought to the office by her daughter, has been seen and examined by the physician. After the visit, the physician requires extensive time to talk with the daughter, to review complex and detailed medical records transferred from the patient's previous physicians and to complete a comprehensive treatment plan. This plan also requires the physician to personally initiate and coordinate the care plan with a local home health agency and a dietician.

KEY REFERENCE SERVICES(S):

CPT Code	CPT Descriptor	RVW
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.	0.98

Relationship to Key Reference Service(s):

See TT5. The joint committee believes that TT6 involves approximately the same time and stress; less technical/physical effort but more mental effort than 99214 (.98 RVW). The surveyed value of 1.00 also equals slightly less than 50% of TT5.

SURVEY DATA:

SPECIALTY : Family Practice and Internal Medicine

Median Intra-Service Time: N/A Low: N/A High: N/A

Medica Pre-Service Time: 15 Medical Post-Service Time: 25

Length of Hospital Stay: N/A

Number & Level of Post-Hospital Visits: N/A

Other Data:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
CONSENSUS RECOMMENDATION

Tracking Number: TT7 CPT Code: ●993X7 Global Period: XXX

CPT Descriptor: Physician standby service, requiring prolonged physician attendance; each 30 minutes (e.g., operative standby, standby cesarean delivery for newborn care)

Clinical Description of Service (including pre- intra- and post-service work, and typical patient):

24 year old female patient admitted to OB unit attempting VBAC. Fetal monitoring shows increasing fetal distress. Patient's blood pressure is rising and labor progressing slowly. A primary care physician is requested by the OB/GYN to standby in the hospital for possible cesarean delivery and neonatal resuscitation as needed.

KEY REFERENCE SERVICES(S):

CPT Code	CPT Descriptor	RVW
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: 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) of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.	1.19

Relationship to Key Reference Service(s):

See Rationale for TT5. The joint committee chose 99203 (1.19 RVW) as the key reference service there being no clear consensus among those surveyed. TT7 involves standing by for the provision of services requiring time equivalent to 99203; obviously less physical/technical effort; but arguably more mental effort in analyzing detailed and complex information and stress in anticipation of providing services to an average patient with complex/severe medical or surgical problems. Thus, the survey median of 1.20 appears appropriate.

SURVEY DATA:

SPECIALTY: Family Practice and Internal Medicine

Median Intra-Service Time: N/A Low: High:

Median Pre-Service Time: 30 Medical Post-Service Time: N/A

Length of Hospital Stay: N/A

Number & Level of Post-Hospital Visits: N/A

Other Data:

		Family 1			
		99354 Prolonged physician service		99355 Prolonged physician service	
	CMS CODE				
LOCATION		In Office	Out Office	In Office	Out Office
GLOBAL PERIOD		XXX	XXX	XXX	XXX
TOTAL CLINICAL LABOR TIME	1130	13.0	0.0	13.0	0.0
TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	0.0	0.0	0.0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME		10.0	0.0	10.0	0.0
TOTAL POST-SERV CLINICAL LABOR TIME		3.0	0.0	3.0	0.0
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					
Office visit before surgery/procedure: Review test and exam results					
Provide pre-service education/obtain consent					
Follow-up phone calls & prescriptions					
Other Clinical Activity (please specify):					
End:When patient enters office/facility for surgery/procedure					
SERVICE PERIOD					
Start: When patient enters office/facility for surgery/procedure					
Pre-service services					
Review charts					
Greet patient and provide gowning					
Obtain vital signs		10		10	
Provide pre-service education/obtain consent					
Prepare room, equipment,supplies					
Prepare and position patient					
Sedate/apply anesthesia					
Intra-service					
Assist physician during exam					
Post-Service					
Monitor pt. following service/check tubes, monitors, drains					
Clean room/equipment by physician staff					
Complete diagnostic forms, lab & X-ray requisitions					
Review/read X-ray, lab, and pathology reports					
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
Coordination of Care					
Discharge day management 99238 --12 minutes 99239 --15 minutes					
Other Clinical Activity (please specify):					
End: Patient leaves office					
POST-SERVICE Period					
Start: Patient leaves office/facility					
Phone Calls		3		3	
End: with last office visit before end of global period					
MEDICAL SUPPLIES					
Equipment					
Exam table		30		30	

	99356 Prolonged physician service		99357 Prolonged physician service		99 Prolo physicia
LOCATION	In Office	Out Office	In Office	Out Office	In Office
GLOBAL PERIOD		XXX		XXX	XXX
TOTAL CLINICAL LABOR TIME	0.0	3.0	0.0	3.0	3.0
TOTAL PRE-SERV CLINICAL LABOR TIME	0.0	0.0	0.0	0.0	0.0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME	0.0	0.0	0.0	0.0	0.0
TOTAL POST-SERV CLINICAL LABOR TIME	0.0	3.0	0.0	3.0	3.0
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					
Office visit before surgery/procedure: Review test and exam results					
Provide pre-service education/obtain consent					
Follow-up phone calls & prescriptions					
Other Clinical Activity (please specify):					
End:When patient enters office/facility for surgery/procedure					
SERVICE PERIOD					
Start: When patient enters office/facility for surgery/procedure					
Pre-service services					
Review charts					
Greet patient and provide gowning					
Obtain vital signs					
Provide pre-service education/obtain consent					
Prepare room, equipment,supplies					
Prepare and position patient					
Sedate/apply anesthesia					
Intra-service					
Assist physician during exam					
Post-Service					
Monitor pt. following service/check tubes, monitors, drains					
Clean room/equipment by physician staff					
Complete diagnostic forms, lab & X-ray requisitions					
Review/read X-ray, lab, and pathology reports					
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
Coordination of Care					
Discharge day management 99238 --12 minutes 99239 --15 minutes					
Other Clinical Activity (please specify):					
End: Patient leaves office					
POST-SERVICE Period					
Start: Patient leaves office/facility					
Phone Calls		3		3	3
End: with last office visit before end of global period					
MEDICAL SUPPLIES					
Equipment					
Exam table					

	58 nged service	99359 Prolonged physician service		99360 Physician standby service	
LOCATION	Out Office	In Office	Out Office	In Office	Out Office
GLOBAL PERIOD	XXX	XXX	XXX		XXX
TOTAL CLINICAL LABOR TIME	3.0	3.0	3.0	0.0	0.0
TOTAL PRE-SERV CLINICAL LABOR TIME	0.0	0.0	0.0	0.0	0.0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME	0.0	0.0	0.0	0.0	0.0
TOTAL POST-SERV CLINICAL LABOR TIME	3.0	3.0	3.0	0.0	0.0
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					
Office visit before surgery/procedure: Review test and exam results					
Provide pre-service education/obtain consent					
Follow-up phone calls & prescriptions					
Other Clinical Activity (please specify):					
End:When patient enters office/facility for surgery/procedure					
SERVICE PERIOD					
Start: When patient enters office/facility for surgery/procedure					
Pre-service services					
Review charts					
Greet patient and provide gowning					
Obtain vital signs					
Provide pre-service education/obtain consent					
Prepare room, equipment,supplies					
Prepare and position patient					
Sedate/apply anesthesia					
Intra-service					
Assist physician during exam					
Post-Service					
Monitor pt. following service/check tubes, monitors, drains					
Clean room/equipment by physician staff					
Complete diagnostic forms, lab & X-ray requisitions					
Review/read X-ray, lab, and pathology reports					
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
Coordination of Care					
Discharge day management 99238 --12 minutes 99239 --15 minutes					
Other Clinical Activity (please specify):					
End: Patient leaves office					
POST-SERVICE Period					
Start: Patient leaves office/facility					
Phone Calls	3	3	3		
End: with last office visit before end of global period					
MEDICAL SUPPLIES Equipment					
Exam table					

		99420
	CMS CODE	Administration and interpretation of health risk assessment instrument
LOCATION		In Office / Out Office
GLOBAL PERIOD		XXX / XXX
TOTAL CLINICAL LABOR TIME	1130	16.0 / 0.0
TOTAL PRE-SERV CLINICAL LABOR TIME		0.0 / 0.0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME		15.0 / 0.0
TOTAL POST-SERV CLINICAL LABOR TIME		1.0 / 0.0
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		
Office visit before surgery/procedure: Review test and exam results		
Provide pre-service education/obtain consent		
Follow-up phone calls & prescriptions		
Other Clinical Activity (please specify):		
- Review/read X-ray, lab, pathology reports		
End:When patient enters office/facility for surgery/procedure		
SERVICE PERIOD		
Start: When patient enters office/facility for surgery/procedure		
Pre-service services		
Review charts		
Greet patient and provide gowning		
Obtain vital signs		3
Provide pre-service education/obtain consent		2
Prepare room, equipment,supplies		
Prepare and position patient		2
Sedate/apply anesthesia		1
Intra-service		
Assist physician during exam		
Post-Service		
Monitor pt. following service/check tubes, monitors, drains		
Clean room/equipment by physician staff		
Complete diagnostic forms, lab & X-ray requisitions		2
Review/read X-ray, lab, and pathology reports		
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		
Coordination of Care		
Discharge day management 99238 --12 minutes 99239 --15 minutes		
Other Clinical Activity (please specify):		
- Review history, systems, and medications		5
- Education/instruction/counseling		
- Coordinate home or outpatient care		
End: Patient leaves office		
POST-SERVICE Period		
Start: Patient leaves office/facility		
Conduct phone calls/call in prescriptions		1
End: with last office visit before end of global period		
MEDICAL SUPPLIES		
Standard E/M Supply Package		
Patient education booklet		1
Equipment		
Exam table		
Otoscope/ophthalmoscope		

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Peripheral Vascular Rehabilitation

Work Relative Value Recommendations

New code 93668 *Peripheral arterial disease vascular rehabilitation, per session* describes supervised, treadmill based programs of progressive limb exercise, with a subsequent transition to a home-based exercise prescription. This service is intended to treat patients with intermittent claudication, patients recovering from peripheral vascular surgeries or from peripheral angioplasty/stenting procedures. Currently, CPT does not contain an existing CPT code that accurately describes therapeutic vascular rehabilitation.

The RUC evaluated the survey results for new code 93668 *Peripheral arterial disease vascular rehabilitation, per session* and agreed that there was no physician work.

Practice Expense Recommendations

The RUC recommends that there are direct inputs for this service when performed in a non-facility setting. Specifically, the RUC recommends 20 minutes of RN/Exercise physiologist time for this service, as well as supplies and equipment as attached.

Medicine
Cardiovascular
Other Procedures

Peripheral vascular rehabilitative physical exercise consists of a series of sessions, lasting 45-60 minutes per session, involving use of either a motorized treadmill or a track to permit each patient to achieve symptom-limited claudication. Each session is supervised ~~on a one-to-one basis~~ by an exercise physiologist, ~~physical therapist~~, or nurse. The supervising provider monitors the individual patient's claudication threshold and other cardiovascular limitations for adjustment of workload. During this supervised rehabilitation program, the development of new arrhythmias, symptoms that might suggest angina or the continued inability of the patient to progress to an adequate level of exercise may require physician review and examination of the patient. These physician services would be separately reported with an appropriate level E/M service code.

● 93668	AA1	Peripheral arterial disease vascular rehabilitation, per session	XXX	0.00 No physician work

AMA/Specialty Society Update Process
Summary of Recommendation
000 Day Global Period

In Office Direct Inputs

CPT Descriptor: Peripheral Arterial Disease Vascular Rehabilitation, per session. Code 93668. Tracking number AA1.

Questions below are not applicable – survey was not conducted.

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

Tracking Number:_____ Reference Code 1_____ Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Patient orientation to the program. Completion of miscellaneous paperwork.

Intra-Service Clinical Labor Activities.

Supervision of patient during exercise session. Progressive conferences with patient. Discharge conference. Completion of report to referring physician.

Clinical Labor	Staff Type	Pre-Service Time	Service Period (Day of service)
RN/Exercise Physiologist	1033	5 minutes	15 minutes

The RUC assumed that this service is not performed with 1 to 1 supervision and agreed that the RN or exercise physiologist is typically supervising three or four patients. Each patient typically undergoes Peripheral Arterial Disease Vascular Rehabilitation for 1 hour.

American College of Cardiology
Revised
5/10/00

CPT Code 93668: Peripheral Vascular Rehabilitation
AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Medical Supplies	Quantity of Supplies	Supply Code
Razor, disposable	1	11104
Swab, alcohol	2	31101
Gauze, 4x4, non sterile	1	31501
EKG paper	1	71005
ECG electrodes disposable	3	71006

Procedure Specific Medical Equipment	Equip Code	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
Treadmill w/ECG monitor	E55020	varies	60	3**	$16,000
Blood Pressure monitor	E55006	varies	60	varies	$2,995

**Note: 3 sessions per week (for one hour each) per patient.

Overhead Medical Equipment	No. of units in practice	Equipment Code
Crash Cart	Varies	E91002
Defibrillator	Varies	E55001